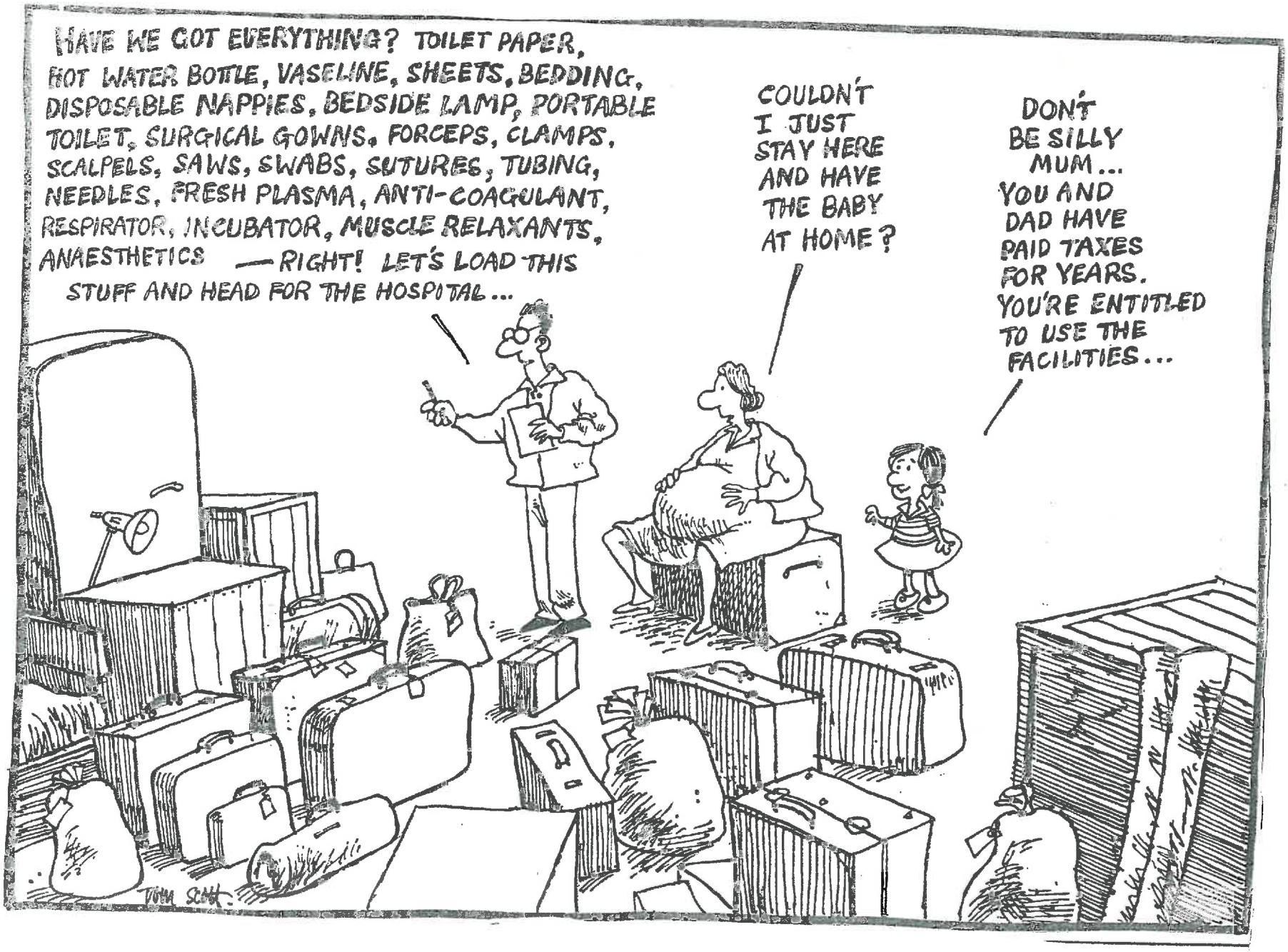

HAVE WE GOT EVERYTHING? TOILET PAPER, HOT WATER BOTTLE, VASELINE, SHEETS, BEDDING, DISPOSABLE NAPPIES, BEDSIDE LAMP, PORTABLE TOILET, SURGICAL GOWNS, FORCEPS, CLAMPS, SCALPELS, SAWS, SWABS, SUTURES, TUBING, NEEDLES, FRESH PLASMA, ANTI-COAGULANT, RESPIRATOR, INCUBATOR, MUSCLE RELAXANTS, ANAESTHETICS — RIGHT! LET'S LOAD THIS STUFF AND HEAD FOR THE HOSPITAL...
COULDN'T I JUST STAY HERE AND HAVE THE BABY AT HOME?
DON'T BE SILLY MUM... YOU AND DAD HAVE PAID TAXES FOR YEARS. YOU'RE ENTITLED TO USE THE FACILITIES...
TOM SCOTT

Upper Hutt residents lose fight to save Elderslea maternity wing

By LYNNE WALSH
Health reporter

Upper Hutt residents have lost their long battle to retain the maternity wing at Elderslea Hospital.

The 10-bed unit will be axed as part of the services slashed by the Wellington Area Health board in an attempt to meet its almost $17 million deficit.

The maternity wing is to be replaced by a birthing unit, described by board general manager Karen Poutasi as a home delivery service.

Women would come to the unit, give birth, and then return home in six to eight hours.

At Paraparaumu Hospital the 11-bed maternity unit is also to be replaced by a four-bed birthing unit.

The financially troubled board today finally approved its estimates after a day and a half of debate.

Health Minister Helen Clark has given the board until tomorrow to produce a workable budget, or faced being sacked, and replaced by a Government appointed commissioner.

Service cuts throughout the region have identified savings of $8.9 million but only $3 million can be obtained this year.

In line with the decision made at the board's September meeting, will use loan finance to bridge the deficit between the two years.

Some $4 million will be obtained through overdraft facilities, while another $4.7 million will be raised by a term loan to purchase equipment, which added to the expected $3 million saving this year, reduces the deficit to $11.8 million.

The board had agreed to use asset sales to fund redundancies estimated to cost $1.6 million.

The remaining $3.5 million of the defict has been cut by measures not revealed publicly because of "commercial sensitivity."

However, The Post understands the reduction in amount of land tax, and the recent agreement by health unions to accept a 2 percent wage settlement until June 1990 are among the factors involved.

The services cuts see surgical services centralised at Wellington Hospital with cuts to the outlying areas.

Geriatric services are to be leased out to private or voluntary agencies.

Opposition to the board estimates came from retiring board member Trevor Roberts who claimed inadequate figures and "soft budgeting" would mean the board would not be able to meet its budget.

The blunt fact was with the best will in the world the board had not made enough cuts to meets its statutory obligations.

He said he agreed the board was underfunded and under resourced but that was beside the point.

It had to tailor its estimates to meet its allocation.

Mr Roberts said the board was taking a punt on whether soft budgeting would catch up with the board this year or next.

"If it's this year it's egg on our faces. If it's next year it's eggs on the faces of the new board."

Only five of the 14 board members approving today's estimates were re-elected at last week's local body elections.

The new board does not take over until December, but will have to implement the decisions of the old board unless, of course, Ms Clark carries out her threat to sack the board.

Board member Doug Catley said he agreed some costs could be under-estimated in the figures but he believed there would be compensatory savings in other figures.

He believed if the board's revenues were professionally managed with some entrepreneurial skills for about another 24 months then the board should see itself in the clear.

Plea to keep maternity units

Proposals to close Elderslea and Paraparaumu hospital maternity units were criticised at today's Wellington Area Health Board's meeting.

