SAVE THE MIDWIVES

17 SUMMER 88/89

CONTENTS:

A HIGHER AND MORE POSITIVE PROFILE FOR CHILDBIRTH AND MIDWIFERY CARE:

The encouraging number of childbirth activists visiting NZ to increase the awareness of womens inherent ability to birth competently and superbly when left to birth spontaneously without interference is a real strength for both the childbirth and midwifery movements.

Clearly the need for change within conventional obstetric practice is something which is being felt worldwide. Equally strong is the need for women to reclaim control of childbirth so the power, achievement and ecstasy of birthing is not denied them by reducing them to vulnerable victims of an insensitive and often invasive process.

Elizabeth Noble further challenges the role of childbirth education. Rather than telling women what to do and how to breathe.....she emphasises the inappropriateness of a shared reality where in actual fact all birth experiences are very different and the best preparation is to assist women to trust their body to allow themselves to let go during birth, permitting labour to take its natural course.

The challenge to midwives is to be able to accept a less active hands on role, which is in line with the knowledge that women are very well equipped to give birth and the less interference of any kind - the better. Research consistantly shows that the less interference - the more positive the outcome, both in ppactical and physiological terms and also in the level of maternal satisfaction.

Parenting is such a profound and perilous journey to embark upon, it is absolutely essential that the journey get off to a good start. Undermining the confidence and ability of pregnant and birthing women is to be avoided at all cost. The role of the midwife as advocate to the woman is an important and empowering responsibility.

" The mystery of life is not a problem to be solved .

but a reality to be experienced. " Alan Watts

Women can further be empowered by being better informed about the risks of procedures involved in other aspects of their health care. For example re-use of plastic disposable speculums has been observed as an effective way of spreading the genital warts virus. As a midwife, are you aware of this happening? As a woman, when you have a cervical smear test do you ask what sort of speculum will be used and if it is a disposable one, do you ask if it has been used before? Ensure you are aware of all risks and procedures. Judi Strid

FROM THE NZ COLLEGE OF MIDWIVES:

They have been asked by the Department of Health to provide a representative from the College to look at Safe Options for "Low Risk" Childbirth and to draw up a protocol with a technical group (consisting of Obstetricians, GP's and Midwives). This protocol is to act as input into a second group which is to include additional representation from both consumers and professionals.

Self-adhesive bumper stickers **MIDWIVES MAKE IT A LABOUR OF LOVE** are available at $1.50 plus 40 cents postage from the College PO Box 21 106, Christchurch.

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* First AGM of the College will be in Christchurch 2.4.89 - Enquiries - NZ College of Midwives, PO Box 21-106, Christchurch *

THE BOOK OF NZ WOMEN

Is to be a comprehensive, biographical dictionary of women teaching back as far as possible. It will include women whose lives usually escape the record as well as those who are well known. The purpose of this book is to offer an alternative herstory of women, bringing into awareness women whose lives otherwise pass unnoticed. Publication is anticipated late 1990 so if you know of any interesting women whose lives have a story to tell send details as soon as possible to -

The Editors, Charlotte McDonald & Bridget Williams
c/-The Stout Centre, Victoria University, PO Box 600,Wellington

Details required - Name, DOB and death where appropriate & a short paragraph explaining what she did. State whether you are prepared to write the article or if you can suggest someone who would. A fee will be paid for any contribution.

MIDWIFERY EDUCATION 1989

Two options for midwifery training are now available -

Separate Midwifery Course - full-time is available at Otago/Southland Polytechnics - Sally Pairman -38 weeks duration commencing 22.5.89. Applicants need at least 1 year post-basic experience and there have so far been 52 applicants for 10 places! Curriculum developed between consumers & professionals
Wellington Polytechnic - Beryl Davies/Laura Lambia - 40 week course commencing Feb'89 until Nov'89 with a pre-requisite year including obstetrical or maternal/child health required. 17 of 20 places so far accepted. Curriculum consulted consumers also
Auckland Tech. Institute - Liz Smythe Jacki Gunn & Liz Schollum 38 week course commencing Feb'89. 20 positions available with clinical experience in variety of hospitals, with dmw's & GP's.

