Health board asked to think again

Wellington area health board members are being asked to look again at plans to reorganise hospital maternity services in the region.

Wellington Maternity Action is concerned that in order to maintain maternity services at Paraparaumu and Elderslea the board will now make compensatory cuts at Wellington and Hutt maternity units.

Wellington Maternity Action was formed 12 months ago because of dissatisfaction over conditions at Wellington Women's Hospital. It widened its brief in April this year because of the change of administration from hospital to area health board.

Barbara Johnsen, spokeswoman for Maternity Action, says the board has as an option the closure of a maternity ward at Hutt Hospital along with the closure of the Elderslea Maternity wing.

This would place intolerable pressure on the one remaining ward at Hutt and would leave the Hutt Valley grossly under serviced in the maternity area, Maternity Action says in the submission.

Says Barbara Johnsen: "In these circumstances, our calculations show there would only be 25 post-natal beds available for an area from Wainuiomata to Upper Hutt.

"We believe this would mean women and their babies would be discharged early, 24 hours after the birth. In the Hutt Valley at present there is one community midwife working part time, 30 hours a week, to follow up all the mothers sent home. If they are discharged early they and their babies need to be visited at least once a day."

In their submission, Wellington Maternity Action says it feels that while an early discharge should remain a choice for women it should not be an enforced policy.

According to the submission: "Closure of a ward at Hutt Hospital on the basis of a policy of forced early discharge is ludicrous and totally unacceptable in view of the woefully inadequate community support services available at present."

The group is concerned that if one of the two remaining post-natal wards at Wellington Women's could also be closed, this would place "intolerable pressure" on the remaining ward and leave the Wellington area grossly under serviced.

Maternity Action says maternity services at Hutt and Wellington Women's hospitals have already borne cuts. These include the closure of post-natal wards, reduction in staffing levels, axing of nurse manager positions at Wellington.

Barbara Johnsen says the area health board needs to look at the possibility of providing special birthing units for low risk births. "In Wellington, for instance, St Helen's, a custom built maternity unit has been standing empty for eight years."

Women asked to pay

By SARAH SANDS

A member of the Canterbury Hospital Board has called on Canterbury women to raise $125,000 for a breast screening machine.

Mrs Caroline Cartwright said that breast cancer was the most common cancer in women.

"If the women of Canterbury really feel strongly about this then I am sure they could do something to raise the money — it is in their own life interest."

Board members were told last month that the existing mammography machine, installed in 1977, was obsolete and a replacement unit would cost $125,000.

The chairman of radiology services, Professor Robin Gibson, said the existing machine could not detect fine calcifications in the breast nor did it allow for breast compression or magnification techniques, "all of which are now standard on modern equipment for diagnostic purposes."

Mrs Cartwright said the Timaru public had been asked to subscribe to a mammography machine for South Canterbury.

The new machine was necessary for diagnostic procedures but the $125,000 was a significant cost to a board that was underfunded, she said.

The chairman of the health services committee, Mrs June Gardiner, said a letter from the Cancer Society indicated there might be some funding for the mammography machine but it was too early to give details.

Further reports, page 3

Times 2·11·

Midwive sign contract

By Joelle Thomso

A new contract tween the Otago Health Board and Dunedin Domicil Midwives Collective given the midw rights to use hospita cilities and equipn previously unavail to them.

The contract was proved at the beginnin September, midwives lective member S Pairman said yesterday

Intravenous equipme monitors and the availa ty of an anaesthetist w among the facilities midwives were now abl use.

Some doctors might have realised the new c tract existed, but the m wives and good relati ships with the doctors t did work with, she said.

The move had "rea opened the door for m wives to have their o clients", and was probal the beginning of increas independence for midwi to practise without t supervision of doctors, Pairman said.

Under present legislati doctors must be present deliveries, but they are gi ing increased responsibili to midwives.

More choosing home births

PA Wellington

Overcrowded and uncomfortable hospitals could account for more and more women choosing to have their babies at home, the Home Birth Association says.

Last year, nationwide, 680 women had home births, nearly double the number five years ago.

Dr Wally Metcalfe, of Wellington, said home birth was becoming a preferable option for many women as the ability of local hospitals to cope decreased through funding cuts.

"Home-birth figures for no-intervention births are very good, whereas in hospital morale is low and it is a less pleasant environment for giving birth," Dr Metcalfe said.

The Home Birth Association said its statistics showed mothers who delivered at home had a very low incidence of post-natal depression.

A Wellington midwife, Judy Skinner, said home birth had many benefits for the whole family.

This is Home Birth Week.

Labour day 89
Ch-Ch Star

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

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

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

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

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

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

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

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

Patricia Johnston-Epiha
(Papakura)

BIRTH: WHO DELIVERS BEST?