The board held a special meeting today to approve estimates in order to meet Friday's deadline by which it must deliver a workable budget to Health Minister, Helen Clark.

Ms Clark has warned that if a workable budget providing a comprehensive range of services is not produced, she will appoint a commissioner to run the board's affairs.

The options being discussed today to meet a $17 million deficit in the board's budget involved centralising services at Wellington, and cuts to the outlying areas.

The operational plan produced today sees a net reduction in surgical beds of 66 and an increase in day surgery beds by 20.

Kenepuru is to lose 30 surgical beds and get 15 day surgical beds.

Hutt Hospital will lose nine surgical beds and Wellington has also suffered a loss of 27.

In medical services Hutt Hospital will lose 10 beds.

In obstetrics there is to be to-tal regional reduction of 25 beds.

The plan recommends the 10-bed Elderslie maternity hospital to be replaced by a birthing centre.

Paraparaumu maternity unit should become a birthing centre closing all 11 in-patient beds.

Upper Hutt Mayor Rex Kirton asked the board to retain Elderslea. Closure was an extreme step which would recoil on the board, he told board members.

Elderslea Action Group spokeswoman Mrs Gail Stevens challenged the board's costings. She said the reported cost of $150,000 to establish the birthing unit was a gross underestimate.

Baby boom hits Levin

Otaki doesn't have a corner on the baby boom — the Levin Maternity Hospital has also been joining in the fun and games.

Not to be outdone by the Otaki Maternity Hsopital, which produced six babies in 16 hours last month, yesterday four babies were born within 16 hours of each other at Levin.

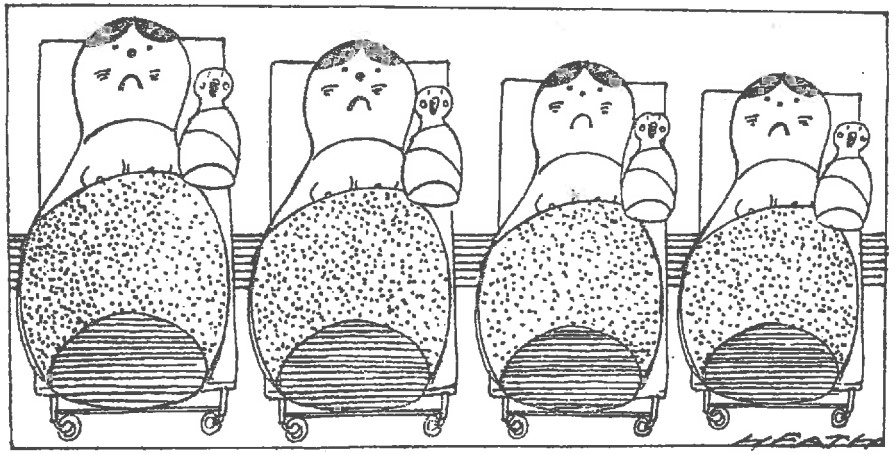
Acting principal nurse Peggy Taplin said it was the first time in almost 10 years that four babies had been born on one day, let alone in 16 hours.

The occasion would go down in history and certainly would not be forgotten in a hurry, she said.

Jane Kay (left front) and baby Matthew, first at 12.15am, Ginny O'Connor was third with her as yet unnamed baby boy at 7am, Ellen Renata was last to bring Christopher into the world just before four in the afternoon while Leighanne Verrent (right front) gave birth at dawn to the only girl, Sarah, at 5.50am.

The run-off-their-feet staff look on (left to right) Steve Norris, acting principal nurse Peggy Taplin, Paul Tapling, Janet Gillard and Wendy Devlin.

Soviet hospitals shock child-care experts



WILLIAM MILLINSHIP reports on the Soviets' "outdated, cruel" obstetric practices.

IT IS cattle-market obstetrics, according to Sheila Kitzinger, anthropologist and child-care specialist, who was describing what she had just seen of the Soviet way with childbirth in Moscow National Health hospitals.

Wendy Savage, senior lecturer in obstetrics and gynaecology at the London Hospital, was with the same group of British doctors and specialists. She agreed that on this evidence the Russians were 25 years or more behind Britain — she was reminded of an article in the *Lancet* in the 60s by paediatrician Norman Morris about human relations and obstetrics, "where he talked about women being left alone and the abrupt manner of midwives".

Women she had seen in the Moscow hospitals were just "bodies on the bed. The babies were forcibly removed from them. To us it was quite horrific, because we've mostly forgotten how that was in Britain".

She described a Caesarian section in Moscow when "a huge paediatrician (male) like a bear" ignored British suggestions that the mother might like to see the new baby. Instead, "he picks it up in one hand, throws it into the incubator and wheels it out".

Sheila Kitzinger says of the same delivery: "He let us see the baby for a moment, but the mother didn't see it, although she had had epidural anaesthesia. The handling of the new-born is very violent." She added: "And women are shaved — bald as boiled eggs."

Savage commented: "That's what we used to do. I remember the feeling as the hair grew back — itchy, itchy, itchy for ages." Kitzinger reports seeing a new-born Russian child turn blue after being washed under a cold tap. She has learned that the Soviet perinatal death rate is 22 per thousand, compared with 9.7 in Britain.

Speaking with great warmth and expressive gestures, Kitzinger described how Russian women laboured on narrow beds in communal rooms behind "great big windows, as if in a shop window. The staff and visitors like us can just watch women in agony, writhing around on the beds and screaming. You see a nurse or midwife pat them on the arm and say what looks like 'It'll soon be over — shush.' The message, I suppose, is: 'Be a good girl, don't let Russia down.'

"Then, when they go into the second stage of labour, they move to a high delivery table, flat on their back, with just a little cushion under head and shoulders. And they are told: 'Push, push, come on, Irina, push.' As soon as the midwife or doctor, usually a woman, can get her hands on the baby, it is forcibly extracted. There is no question of a baby swimming out of a woman's body."

After a normal birth, the baby is shown to its mother just long enough for her to see its sex. Then it is taken away while she recovers — usually in a corridor. "You see pale-faced, sad-looking women lying absolutely still with ice-packs on their tummies — the idea is that the ice will make their uterus contract."

The baby is treated, Kitzinger said, speaking as an anthropologist, as if it is the property of the hospital until certain rituals have been performed. "I think the raw little creature that has just emerged is not regarded quite as a human being. It's only when the mother has waddled it under a nurse's supervision that the baby becomes a person. Until then it's handled very much like a hunk of meat."

The visitors were dismayed at how long Russian mothers had to wait before they were allowed to hold their babies: two to four fours after a normal birth, several days after a Caesarian. Savage, who had spoken to Russian women about this, had no doubt that they would have preferred to have their new-born babies with them. "Women are the same. Russian women are not different. Our midwives in the 50s used to say: 'Mothers are too tired after labour, they'd must prefer their babies to be in the nursery.'"

Was there any sign of a Russian women's revolt? Kitzinger said: "It's quite obvious thing are going to change, but at the moment I don't get any sense of an emerging woman's movement. It's been a terribly closed society for many years. Women don't know what is possible." □

London Observer

Early-release mothers short on basic skills

By DEBORAH McPHERSON

Women lacking mothercraft skills and having difficulty in breast feeding are problems encountered by midwives as a result of early discharge from Christchurch Women's Hospital.

The Nurse Maude District Nursing Association's chief executive, Mrs Anthea Bowden, said its midwifery services had been under increasing pressure for two years.

The midwives were finding they had to spend more time on their visits with mothers just out of hospital.