Advanced Diploma In Nursing/Midwifery Option available at-
Christchurch Polytechnic - 6 applicants so far
Hamilton Polytechnic - has 14 applicants

PRESS RELEASE FROM JUDY KEALL, MP FOR GLENFIELD, ON THE OPENING OF THE NEW MIDWIFERY COURSE AT I.T.I., MONDAY, 13 FEBRUARY 1989

SEPARATE MIDWIVES COURSE ESTABLISHED

Opening the separate midwifery course of training at the ATI, Judy Keall said, "This course is a major step forward for midwives. It gives recognition to the fact that midwives are an independent, professional group."

"Midwives are reclaiming their independent status and are being helped in this by the many women who are comming to realise that with the help of a midwife they have a better chance of giving birth normally and naturally."

She said that many women were now questioning the extent of interference by doctors in the birth process. Recent statistics show that NZ has a high incidence of birth by caesarean section and it was difficult to believe that all such operations were justified. Other types of intervention that could be challenged were the use of an oxytocin drip to bring on a birth early and the routine use of an episiotomy. Some forceps deliveries could also be questioned.

"It is clear to me that when a woman is in the care of a trained midwife there is far less likelihood that any intervention will be necessary, and this is one reason why more women were choosing home birth as an option."

She reported that the Government had encouraged domiciliary midwives to practise by increasing their fees and she was pleased to note that there had been an almost 50% increase in the number of domiciliary midwives in the last year.
"Midwives claim that 85% of women can give birth normally and naturally, and I am keen to see them operating independently in all low-risk birth situations."

We are entering an exciting era with the advent of the Area Health Boards and an increasing emphasis on community health services. Already the Auckland Area Health Board is revamping its midwifery service to make provision for home visits by midwives after a hospital delivery. In such cases, the midwife would visit mother and baby in their home until satisfied they could be discharged from the service.

"I predict that Area Health Boards will use midwives more and more often for 2 main reasons: their professional skill, and their cost effectiveness."

She congratulated midwives on setting up their own professional association to promote midwifery. "I congratulate all those who have worked so hard to establish the separate course for midwives. Government approves this move and I am very pleased to be able to declare the course open."

DATES TO REMEMBER

SUPPORT PLANET EARTH - The Centre For Continuing Education, Auck. University presents a major conference THE LIVING EARTH Exploring the Gaia Hypothesis that the Earth is a single living organism with interlinked life systems and species- March 22-26

FIRST AGM OF NZ COLLEGE OF MIDWIVES, Christchurch 2 April'89
Enquiries: NZ College of Midwives, PO Box 21-106, Christchurch

MAMMOGRAPHIC SCREENING FOR BREAST CANCER - BENEFITS OR RISKS?
NATIONAL CERVICAL SCREENING PROGRAMME - WHAT PROGRESS IS BEING MADE? - Tues. 4.4.89, 7-10pm Cost-$11 Auckland University

MEDICAL ETHICS SEMINAR - Ethical Issues in Clinical Research Panel. Monday 17.4.89 7.30-9.30pm Cost $5.50
Centre For Continuing Education, University of Auckland.

NATIONAL HOMEBIRTH ASSOCIATION CONFERENCE, New Plymouth
12-14 May 1989 Theme: CONCEPTIONS & CREATIONS
Papers & workshops on - bi-cultural sensitivity, immunisation, acupuncture/acupressure in childbirth, maori medicine, taditional childbirth.....and others.
Enquiries: Jasmin Hales, 33 Wrantage Street, New Plymouth

10TH NATIONAL AUSTRALIAN HOMEBIRTH CONFERENCE, Sydney
12-14 May 1989 Theme: CELEBRATING A REVOLUTION IN BIRTH
Enquiries: 521/197 Pittwater Road,Manly, NSW 2095,Australia

9th INTERNATIONAL CONGRESS OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY, Amsterdam, The Netherlands 28-31 May 1989
The main theme of the congress will be "Psychological, emotional and emancipatory aspects of women's health care."
Enquiries: Congress Secretariat, c/- QLT Convention Services, Keizersgracht 792, 1017 EC Amsterdam, The Netherlands.