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

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

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

Heather Sangster Smith
(Raumati South)

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

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

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

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

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

Rosalind Norrish
(Brooklyn)

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Lauris Edmond

BIRTH: WHO DELIVERS BEST?

I do not usually consider a lay publication the appropriate place to air medical matters, but if the facts reported in the March 26 *Listener* are a true record of the Gallagher case, one cannot help feeling appalled and moved to convey one's deepest sympathies to this unfortunate couple and to the medical and nursing staff involved. It is hardly surprising that women placed in such a situation may feel they have been denied any real say in decision-making, and choose, perhaps misguidedly, to have their next pregnancy under the total care and responsibility of a midwife, with a home birth, right away from hospitals, doctors and modern technology.

It was not that many years ago, before ultrasound and prostins, that most obstetricians would probably have adopted a conservative approach in such a case and allowed labour to start spontaneously. This often occurred quite shortly and proceeded to an uneventful delivery with a very low incidence of complications.

In those days I began to collect measurements of the fundal height of the uterus which led, in 1982, to the invention of an obstetric measuring tape as a simple aid in assessing the duration of pregnancy and the size and growth-rate of the infant. With the advent of ultrasonic foetal heart detectors and scanning machines, it seemed that the tape would no longer be of use (except perhaps in underdeveloped countries) because ultrasound was displacing accepted clinical methods of examination and being relied on totally.

As time went on, however, it became apparent that ultrasound diagnosis, depending on human application of high-frequency sound waves and interpretation of their echo patterns, was not infallible. There is thus still a place for routine clinical assessment, particularly regular measurement of the fundal height of the uterus. In general, clinical methods should be combined with scan findings in order to arrive at a more accurate diagnosis.

It is unfortunate that obstetricians, frequently overworked and stressed from the pressures of peer and media review and the threat of medico-legal claims, may take some action which can prove to have been unnecessary or incorrect. One can understand why it is felt that doctors interfere too readily with normal processes and should not employ modern methods of diagnosis and treatment.

Such critics overlook that, in the past, the incidence of complications, of maternal and foetal loss and brain-damaged infants, was so much higher when the pregnancy was left to Nature out of necessity. In fact, Nature also is not infallible. Turning the clock back is not the solution to many of today's medical dilemmas. Few today would seriously question the safety and value of the judicious use of, eg, sphygmomanometers, x-rays, cervical smears, and the many varied scopes, monitors, procedures and lab investigations, yet there was a time when each of these was considered an unsafe modern technological advance.

(Mr) J D Baeyertz
(Wanganui)

Please address letters to: **The Editor, Liste** reserves the right to edit, abridge or decline published only over genuine names: pen names (not for publication) must also be included. A te.

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specialists and health administrators I spoke with in each country I visited were happy with the midwife's role. There was no question that safety was being compromised in any way. The statistics confirm this. I believe midwife autonomy will provide a real choice for New Zealand women.—Yours, etc.,

CELIA GRIGG SOWMAN.
April 2, 1990.

most cases where the cord is around the baby's neck it can be slipped over the baby's head or shoulder. If this is not possible it is a simple matter to clamp and cut the cord. This does not require the presence of a doctor, but is a minor disorder that midwives deal with on a regular basis. In a significant proportion of births the doctor does not arrive until after the birth. Midwives are qualified to deal with complications such as haemorrhage and often have done so prior to the doctor's arrival. Haemorrhage is uncommon unless there has been some form of medical intervention, such as induction, augmentation or forceps delivery. — Yours, etc.,

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

Midwives

Sir,—With regard to the comments of Dr Lewis King, chairman of the Medical Association (April 2), in the case of complications occurring during birth, the doctor/nurse team he refers to is actually a doctor/midwife team. There is a considerable difference between the two. In

Midwife

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

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

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

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

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

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

Midwives

Sir,—Having just returne
from a tour of the Netherlands
Sweden and Denmark to stud
their systems of childbirth, I an
interested in the debate ove
autonomy for midwives. In hi
submission on the Nurses
Amendment Bill, Dr King men
tioned the importance of consid
ering complete systems of care.
agree with him. Each of the
countries I visited has better
statistics than ours, and all of
them have midwives as the
primary professionals caring for
women during pregnancy, child-
birth and the post-natal period.
None of these countries has a
"flying squad," even in the
Netherlands, where 37 per cent
of women give birth at home. In
these countries, G.P.s play a
minimal role in childbirth. If
there are complications, a
specialists is called. G.P.s have
very limited training in obstet-
rics and even less in the field of
normal childbirth. This raises
questions about the motives of
the Medical Association in ob-
jecting to midwives' autonomy.

"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 performacne 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-