Mrs Bowden said she was not casting aspersions on the policy of early discharge. It was fine as long as there were the resources, either in the community or hospital, to meet the needs of mothers.

If the trend to reduce stay at Christchurch Women's continued, increased resources for care in the community were going to be needed.

The association has written to the Canterbury Area Health Board pointing out its increasing workload with mothers and among discharged dependent and disabled people. It awaits a reply.

Nurse Maude provides specialist nursing, district nursing and domiciliary midwifery services on behalf of the board.

Its five midwives, one full time and four part-time, make 125 visits a week to mothers recently out of hospital.

Mrs Bowden said women needed to have confidence in caring for and handling their baby. This might not be established after three days in hospital.

An independent midwifery service providing free home care for mothers after early discharge is astounded that it has been refused permission to advertise at Christchurch Women's Hospital.

One of the service's midwives, Mrs Norma Campbell, said its service was part of the free public health service with the potential to help alleviate the constant pressure on beds at the hospital, she said.

The five midwives who run the service are paid by the Department of Health to provide care for mothers who opt out of hospital early after delivering their babies and need follow-up care at home.

"We are contracted to the Minister of Health and the Health Department is happy that we provide a good service for mothers, which is why it pays us."

Mrs Campbell said she understood the board had a policy of not allowing any general practitioners to advertise there, but mothers were legally required to go to doctors during a pregnancy.

"We are advertising a service, rather than individual practices," she said.

"Women should at least know what their options are, but many are unaware of the service."

The midwives were refused permission to put up a notice in the antenatal and parent-craft classes.

Legislation was expected to be passed in June which would allow midwives to legally take care of mothers who wanted it from the beginning of the pregnancy through to delivery. At present a doctor was required to be present.

The board's manager (secondary care), Dr Winston McKeon, could not be reached for comment yesterday.

Incontinence fact of life for many women

Contrary to popular belief, incontinence or the loss of bladder control — often referred to as "life's best kept secret" because it is so common — is not a problem confined to the over-65 age group.

A study conducted in Dunedin last year found that 31 per cent of women over the age of 18 experience some degree of incontinence — 17 per cent of those are affected regularly.

"Essentially we found that it is a common, yet under-reported problem," says Dr Don Wilson, senior lecturer at the Department of Obstetrics and Gynaecology at Otago Medical School who has been researching incontinence for the last 10 years.

"Only one third of those affected sought medical help — the remainder did not see incontinence as abnormal, or believed treatment would not help."

Dr Wilson's survey of more than 850 women in the Dunedin area, aged 18 years and over, provides some indication of the prevalence of bladder problems amongst New Zealand women. It also revealed the need to encourage sufferers to seek help, rather than feel they are alone in their dilemma.

"We need to educate young women and teach them how to prevent developing incontinence," says Dr Wilson.

"We also need to make them aware that there are a number of simple treatments available if they do need help, and not to feel embarassed to seek advice."

Most common is "genuine stress incontinence" leading to an involuntary loss of urine during any physical effort, such as exercising, coughing or laughing, which increases intra-abdominal pressure.

Pregnancy is considered to be a major cause of stress incontinence. Simple treatments such as pelvic floor exercises have proved to be successful in the past.

Dr Wilson has recently been studying the use of vaginal cones to help women identify and strengthen the muscles of the pelvic floor. Cones are weighted and as the muscles get stronger a heavier cone is used to further strengthen the area.

"If exercises alone are not enough, surgery to support and reposition the bladder can be performed with excellent results," he adds.

More common in older women, but still affecting females of all ages, is "urge incontinence" which involves the urgent need to pass urine, but the inability to control the release of it.

"The bladder muscles just contract involuntarily and treatment is by way of drugs which control the muscle contractions," said Dr Wilson.

Bladder retraining, whereby women are taught to consciously control the passing of urine, is also a successful method of treatment.

In the past, there had been a lack of suitable incontinence products available in this country, especially for younger women.

"Many sufferers rely on using sanitary pads which are not designed for that purpose, or they have had to rely on wearing bulky, unattractive undergarments not at all suitable for an active lifestyle," he says.

A new range of relatively fashionable and certainly more socially acceptable underwear has just been released and the garments are available to sufferers through Fisher and Paykel Home Healthcare Centres (a chain of independent health dealerships established last year) throughout the country.

Dr Wilson says the garments were most suitable for younger women in particular, especially the "mini" style and gave them far greater freedom to enjoy a "normal" lifestyle.

Electronic fetal monitoring criticised

NEW YORK

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

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

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

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

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

"Several years ago we published a paper about complications of early amniocentesis. We have met severe and open criticism — complications like these could only occur with inferior techniques used by bad doctors."

Dr Treffers says checks on performnacne were needed for all, midwives and obstetricians.

He favours compulsory national registration of births. It has been done voluntarily, with obstetricians registering 70 to 80 per cent of their deliveries and midwives a higher percentage.

Emphasis on problem solving, communication and constructive criticism are the basis for midwifery training at the St Elisabeth Clinic, says Ms Elinys.

A new system of training began with changes to the way problem pregnancies are selected by midwives.

Dutch midwifery training is aimed at preparing the midwives for independent practice.

There is competition for places in the three-year course and it is very hard for nurses to get admitted.

Midwife campaigner Ms Astrid Limburg comments: "Women who train as nurses have learnt to become a part of the hospital hier-

In Deventer the older generation of Turkish immigrants preferred home deliveries but younger women now see this as old-fashioned.

In rural communities home birth has tended to hold out more strongly.

In Amsterdam Dr Treffers reports a new trend.

He says research has found a major difference between women preferring home and hospital births in Amsterdam.

Those choosing home births were older, more educated with better paid jobs and more status in society.

These more educated, independent women are also preferring to have vertical deliveries more often.

Vertical deliveries were introduced to Amsterdam by midwife campaigner Ms Limburg.

Dr Treffers says women choosing to deliver babies in his hospital were often immigrants. They came from Africa, Pakistan, India and Indonesia.

"These people like to deliver in hospital because in their own country delivery at home is something only the poor do."

Jan 30 Nelson Evening Mail

Emphasising home birth as normal and healthy event

SO MANY Dutch babies being born at home means women can see pregnancy and childbirth not as illnessess but as normal events, says a Dutch professor in obstetrics and gynaecology.

Professor Pieter Treffers, head of obstetrics at a major Amsterdam Hospital, the Academical Medical Centre, says if hospitals are the only birthplaces an unhealthy impression is created. Birth is seen as something like an operation.

He is an influential figure in Dutch medicine as his department is part of the University of Amsterdam and medical students are trained at the hospital.

Here they work alongside midwives. In some medical training hospitals in Holland midwives are absent.

The full range of births from normal to the most difficult are dealt with. Medical students can also volunteer to spend time working with an independent community midwife at the end of training, so seeing home births.

The professor is a striking character. He comes across as remarkable for his ability to objective open criticism of his own profession, along with midwives.

"It may be important that normal pregnancies are under the care of a profession not entitled to interfere in normal pregnancy and normal labour because in the whole world the number of interventions is increasing." he says.

He cites Holland's low rate of caesareans and low use of pain relievers during labour as due to the influence of midwives and women's views of labour.

In a paper published in 1986 in the journal Hormones and Behaviour, Dr Treffers graphically describes a serious mistake he made in a foreceps delivery of a baby.

He goes on to challenge doctors to openly admit making mistakes.

"It is difficult, after having failed, to go back to the patient and to discuss it openly. Nevertheless, that is what the patient usually needs most and, truly, what the doctor needs himself."

In obstetrics Dr Treffers says both midwives and obstetricians have confidence in their management of deliveries.