SIXTH BIENNIAL CONFERENCE OF THE AUSTRALIAN COLLEGE OF MIDWIVES
Darwin, Northern Territory 21-23 June 1989
Theme: Midwifery - Back To The Future Key Speaker- Ruth Lubic
Enquiries: Teresa Raines, Conference Convenor, ACMI NT. Branch, PO Box 41781, Casuarina, NT 0811, Australia.

1989 INTERNATIONAL ICEA CONVENTION, Minneapolis USA June 23-25
For all those who work with women in any childbirth related field, consumers, childbirth & parent educators, nurses, midwives, physicians and other health professionals.
Enquiries: ICEA Minneapolis Convention,PO Box 20048,
Minneapolis, Minnesota 55420-0048, USA.

PROMINENT BRITISH FEMINIST, SOCIOLOGIST & WRITER *ANN OAKLEY* WILL TOUR NZ - Sept'89. She is well known for her work in the area of women's health & childbirth issues, and for her books "The Captured Womb" and The Sociology of Housework & Housewife
Enquiries: Centre For Continuing Education, Auckland University

DIRECT ENTRY TO MIDWIFERY

DESPITE the support of the English National Board for Nursing, Midwifery and Health Visiting, a recommendation for such courses from the Department of Health and Social Security, the backing of the Royal College of Midwives and the Association of Radical Midwives, encouragement from various lay and 'consumer' groups, and press eulogies, direct entry midwifery training is only available in one school. Several other schools are planning or considering such programmes, but the progress is slow. To investigate this paradox, and to research all aspects of direct entry midwifery training, the ENB obtained funding from the DHSS and commissioned the Department of Educational Studies at the University of Surrey to carry out an independent study. These two articles report on some of the findings of the study – the first gives a brief historical background and reports on the current state of development of direct entry midwifery training programmes. The second will look at some of the areas which will be important in determining the courses of the future – the potential candidates and educational issues.

HISTORICAL AND IDEOLOGICAL BACKGROUND

Arguments about how a person should be trained are based on assumptions and beliefs about what skills and knowledge the qualified person needs and should have, which in turn depends upon her role. Those who see midwifery as a 'separate tree' feel there is a need for a distinct and special training. There is often a belief that training a 'different sort' of midwife will improve and change the delivery of care and the actual role. Some feel that nurse training is actually undesirable as a preparation for midwifery, others that the present role of a midwife requires her to have nursing knowledge, and that nursing training is an important foundation for becoming a midwife.

These assumptions and beliefs are rooted in history. On the one hand, there was the gradual erosion of the status of the direct entrant and the change from the practice of midwifery as a separate profession to 'a branch of intensive care nursing'. On the other hand, there is the tradition of the midwife as a practitioner in her own right, and the current trend of 'de-medicalising' childbirth. From 1906 until 1916, there was a single path for nurses and non-nurses to enter midwifery – a three month course. In 1916, this was changed to three months training for nurses, and six months for non-nurses. The training was lengthened in 1926 (six months for nurses and a year for non-nurses), 1938 (a year and two years respectively), and 1981 (18 months and three years). The increase in training time acted as a disincentive to direct entrants. Other influences on the declining number of direct entrants were various reports such as Stocks[1], Salmon[2] and Briggs[3] and the increasing hospitalisation of childbirth. Figure 1 illustrates how the proportion of direct entrant student midwives changed over the years.

DECISIONS FOR OR AGAINST DIRECT ENTRY MIDWIFERY TRAINING WERE USUALLY BASED ON PERSONAL EXPERIENCE OR OPINION — INDEED THE SAME FACTS WERE USED TO 'PROVE' THE CASE FOR OR AGAINST NON-NURSE MIDWIVES

The last decade has seen a swing away from the medicalised model of childbirth towards natural birth. Writers such as Inch[4] and Kitzinger[5], as well as an increasingly high media profile for childbirth related topics and the feminist lobby have increased interest in the role of the midwife as the specialist in normal childbearing, particularly non-nurse midwives, who are seen as 'untainted by the sickness model'.

Another influence was the increasing contact with Europe and its different traditions and trainings for midwives.

The '80s also brought a flood of educational documents relating to nursing and midwifery – the RCN Commission on Nursing Education[6], the ENB Strategy Document[7], RCM's Role and Education of the Future Midwife[8], ARM's The Vision[9] and Project 2000[10]. The midwifery profession reacted with surprising vigour to the initial Project 2000 proposals to incorporate midwifery as a branch of nursing. Seemingly challenged and stimulated by the Project 2000 debate, midwives moved on to seek an increase in specialist direct entry midwifery training programmes. To accelerate development one must first know what influences it, and determine the stage it has reached so far. The following section briefly describes the national picture regarding direct entry midwifery training and the factors influencing decisions on its implementation.

PRESENT NATIONAL SITUATION

The excellent response rate to the survey of all regions, districts and schools (100%, 91% and 99%), and the co-operation of a multitude of interviewees (managers, tutors, student midwives, clinical staff, representatives of statutory and professional organisations, and lay agencies, and so on) ensured that a comprehensive national picture was gained. Overall, there was considerable interest expressed in direct entry midwifery training. Figure 2 shows the policies of regions and districts. Figure 3 shows the actual situation at the time of the survey.

A slight shift was evident in the position of several health authorities during the course of the project, which can be largely attributed to three factors. At the beginning of the study, many of the RHAs were in process of investigating midwifery staffing and

education in order to formulate strategy, and some DHAs were studying the possibility of direct entry midwifery training. Some of these investigations were completed during the project and caused a change of policy, one way or another. A few resulted in recommendations to run direct entry midwifery courses, and one district found they would be unable to afford such a programme. Second, the DHSS recommendation that each region should have a least one such course (in a letter to do with nursing recruitment, 7 August 1987) caused certain health authorities to reconsider a neutral or negative stance. Finally, as people became aware of the University of Surrey study, many deferred a decision until the results of the study became available.

INFLUENCING FACTORS

Decisions for or against direct entry midwifery training were usually based on personal experience or opinion – indeed, the same facts were used to 'prove' the case for or against non-nurse midwives. In some cases the RHA, DHA, and school were all in agreement about the desirability of such a programme, but had diametrically opposite ideas about the purpose, content and conduct of a course. In general, the RHAs and DHAs wanted to implement direct entry midwifery training for pragmatic reasons. The most important reason given by RHAs and DHAs was present and/or predicted manpower shortages. There was also the hope that a three year course would be more cost effective than RGN training followed by 18 months training. Tutors and midwife managers in favour, although they saw direct entry as a possible solution to manpower problems, espoused the cause because they felt it would re-establish the special role of the midwife.

Decisions against non-nurse midwifery training were also made on both pragmatic and ideological grounds. The practical factors inhibiting it are the organisation of funding for post basic training, shortage of tutors and lack of information (on supply of candidates, structure of course, acceptable experience and so on). The historical and ideological factors inhibiting the development of non-nurse midwifery training are touched on above. Downes' current

DIRECT ENTRY WILL NOT NECESSARILY SAVE THE MONEY WASTED ON TRAINING THOSE WHO DO NOT PRACTISE. WASTAGE WILL DEPEND ON SELECTION AND ORGANISATION OF TRAINING

study[12] on attitudes to direct entry midwifery should provide interesting detail on the prevalence of the various viewpoints.

The perception of cost effectiveness was a very important factor for most of those making a decision on the implementation of new training. Yet few of the respondents had done detailed costings – partly because this is impossible until decisions on curriculum are made, and partly because many felt they needed guidelines on costings. The study produced a costings guide, which proved effective in trials. This shows both net and yearly costs to the maternity budget, DHA and NHS. The cost of a direct entry course would vary dramatically depending on the amount of service contribution, shared learning, and organisation of training. Direct entry will not necessarily save the money wasted on training those who do not practice. Wastage will depend on selection and organisation of training. If the selection procedures and learning conditions are similar to nursing, wastage during training will be high. If working conditions on qualification are unchanged, qualified wastage among single qualified midwives will be as high as among their RGN, RM colleagues – they may not return to nursing, but many other careers are still open to them.

The University of Surrey/ENB study showed that although there was theoretical support for non-nurse midwifery training, few centres are taking any positive steps towards implementing such courses. Most areas are 'on the shore', waiting for someone else to 'try the weather' or for some incentive to 'take the plunge'.