This attitude will not do too much harm if they stick to selected patients — low-risk pregnancies for midwives and high-risk for obstetricians.

Obstetricians who are not critical of themselves are in danger of performing more and more unnecessary interventions, says Dr Treffers.

"The uncritical obstetrician will be convinced his therapy is effective because normal pregnancies usually children despite all the interventions by the obstetrician. ."

Dr Treffers says the medical specialists should also keep a critical eye on midwives and vice versa.

Obstetricians have to point out that problems should be recognised in time, and midwives remind them that sometimes more investigation and intervention is done than necessary.

A criticism of the Dutch system comes from obstetrician Dr Frans Roumen, who works at one of Holland's three training hospitals for midwives — the St Elisabeth Clinic in Heerlen.

He says midwives select normal pregnancies and refer on pathological ones but there is no requirement to monitor standards or give feedback.

"If there are problems with the delivery, the midwife may not tell anybody. No one has to check.

"Of course we think all of the midwives try to do their job as best they can but there is a problem in this system because everybody wants to have a good result — obstetricians, midwives, paediatricians, parents — and when the results are not as good as you want them to be you can do two things, talk about it or not talk about it."

For midwives working alone it is easier to fudge the results, he says.

But a midwife tutor at the clinic, Margot Elinys, says more and more midwifery graduates are working in group practices. About 8 per cent work solo.

She says there is feedback from colleagues. Obstetricians are in the same position at deliveries — with only assistants present.

Dr Roumens also cites doubts that all midwives bring babies with low birth weights into hospitals for checks, that midwives underestimate blood loss during labour and that perinatal mortality rates are underestimated in Holland because both obstetricians and midwives do not always record them if parents want to avoid the expense of burying their baby.

Ms Elinys says: "Whatever it is there will always be people who work with the rules and try to do a good job ... and you always have a group who do not.

"I do know that obstetricians see just our mistakes and that gives them the wrong impression of our work."

But Dr Roumens says mistakes are not the problem. It is when midwives are conscious of mistakes but put them aside which concerns him.

This was a point Dr Treffers made about doctors themselves. His 1986 paper noted medical literature was biased against reporting failures and complications. Only positive results tended to be written up for archy — a threat to the independence and strength of midwifery."

In a region of eastern Holland, Deventer, work of independent midwives in the community has been integrated more closely with the hospital system to attempt to overcome some of the communication problems.

Here complicated cases can be discussed by a team involving midwives or general practitioners and obstetricians.

When midwives or GPs do hospital deliveries they work as registered hospital staff members. Regular meetings take place to air problems.

There are about 155,000 people in the region. The city of Deventer is becoming industrial and has attracted workers from Turkey, Morocco, Spain and Italy. In the city about 50 per cent of deliveries are at home.

In the surrounding rural area between 50 and 80 per cent of deliveries are at home.

Deventer obstetrician Dr Jaap Schierbeek says: "In this region obstetricians and midwives get on well, but there are also regions where they don't talk to each other.

"When there is bad communication there is always trouble."

The Deventer team talks of problems in other areas and also in their own region of fierce competition between midwives and GPs.

Obstetrician Dr Bram Donkers says in some areas hospital specialists feel their hospitals become a "large dustbin" of problems when complicated deliveries are brought in at the last minute.

But Deventer midwife Ms Therese Hoorn says: "Because there is good communication (in Deventer) between midwives and doctors not many cases are sent at the last minute."

Different attitudes between midwife and obstetrician are still apparent here.

Ms Hoorn says: "Sometimes it's easier for us to go to the hospital for deliveries, but it's more cosy to do it at home. I like it more at home, but in hospital I admit it's easier for the midwife."

Dr Schierbeek says: "I see hospital as safer. I wouldn't be comfortable to do a delivery at home in a strange room."

Across cultures and regions in Holland variations in the home birth rate are evident.

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healthline

As winner of the 1989 Researched Medicines Industry Travelling Fellowship Nelson Mail health reporter JULIE SMITH (pictured right) visited Holland which has a unique system of obstetric care that attracts worldwide interest.

In this special healthline she reports on its home birth practice and talks to midwives and obstetricians there plus updates the New Zealand situation on home births.

Jan 30 1990 Nelson Evening Mail

Midwives lobby for NZ law change

A law change is currently under review in New Zealand which would enable midwives to practice independently.

President of the New Zealand College of Midwives, Ms Karen Guilliland, says the organisation is lobbying in favour of the law change.

At present the Nurses Act requires a doctor to take the final responsibility for deliveries.

In early November last year an amendment went through a first reading in Parliament removing the requirement for a doctor to take responsibility.

It is now being considered by the Social Services select committee with submissions closing on February 9.

Ms Guilliland says midwives are also trying to get a direct-entry three-year course in midwifery set up.

Irrelevant parts of nursing training would then be left out of a midwife's training.

Presently, midwives attend a one-year post-graduate course after qualifying as registered nurses.

Spokeswoman for the Nelson region of the college, Mrs Angela Kennedy, says a submission supporting the law change had gone forward from the Nelson members.

If the law change goes ahead it would have a more immediate effect on domiciliary than hospital midwives.

Spokeswoman for the New Zealand Domiciliary Midwives Society, Ms Bronwen Pelvin of Nelson, says some women in the Nelson region have problems getting a doctor to support their plans for home births.

In Motueka no doctors are prepared to attend or take responsibility for them.

Ms Pelvin publicly admits having attended a home birth 1988 without a doctor taking responsibility.

She says the law change would relive the situation for women wanting home births and also meant midwives would be able to give more complete care.

A member of the Nelson branch of the Home Birth Association, Mr Nigel Costley, sees the law change as a first step.

The home birth versus hospital birth argument is secondary, he says.

The most important issue is the right of women to make choices about the obstetric care they wanted.

Developing a system that gives better continuity of care is also important. He says it might take years to develop a new system.

The present system is fragmented because women are cared for by a range of people in hospital and after discharge, he says.

The law change could clear the way for women to choose to take out contracts with midwives who could provide pre-natal, delivery and post-natal services.

Opposition to the law change is being shown by some general practitioner groups, who are also using the argument for continuity of care.

One submission endorsed by the Auckland Faculty of the Royal New Zealand College of General Practitioners was published in a November issue of the New Zealand Doctor newspaper.

It said if midwives were allowed to carry out obstetric nursing without a doctor taking responsibility, it breached continuity of care and meant the patient had no one to turn to in an emergency other than the midwife she chose.

"We suspect few midwives would relish this responsibility but some may accept it, with possible dire consequences for mother and-or child."

It went on to quote a midwife's submission which said GPs should be available as a back-up and consultant for midwives when childbearing deviated from normal, physically or mentally.

GPs knew the families and were valued colleagues. Working together midwives and GPs could provide a very high quality of care and comprehensive follow-up.

In New Zealand in 1988 there were 515 home deliveries, according to the National Health Statistics Centre.

Another 77 were classified as not planned and for 24 it was not stated if the home birth was planned or unplanned.

Including these deliveries makes a total of 616 at home, while there were 55,771 hospital deliveries, meaning home deliveries made up a little over 1 per cent of births.

Nelson Evening Mail Jan 30 1990

As model or oddity Holland stands out

In Western countries birth is an event shrouded within the safe confines of hospitals and clinics. But one country stands out.

To some the large number of babies born at home in Holland sets it apart as a historic oddity; to others, it is a model over-medicalised countries can learn from.

Undoubtedly in Holland women are free to see birth through different eyes from their sisters across the borders. And the health system is forced to respect women's freedom to choose to a much greater extent.