Positive action must be taken if the midwifery professioon really wants direct entry midwifery to succeed. Whether this action is taken by the ENB, and UKCC, DHSS and HAs, RCM, ARM, MIDIRs, NCT, and AIMS, depends on resources available and the role each of these wishes to play. More information and support should be available to those considering the direct entry option. This could be done by newsletters, support groups, study days, or increased advice from statutory and professional bodies. Independent evaluation of existing and new courses would provide valuable lessons. The midwife's role and the possibility of direct entry training should be more widely publicised. The organisation of funding for such training needs to be restructured. A coherent national or regional strategy for all midwifery training needs to be developed.

Part two discusses the potential candidates and the learning environment. **NT**

For information on the availability of the full report of the study, Direct entry: A preparation of midwifery practice, contact the ENB.

REFERENCES
[1]Stocks, M. Report of the Working Party on Midwives Ministry of Health. London: HMSO 1949
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[3]BRIGGS, A. Report of the committee on nursing DHSS. London: OHMS 1972
[4]Inch, S. Birthrights: A Parents Guide to Modern Childbirth London: Hutchinson, 1982
[5]Kitzinger, S. Freedom and choice in childbearing. Harmondsworth: Viking 1987
[6]Judge, H. The Education of Nurses: A New Dispensation London: RCN 1985
[7]ENB Strategy Document. ENMB 1985
[8]RCM The role and education of the future midwife in the UK London: RCM 1987
[9]Association Radical Midwives The vision: proposals for the future of the maternity services. ARM 1986
[10]UKCC Project 2000: A new preparation for practice. UKCC 1986
[11]Downes, S. Proposed research project: An assessment of attitudes of midwives and tutors to direct entry midwifery training unpublished 1987

Nancy Radford and Anne Thompson are researchers at the Department of Educational Studies, University of Surrey

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In the second of their reports on the development of direct entry midwifery courses, Nancy Radford and Anne Thompson look at some of the issues that should be considered by those implementing such courses

CHOOSING THE DESIGN

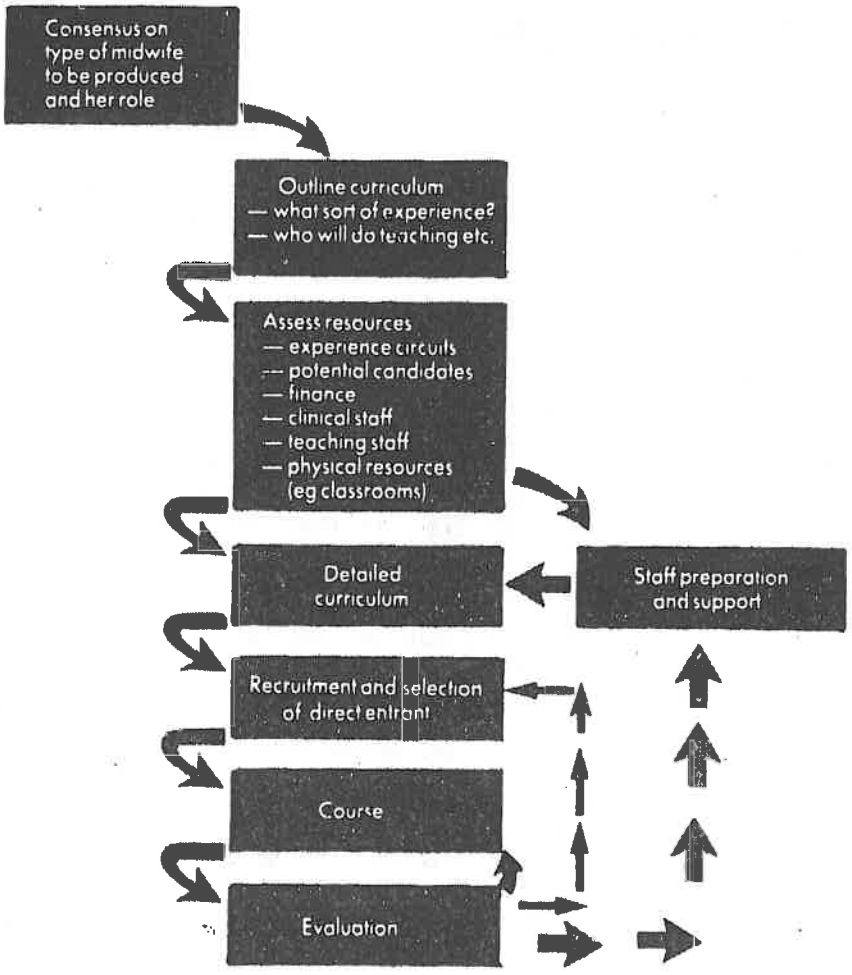
A MOST important issue, and one on which there is little consensus, is the role of the qualified midwife. All involved midwifery and general managers, tutors, and so on should be in agreement on why they want to implement direct entry and the ideal and the role the midwife will perform once qualified.