In neighbouring countries around 99 per cent of births take place in hospital. In Holland around 35 per cent of births are at home.

The proportion has stayed fairly constant, increasing slightly since 1978, with a previous trend to hospital births having levelled.

Hospital births started to increase steadily from 1945. Not until 1971 were more than 50 per cent of deliveries in hospital.

An independent midwifery profession is the key to the Dutch system. It is supported by the Government, with protection, such as a decree in 1941, that women covered by the national health service get a midwife's services free — provided a midwife is working in her area. Her own family doctor is not paid for obstetric care.

There are also built-in backups, such as maternity aid nurses who help in home deliveries and after care in the home. This means new mothers can have help at home in the early days following the birth.

A complex list of selection criteria rates Dutch women's pregnancies as either normal (physiological) or having complications (pathological).

Under this revised system midwives are gaining more control over birth. They have the initial responsibility of deciding who comes into which criteria.

For women this means sometimes having to deliver in hospital under the care of an obstetrician. Sometimes if there are less serious complications, the midwife does the delivery — but it has to be at a hospital.

But for women with normal pregnancies there is a free choice whether they give birth at home or in hospital where their midwife can work independently — though the ability to choose is sometimes complicated by added costs for hospital births.

Of all births about 42 per cent are attended by midwives, 42 per cent by obstetricians and only 16 per cent by family doctors. For home births up to 60 per cent are attended by a midwife.

About 50 per cent of women start out their pregnancies opting for a home birth and midwife. Of these, complications or choice land some in hospital, leaving 35 per cent having home births.

At times a fierce debate rages between midwives and obstetricians — each trying to hold onto their positions in the ring.

It has also produced some other side effects — a low rate of caesareans, around 6 per cent compared with a soaring 25 to 30 per cent in the United States, and what a leading Dutch obstetrician calls a very low use of pain relievers in labour with about 5 per cent of deliveries.

One of the hot topics of debate is Holland's perinatal death rate. This is a widely used indicator of the outcome of pregnancy and childbirth and standards of care.

Holland leads with the world's lowest perinatal death rate for 25 years, some obstetricians are keen to point out. Now it has lagged behind, but the rate continued to drop from 13.9 per 1000 in 1975 to 10.0 in 1982.

One of the points of debate is over the reliability [illegible] perinatal mortality. the St Elisabeth Clinic, a training hospital for midwives, in Heerlen, reflect the concern of some obstetricians. He sees the system as something of an experiment.

He does not blame home birth for the perinatal mortality rate, but calls for better standards for registration of births.

"I think we can be very happy to live in this special country where there are very good social environments so we can have an experiment of this kind.

"It would be impossible in Spain, France or Sweden. Distances between home and hospital are far too great.

"In Holland it's always possible to be in hospital within 15 minutes, so when there are real problems you can come to the hospital."

Linking natural safe birth to women's independence

NATURAL safe birth goes hand in hand with autonomy and independence for women, says Astrid Limburg.

She is one of the new generation of Dutch midwives. In partnership with two other midwives her independent practice attracted about 350 clients last year.

She is a militant fighter for the midwives' role and works closely with prominent midwife Beatrys Smulders, vice-president of the Dutch midwives association (the Netherlands Association for Wise Women).

Through her practice about 90 per cent opt for home birth.

"A woman has to give birth where she feels safe, whether at home or in the hospital, because there she delivers best."

Limburg says: "The Government says if you are healthy it's very responsible and safe to deliver at home.

"If you want to deliver in hospital that is a choice but then you have to pay for the hospital room.

"I think this is a hideen persuader to give women self-confidence."

Within Limburg's practice the three midwives work a duty roster and every client sees each midwife.

In some joint practices the clients have their own individual midwife.

Limburg says in her practice the midwives are trying to make women self-confident and independent.

"Some clients ask if we will be on call when they are giving birth.

"We never say we will try to be there because that is making yourself too important.

"She has to know that she is doing the birth and that she can do it."

Limburg says there is an advantage in Holland where giving birth at home is an accepted option.

"Giving birth at home is a national asset and it's never gone away. It went down during the 1970s but never completely vanished."

Limburg describes the Dutch as having a "healthy doubt in medical omnipotence".

She tries to get across to women that a successful birth is not necessarily one without complication. But being in charge of the birth is important.

"You were in charge, you were doing the birth. It might have been an artificial birth with an obstetrician, but it's fantastic to see a woman working with an obstetrician — not having it done for her.

"She feels the same as a woman who has a natural birth because the baby wasn't pulled out of her — she pushed with the obstetrician."

She believes the Dutch midwife has been able to hold onto her position because obstetricians have always had to recognise her as an independent practitioner.

"Here in Holland, in a way, we are complementary."

There are midwives and maternity aid nurses working with women having normal pregnancies and births, and obstetricians and hospital staff working with women with complications.

Beatrys Smulders says the influence of midwives has meant hospitals have had to adapt their approach to women giving birth.

"The obstetricians have been influenced to meet the particular wishes of women in labour, and the result is that the doctors in Holland intervene less."

For Smulders and Limburg the fight ahead is to ensure home birth retains a place in Dutch obstetrics.

What is wrong with hospital births?

Smulders says: "For women, it means that they are always, and often unnecessarily, submitted to standard procedures.

"However flexible and open-minded the hospitals present themselves, invariably the woman in labour is turned into a patient and she loses autonomy, independence, self-confidence and strength — in short, qualities which are vital for effective contractions and, ultimately, for a successful, uncomplicated and safe birth. She unnecessarily becomes a risk."

Retaining home birth is the key to midwives wanting to maintain their independent status.

Smulders says if home births are prohibited, most midwives will lose their independence. With that would go specific skills, their reliance on nature and the capacity to differentiate high-risk from low-risk situations.

Midwives would be downgraded to obstetricians' handmaids.

She says most Dutch midwives work very long hours, for too little.

Little time is left to evaluate their work, to do research or contribute to the union of midwives.

This has led to some worrying trends for those pushing to maintain the independence of the profession.

Limburg says midwives are warned not to opt to do too many hospital births.

A midwife on duty in the weekend and wanting some free time might more easily refer a woman in labour to an obstetrician.

Some midwives refuse to do home births because they are more time consuming.

Limburg says hospital deliveries are easier for the midwife. All the equipment and materials are on hand and the midwife has the hospital back-up and therefore less responsibility.

The Dutch system has attracted a lot of interest from foreign midwives and obstetricians.

Limburg says the breakdown of European borders has encouraged many midwives to seek work in Holland.

As a member of the Commission for Foreign Midwives she is one of those debating the issues this raises.

She says the foreign midwives are not trained in selecting out physiological and pathological pregnancies — the essence of the Dutch system.

"Midwives are concerned there will be accidents and these midwives will not have the confidence to work at home — which is what the obstetricians would like — midwives at hospitals as handmaidens."

However, the foreign interest has also encouraged the Dutch home birth movement.

Smulders told a London midwifery conference in 1987: "We felt that everywhere in the Western world people were working very hard to get home birth accepted in their society again. This support has been an inspiration for our survival."

Nelson Evening Mail.

Keeping a birth in the f

Steve Attwood

Slice of life

The increasing trend for women to have their babies at home has attracted its critics.

Some doctors have questioned the safety of home births and mothers desiring them have been been branded as belonging to the fringe cultures of society.

But supporters of home births claim to be ordinary people. They discount claims that they are putting themselves and their babies at risk. They point out that having babies in hospital is a recent phenomenon whereas the practice of having babies at home has lasted for hundreds of years and is still a matter of course in many modern countries.

Women say that the comfort and needs of the mother and baby, and those of their family, should be paramount rather than what is easy or convenient for doctors and hospitals. They argue that with qualified oversight there should be no reason home births should not be safe.

The move is away from perceiving pregnancy as some sort of sickness and towards seeing it as a natural function that most women can experience without the need for any medical assistance, other than general supervision

profession. That experience is more than sufficient to deal with the 80 to 90 per cent of women who have a normal pregnancy and straightforward labour, she said.

"We do the same checks that they do at the hospitals and will quickly pick up on anything that might be going wrong which should be referred to a doctor or the hospital."

In addition, Jan points out that women are well screened so that those with potential problems are advised against having the baby at home.

Among the members of the South Canterbury Home Birth Association are many mothers who have had one child at hospital and others at home. They are unanimous that the home birth is the preferred option for a normal pregnancy.

The feeling in the group is that birth should be a natural and joyful occasion to be shared with the family as a normal part of life, not hidden away in the clinical environs of a hospital theatre.

The women reported feeling more relaxed at home, more supported because those they wanted could be there and they felt in control.

Some women chose only to have their husbands present, in addition to the doctor and midwife, others have successfully involved other family members, children, or close friends and report a joyful, very special, birth experience.

A beneficial side effect to home births is that sibling jealously is minimised.

"Mum isn't away for several days and she doesn't come home with a stranger. The children feel involved and can see mum straight after the birth if they haven't actually been a witness to it."

Another important consideration is the distance to maternity facilities for many rural women. Regular visits by men tied up with farming or operating a small rural business are often difficult or beyond their financial means and so the mother is even more isolated from partners and family. Home births mean family life is not disrupted and, as one woman put it: "It's great being able to snuggle up in your own bed, with your husband beside you, rather than be alone in a hospital bed."

Said Sandra Smith, area coordinator for the association: "At home you are in your own territory and you know no-one is going to make you do what you don't want to do. Often at hospi-

amily

tal women have reported being told to do things that are uncomfortable for them simply because it is more convenient for the hospital and/or the doctors."

Women in the group reported feeling pressured into taking pain killers, or of needing them because they could not relax in the unfamiliar surroundings. Most home births are accomplished without any drugs and the babies are reported to be better off for it, being born more alert, a better colour, and more relaxed.

The association points to New Zealand Federation of Parents Centre statistics which show that there have been very few problems with home births, the use of drugs and pain killers has been just about eliminated, and the incidence of post natal depression among home birth mothers is much lower than that experienced by mothers birthing in maternity hospitals.

An important point for mothers considering home births to realise is that it requires a more active participation in the pregnancy by both the expectant mother and her family. The mother must make sure she is healthy and maintains a reasonable level of fitness as this helps ensure a normal pregnancy and labour. The family, particularly the partner of the mother, must also be involved. The work, and the responsibility, cannot be abdicated in favour of some anonymous hospital doctor and staff.

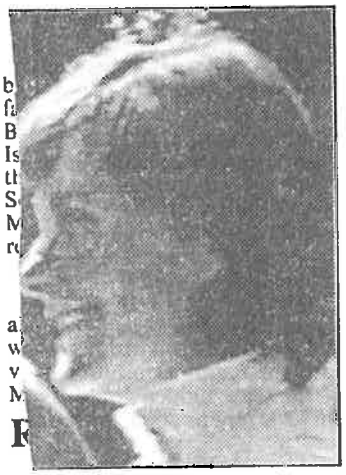
"For this reason," said Kate Elsen, a mother who recently delivered a son at home, "women who want home birth are not the hippies people perceive us to be but are usually well informed, well educated women who want to exercise a real choice and have some control over their own lives."

It is also one of the reasons why the home birth association was reformed.

"Women found that having a home birth in South Canterbury was difficult," Sandra said. "Some doctors would not co-operate or even advise women where they could ask for advice so they could make an informed decision. There are still only a few doctors who will attend home births, and some of them will only do so for their own patients. The home birth association gives women the opportunity to learn what is involved, who the midwives are, and which doctors are prepared to help."

"Increasingly parents believe that the environment for childbirth should be a personal choice, with the decision made by an informed mother."

aughter



Anzus withdrawal Pope's idea, says

Prime Minister Geoffrey Palmer yesterday dismissed suggestions that Margaret Pope, speechwriter to former prime minister David Lange, may have persuaded Mr Lange to raise the prospect in April of New Zealand formally withdrawing from the Anzus council.

Opposition Deputy Leader Don McKinnon asked in Parliament about speculation that Ms Pope may have contributed to the Anzac Day speech a section floating the prospect of withdrawal from the alliance.

Before delivering the speech at Yale University on Anzac Day Mr Lange had undertaken to give his

By Mike Munr
Wellington Corresp

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"I would say I feel it is necessary for people to live in Wellington, especially when you have children."

Lady Muldoon said she had three school-aged children when Sir Robert was Finance Minister, before becoming Prime Minister, and she learnt then the only way to cope was to be in the capital.

"That way the children can see their father at breakfast, and sometimes at dinner.

"You can also arrange for him to see them playing sport — sometimes not the whole game but, say, the last half-hour before he gets on a plane," Lady Muldoon said.

"It helps if you can have something like a normal family life.

"Otherwise, you are a solo parent, at least part time, and that is extraordinarily difficult.

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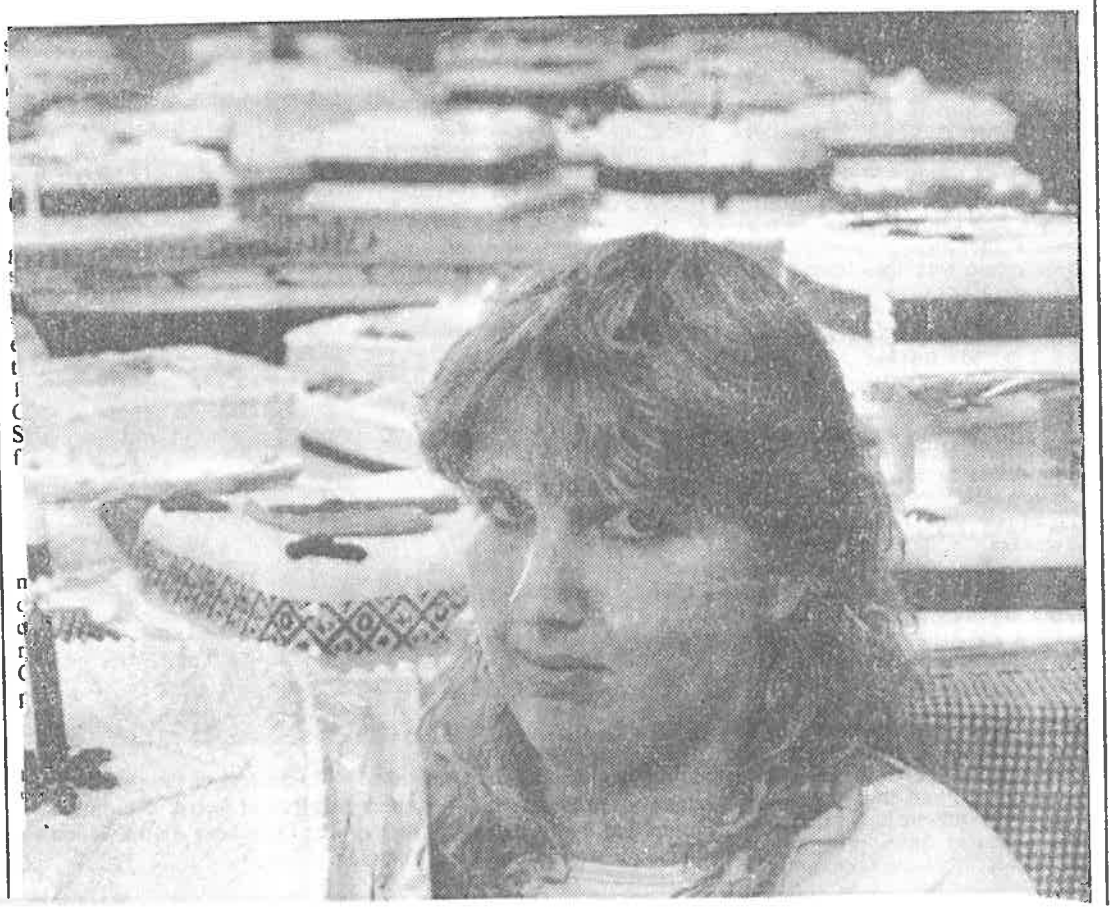

The Government has supported this move. Legislation recently introduced to Parliament by Health Minister Helen Clark will give midwives the right to take sole responsibility for the care of a woman and baby during childbirth. At present only a medical practitioner can take responsibility for a birth.