Is direct entry midwifery being considered as an answer to recruitment or retention problems, a cost saving exercise, or as a radical rethink of how a midwife should be prepared for practice? Should the midwife work under the guidance of doctors or as 'obstetric nurses' (as appears to be the case in many areas[1,2]. Or should she be an independent practitioner? These were among the questions addressed by the ENB study, which was carried out by the University of Surrey.

The reasons for implementing non-nurse midwifery training will have implications for areas such as the status of the single qualified midwife, curriculum, recruitment, selection and financing. For instance, if the single qualified midwife's training is similar to that of the RGN plus RM training, but cheaper and shorter, the status of the former will be lower than the latter. A training which costs less may often be seen as being worth less. A completely different specialist education/training would be more likely to carry equivalent or superior status.

The course curriculum is a vital issue, which needs to be considered at an early stage, as it will affect the feasibility and cost of the project. What sort of experience and knowledge base do the students need? The accurate identification of the role of the qualified practitioner is an essential pre-requisite for any curriculum design. The amount and type of 'general nursing' experience needed will depend on the role the midwife will play on qualification. Curriculum planners will need to be imaginative and resourceful in seeking out appropriate placements in areas where available experience is limited. One also needs to consider the desirability/feasibility of shared learning with other

Table 1. Stages in considering direct entry



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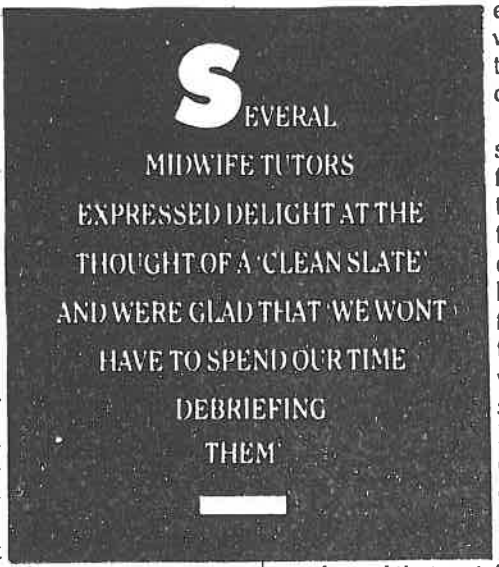
professions.

How will the students be supported and supervised? The national survey and the interviews demonstrated widespread concern about adequate levels of supervision and support for direct entrant student midwives. Inadequate support for a student without the customary knowledge base can place her in embarrassing or even dangerous situations. Current initiatives, such as a mentor system of student-to-midwife attachment and the team approach to the delivery of care, in theory hold out hope of better support and teaching opportunities. Staff attitudes will influence the effectiveness of these methods in practice.

Resources will have to be assessed — the supply and abilities of tutors, staffing levels, classroom and residential accommodation, number of sites, availability of experience (maternity and other), possibility of collaboration, and sources of finance.

Development of a completely new curriculum will put an additional strain on midwifery tutors, but will also act as a stimulant. Several midwife tutors expressed delight at the thought of a 'clean slate' and were glad that 'we won't have to spend our time debriefing them'. (Comments from interviews).



Shortages of staff had held back the development of direct entry in some areas, because it was felt impossible to provide an adequate level of support and supervision in the clinical areas. Because students will be in the midwifery school for twice as long, additional classroom and residential accommodation may be required.

The shortage of experience, accommodation and tutors has led to moves to rationalise midwifery training to make better use of existing resources. A viable direct entry project requires more facilities than a small midwifery school can normally provide. Co-operation and amalgamation would change this situation.

The study covers these areas in detail and provides guidelines on costing. Current funding for midwifery training, whether post-registration or direct entry, comes from the district health authority (DHA) budget, whereas part of the cost of RGN training is centrally funded, so the 18-months course seems at present a more attractive financial proposition for the DHAs. The implementation of Project 2000 and/or changes in the funding of midwifery training could make the direct entry midwifery option more financially attractive.

A survey of potential candidates was carried out as part of the study, and though this provided only a partial picture of the supply of candidates, the exercise as a whole was of great value. First, it showed the difficulty in finding concrete evidence of demand, and highlighted the need for detailed records of enquiries. Few schools had kept any records of enquiries about direct entry midwifery training. Those which had, only recorded the number of enquiries, without any details of the individual enquiring.

The impression one received from the literature and some interviews was of enormous numbers of enquiries from very suitable people. This was difficult to substantiate. From the results of the survey, it is clear that characteristics of respondents varied greatly, and that certain of these characteristics, such as age and dependants influenced the type of course desired (those with dependants tended to prefer a part-time course and were less willing to relocate or travel). Respondents did not all fit into the popular stereotype of mature women with children, and courses designed for such candidates may not be appropriate in all localities.

Lack of awareness of the role and responsibilites of a midwife was also demonstrated. Many respondents seemed unaware that midwives look after women throughout pregnancy, childbirth and the postnatal period. The classic example of this were the 8% who gave some variant of 'I like babies' as their reason for entering midwifery. There must be greater understanding of the midwife's role and conditions of employment, otherwise, some potentially suitable people may never apply, and/or unsuitable ones may take up training. If trainees' expectations are in conflict with reality, there will be a high wastage rate during training.

The survey illustrated that some enquiries about a career in midwifery came from people who would not be able to cope with the training requirements and working conditions, either because of immaturity, intellectual capacity or a multiplicity of other commitments.

To ensure the success of a direct entry midwifery course, there must be a clear idea of the characteristics required in a student midwife, an active recruitment campaign to attract people with these traits, and an effective method of selection. Flexibility in organising of education and working conditions will also play a part in reducing wastage.

Commitment and co-operation between education and service is needed and a willingness to spend time in staff preparation. Some staff will have negative attitudes towards direct entrants, others will have difficulty coping with the students who lack experience in the medical field, but who were perhaps mature, articulate, and experienced in other fields.

There is some evidence from schools with experience of direct entrants that the fresh, questioning approach of the unconditioned students may appear a threat to a well established system, as well as to individual members of staff. Tutors and managers will need clear strategies for the introduction of new ideas, new practices and new people if anxieties are to be calmed and the whole project welcomed with any enthusiasm.

NT

REFERENCES

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● For information on the availability of the full report of the study, *Direct Entry: A preparation of midwifery practice*, contact the English National Board.

● Part 1 appeared in last week's issue

Nancy Radford was, at the time of the study, a researcher at the Department of Educational Studies, University of Surrey. Anne Thompson is senior midwife tutor at Lewisham

Copies of this study are available from ENB Resource and Careers Services, Chantrey House, 798 Chesterfield Road, Sheffield S8 0SJ. Price £10.

Direct entry: a preparation for midwifery practice

Nancy Radford and Anne Thompson,

University of Surrey, Guildford, England.

Conclusions and Recommendations

1. Introduction

One of the most common misconceptions which the researchers had to tackle was about the purpose of this research. Many people thought that the project would result in a judgement on direct entry midwifery. This was not the remit of the researchers. A decision in favour of direct entry had already been taken by the ENB, and the researchers were asked to assess the factors affecting implementation of that decision.

This study had four main goals:

1. To describe the national situation regarding direct entry midwifery training.
2. To discover the factors inhibiting development of such programmes.
3. To advise on issues which should be considered by those contemplating this option.
4. To recommend ways in which the establishment of non-nursing midwifery training could be facilitated.

The report covers all aspects of direct entry training, and readers may not want to read it straight through. It was written to be used by a variety of people for different purposes. The chapters on each aspect can be read either in isolation, or as part of the whole. The report is structured to enable readers to draw from it what they wish. This chapter will first summarise the national picture, then highlight the major influencing factors, recapitulate some of the most important issues, and finally set out some recommendations for encouraging the growth of the non-nurse component in midwifery. The authors wish to stress that for the full picture, the whole report should be read, and that the following chapter is only a brief recapitulation of some of the results of the study.