It is a trend that is strongly evident in South Canterbury where the centralisation of maternity facilities, a growing dissatisfaction with the clinical conditions of hospitals, and a desire by women to feel more in control, has resulted in a rapid expansion of interest in home births from women of all backgrounds.

Five months ago the South Canterbury Home Birth Association was reformed and its membership has grown steadily. A Christmas party scheduled in a few weeks is expected to be attended by some 35 couples, many of whom will have had more than one child at home.

Jan Morrison is one of the domiciliary midwives working in South Canterbury. She said the new legislation, which will allow her to practise on her own, will hold no fears for midwives.

Midwives have to be registered nurses, and then have several years maternity experience and specialist training on top of that before they can take up their

Happy mums and bouncing babes — just some of the growing number of South Canterbury women who have chosen to give birth to their children at home. The mums include those who have had all of their children at home, as well as others who have been disillusioned with hospitals and taken the home birth choice for second and third children.

Kitzinger is a born natural

By RUTH NICHOL

SHEILA KITZINGER'S first grandchild was born last year in a pool of water at her Cotswold home, attended by two midwives and Kitzinger herself.

Her daughter, Tess, swam about, dolphin-style, during the labour and floated around in the water clutching the waistband of her husband's jeans. It was a long labour — hardly surprising given that the baby was a hefty 4.8kg. But, as one would expect of a woman whose mother is at the forefront of the natural childbirth movement, birth was achieved with no medical intervention.

"It was really gorgeous," Kitzinger says. "We didn't have a doctor, and there was a lovely bond uniting all the women there."

No matter how gorgeous, water-birth is unlikely to be first choice for many women; most prefer to stay on dry land and the majority still opt to give birth in hospital rather than at home.

That's fine by Kitzinger. The author of the now classic Pregnancy And Childbirth (just re-released in New Zealand as The New Pregnancy And Childbirth), is often viewed as a natural-birth zealot who wants to see every woman giving birth at home, and stoically refusing any kind of pain relief.

In fact, she has no problems with children being born at hospital — "Good heavens, no," she exclaims in her clipped English accent — nor with the use of pain-killers or of other medical intervention when necessary.

"There's no one right way of giving birth," she says. "I would support a woman in what she wanted. I've had women who decided with their obstetricians that they wanted an epidural almost from their first pain, and if they come to my classes I ask them to play it by ear. I will try and help them with skills to help with the pain, and they can decide to have an epidural at a time that seems right to them."

What matters is a woman's right to make her own, informed, decisions about birth rather than having them thrust upon her by doctors. She talks not of natural childbirth — "No birth is natural, if you mean that it's unaffected by culture" — but of autonomous birth. Assertiveness training is an important part of her child-birth classes.

An imposing woman with a throaty laugh, Kitzinger's own four labours were enviably easy: the shortest was a mere 40 minutes — "I wanted to tuck the baby back inside again," she

She clearly has no need of any assertiveness training and has for years been a spirited critic of the way in which male obstetricians have come to dominate birth. While they may justify their involvement on the grounds that it improves infant mortality rates, Kitzinger argues that the reduced mortality rate this century is largely the result of factors such as better nutrition, better education and better health.

"I think the contribution made by obstetrics is minimal. For babies at risk, babies born prematurely, it's the good neonatalogy which is important, the good pediatrics. It's obstetricians who hand over babies born too soon because they induced them or performed caesarian sections to get them out, and it's the neonatalogists who have to pick up the problems."

Kitzinger traces the beginnings of the male takeover of birth back several centuries, to the time when male midwives were called in to crush or dismember babies to get them out during an obstructed labour.

"They have always been the technicians of childbirth, they came in with the instruments of one kind or another. They were the first to introduce forceps and they kept them secret for 100 years."

A lot of 20th century obstetric practice resulted from the experiences of male obstetricians working with women in charity homes and poor houses.

"They developed a great many interventions which then became an established part of maternity care, like shaving the perineum — they did it because these women had lice in their pubic hair. Then they just stayed, even though women no longer had lice."

Many modern hospitals have now abandoned practices such as routine shaving and enemas — a change Kitzinger attributes to women's refusal to accept them any longer.

"When I rewrote Pregnancy And Childbirth I found a great many things had changed, and also that women had found a voice and were speaking out, wanting a dialogue with their caregivers, and that makes a tremendous difference, that's the beginning of a revolution."

But what she calls the medical control of birth continues. She believes that a lot of modern obstetric intervention can actually cause complications which necessitate further intervention. labour can produce very powerful contractions which interfere with the blood flow to the uterus and cause fetal distress. That in turn makes a forceps delivery, with an accompanying episiotomy, more likely.

Even in normal labour the likelihood of an episiotomy is increased by the way in which the second stage is managed. Forcing women to hold their breath for long periods or making them push on command can lead to fluctuations in the baby's heart rate, making a rapid birth necessary — and thus an episiotomy.

However, it is important to remain realistic about the possibility of unforseen complications. Kitzinger likens labour to setting off on a tramping expedition.

"You make provisions in case things are not straightforward and easy — perhaps the weather will change, for example. It's exactly the same in birth. You need contingency plans so that you know that if such and such a thing happens, your preference would be to do this. But you don't just give up and throw in the sponge and hand it all over to someone else."

That means thinking beforehand about what you want to do if something does go wrong. "It's very good to have a support person with you, usually your partner, who knows how you feel about these things. It's important to have discussed them together beforehand."

Even if an emergency caesarian is necessary, for example, a woman still has the right to ask if she can have an epidural rather than general anesthetic, so that she can at least witness the birth and touch the baby once it is born. If a general anesthetic is unavoidable, she can ask that her support person be allowed to welcome the baby for her.

Kitzinger is heartened by the changes which are occurring in many hospitals, but says that the battle is by no means over.

"A great many hospitals all over the world still put women on conveyer belts, and a great deal of institutional violence is done to women."

She has recently started a network of birth crisis counsellors in Britain, similar to rape crisis counsellors, for women who have had bad births, and is currently carrying out research on the long-term impact that bad birth has on women. Initial results suggest that many feel violated by the experience.

"We've found that women are using the same language for rape as they do for childbirth in which they have been dis-

Mums take merits of cabbages to heart

CABBAGES are not only used in coleslaw at Huntly Maternity Hospital. Staff have discovered they can also help women recover from childbirth.

For the past three weeks nurses have been putting chilled cabbage leaves on women's breasts to help relieve pain and swelling when they start producing milk.

Leaves are also used on the vagina to help ease bruising after an episiotomy (a cut to the vagina) during delivery.

Acting charge nurse Colleen Yorwarth said the hospital started using cabbage leaves after charge nurse Jan Trass read about their soothing properties.

"For a long time we have used ice. That does help, but now we have discovered cabbage," Mrs Yorwarth said on Friday.

She said the hospital has had to increase its cabbage supply.

Two women have been treated with cabbage leaves so far. The leaves are applied to the breasts under a bra and are replaced after every feed or when they become too warm.

Both women had said the leaves were soothing. Now two new mothers in the hospital are thinking about using leaves once their milk comes on.

The idea seems to be catching on. Waikato Women's Hospital nursing supervisor Pat Oettli said a woman had brought a cabbage along with her when she was admitted to give birth.

Raw cabbage contains about 20 different vitamins and minerals, including large amounts of Vitamin B.

Hamilton naturopath Paul Hume said it also contained Vitamin U. This helped in healing and was used to cure stomach ulcers.

Vitamin U also had a drawing action which could help breasts swollen with milk, he said. NZPA

Sue Kedgley — delighted to be a 'domino' mother

Sue is one of the first Wellington women to take advantage of a new scheme aimed at giving mothers the best features of both home and hospital birth. Pam Neville reports.

WELLINGTONIAN Sue Kedgley, known as a feminist leader in the '60s and 70s, and more recently as a television presenter, is one of the first customers of a new "domino" midwifery scheme.

Sue and husband Denis Foot are the proud parents of Zackary Bailey Kedgley-Foot, born during an early morning stop-over at Wellington Women's Hospital on Anzac Day, this year.

Zackary was delivered by Wellington midwife Carey Virtue under a scheme she believes gives mothers the best of both homebirth and hospital birth.

A mother who chooses a domino birth gets to know her midwife during pregnancy. She is supported by the midwife at home throughout labour and then goes to hospital where the same midwife delivers the baby.

Within a few hours of the birth, mother and baby go home. The midwife initially visits twice a day, then less often to a total of 12 visits to advise and help the pair. She is also on call during that post-natal time.

"The domino scheme worked brilliantly for me," says Sue.

"I wasn't prepared to have a homebirth, especially as I was having my first baby at 42, but I had all the advantages of being at home combined with the hospital for pain relief and medical back-up."

The first five hours of Sue's labour were spent at home with her support team — Carey, Denis, and Sue's friend Pamela Meekings-Stewart.

Sue listened to music and relaxed in the bath. When, at 3.30am, she decided she needed pain relief, the four went in convoy to the hospital.

Two hours later, after a shot of pethadine and a stint in the hospital's spa bath, Zackary Bailey was born — a little too quickly for Sue's obstetrician who arrived soon after the delivery. (Under the current law, midwives deliver babies under the supervision of a doctor, but this will become optional if an amendment to the Nurses Act is passed by Parliament.)

A few hours after Zackary's birth, mother, baby, father, friend and midwife left the hospital. Sue says she has felt "extremely well" ever since. Having two visits a day from midwife Carey in the first week after Zackary's birth, provided Sue with all the confidence and support she needed in caring for her baby.

"First-time mothers are often fixated on the delivery and worry about whether the doctor will be there," Sue says.

"But the key time is the preceding six or 36 hours of labour when you need emotional and psychological support. During that time it's so much more pleasant to be at home with an expert midwife and people you are close to."

Going straight home after the birth worked well for Sue, but she warns that a good support system is needed in the early days.

"I'm not sure I'd want to come straight home if I had other small children to look after."

The "domino" scheme is named after a system which operates widely in England. The word is an acronym of the words "domiciliary" and "in and out". A domiciliary midwife works in the patient's home. In and out refer to a brief visit in hospital.

A domino scheme has been operating successfully in Whangarei for more than six months. The Wellington scheme is the first attempt to use the method in a big metropolitan centre with the support and funding of a major area health board.

The domino scheme is an alternative to hospital care, not a replacement, and is paid for by the area health board and the Health Department. Under present law, the state pays for only three ante-natal visits by a midwife so the pregnant woman must also receive ante-natal care from a doctor. The proposed law before parliament will allow midwives to be solely responsible for ante-natal care and for delivery, and will also give doctors and midwives the option of sharing the work.

Carey Virtue believes this option of sharing care between the midwife and doctor will be initially most popular. Rightly or wrongly, women feel more secure knowing their doctor will attend the delivery of their baby, even though midwives will be legally able to work alone.

"Autonomy for midwives is an important recognition of our professional skills and something we have sought for a long time. However domino midwives will happily work alongside the woman's doctor if that is her choice.

"The main purpose of the domino scheme is to offer mothers having hospital births the same caring service homebirth mothers have," Carey says.

"If women in labour are in their home enviroment with people they know and trust they will labour better and have fewer birth complications.

"World Health Organisation figures show that 85 percent of women should be able to deliver babies normally, without medical intervention. Yet in our big hospitals about 40 percent of mothers have epidural anaesthetics (which often lead to medical intervention such as forceps delivery) and 13 to 15 percent have caesarians."

Carey believes the system of

ABOVE: Sue Kedgley, domino midwife Carey Virtue and Zackary Bailey Kedgley-Foot. The domino midwife calls twice daily after the birth to help care for mother and baby at home.

RIGHT: Sue with 11-day-old Zackary. "The domino scheme worked brilliantly for me."

FAR RIGHT: Carey Virtue... a myth that mothers need to stay in hospital for a rest. Photographs: Barry Durrant.

home care from a midwife throughout a woman's labour reduces the rate of medical intervention. But she also says the domino system is not for everyone. For some women and babies, a stay in a hospital maternity unit with staff available around the clock is the best option. For others, a homebirth might be best.

To date, the domino scheme in Wellington is restricted to the southern suburbs where, Carey says, many mothers have large extended families for support. Another noticeable trend is that unemployment is keeping husbands and partners at home and they can offer the necessary home support.

"There is a myth that mothers need to stay in hospital for a rest. Many mothers will tell you that sharing a room with other mothers and babies in a large, noisy hospital ward is far from restful," Carey says.

The domino scheme is run with the blessing of the Wellington Area Health Board which has seconded Carey Virtue from her position as a charge nurse in the Wellington Women's Hospital delivery suite. Carey is now delivering about two domino babies each week and increasing demand means she will be joined shortly by two more midwives.

The appeal of the domino system during labour is clear. At present women in labour arrive at maternity wards with no idea which midwife will care for them. Often they are just beginning to trust their midwife when she is replaced by another midwife because of the shift work system.

In the post-natal area, continuity of care is also difficult to provide, although maternity wards, unlike domino schemes, have the advantage of staff on hand at all hours to advise and help mothers.

Mothers who choose the homebirth option do not have the problem of ever-changing staff, but the majority of mothers prefer or are advised to give birth in hospital. For those who feel no need of 24-hour hospital care after the birth, the domino system is a half-way house.

Hospital and homebirth midwives and most doctors support the domino system, Carey says. But she understands why some doctors feel "a little threatened" by the proposed amendment to the Nurses Act and the greater freedom it gives midwives.

"Doctors still need midwives, but midwives don't necessarily need doctors in a normal delivery."

The other bonus of domino maternity care is financial. Hospital boards around the country may be keen to support domino midwives because the scheme allows patients to be discharged after a few hours rather than after several days. Paying domino midwives to operate throughout the community is probably cheaper than keeping new mothers in hospital.

"The Wellington Area Health Board sees us fitting in with their goal of providing primary health care — and it doesn't cost them any more," Carey Virtue says. ●