2. The national picture

The excellent response rate to the survey and co-operation of schools, districts and regions ensured that a comprehensive national picture was gained. In general, there was a great deal of support expressed for the ideal of direct entry midwifery training, but there seemed to be little agreement as to who should be recruited for such training, what form the training should take, the curriculum, the appropriate environment, etc. etc. As Chapter 8 points out, the RHA, DHA, and school may all be in agreement about the desirability of direct entry, but each have diametrically opposite ideas about purpose, content, and conduct of such a course. Most decisions for or against direct entry were based on personal experience or opinion - indeed the same facts were used to "prove" the case for or against non-nurse training. There are few centres taking any positive steps toward implementing such courses. Most areas are "on the shore", waiting for someone else "to try the water", or for some incentive. The ENB was expected to provide the initial stimulus and ongoing support. (Chapters 3,5,6 and 8)

The survey of potential applicants indicated that there are people interested in a midwifery, rather than a nursing, career. It demonstrated the need for investigating possible recruitment pools, and the necessity of considering changes in selection procedures and organisation of training. (Chapter 4-6)

3 Influencing factors

The factors inhibiting development of direct entry midwifery training, like those encouraging it, are pragmatic, historical, and ideological. The major pragmatic reason encouraging the implementation of such programmes is present and/or predicted manpower problems. The practical factors inhibiting it are organisation of funding, shortage of tutors, and lack of information (on the supply of candidates, structure and organisation of course etc.). Any new project will involve more effort and cost initially.

The historical background and ideological issues are complex. On the one hand there was the gradual erosion of the status of the direct entrant and the change from the practice of midwifery as a separate profession to "a branch of intensive care nursing". On the other hand, there is the history of the midwife as a practitioner in her own right, and the current popularity of "de-medicalising" childbirth. Arguments about how a person should be trained are based on assumptions and beliefs about what skills and knowledge the qualified person needs and should have, which in turn depends on her role. Those who see the midwifery as a "separate tree" feel there is a need for a distinct and special training. There is often a belief that training a "different sort" of midwife will improve and change the delivery of care and the actual role. Some feel that nurse training is actually undesirable as a preparation for midwifery, others that the present role of the midwife requires her to have nursing knowledge, and that nursing training is an important foundation for becoming a midwife. (Chapter 2-6,8).

4. Issues to consider

The issues which must be considered by schools, districts and regions contemplating the direct entry midwifery option are listed below as a series of questions with a brief explanation. The chapters dealing more fully with the issues are indicated in parentheses.

4.1 What sort of midwife will be needed? What should be her role?

The most important issue, and one which has not often been adequately addressed is agreement on the end product. All involved (eg. midwifery and general managers, tutors, etc.) should be in agreement on why they want to implement direct entry, and the ideal and actual role of the midwife (whichever route is used to produce her). Should the midwife work in the same service role as present, but be produced at less cost and lower wastage rates? Or she be someone quite different (eg. independent practitioner)? The type of midwife required will have implications for areas such as the status of the single qualified midwife, curriculum, recruitment, selection, and financing. For example, if the first option is chosen, it is likely that the single qualified midwife will have a lower status than her dual qualified colleague, for her training would be along similar lines, but shorter. A completely different specialist training would be more likely to carry equivalent status. The implications for curriculum are obvious, and it is clear that decisions about the end product affect the choice of raw material and the final cost. Studies (Robinson et al, Garcia et al) have been done into what a midwife's actual role is at this time, but not what it should or could be. This is a decision which the profession must make. The report illustrates the variety of opinion within the profession on the sort of midwife who should be produced and the implications of this decision. (Chapters 2,4,5,6,and 8).

4.2 What sort of training will be needed?

The course curriculum is a vital issue, which needs to be considered at an early stage, as it will affect the feasibility and cost of the project. What sort of experience and knowledge base do the students need? How will the students be supported and supervised? The study explored these and related issues. (Chapter 5 and 6).

4.3 What resources will be required? What is available?

The resources required should be compared to those available

- human, physical, and financial. The report highlights the areas which should be considered, eg. as supply and qualification of tutors, adequate staffing levels for clinical support and supervision, classroom and residential accommodation, number of sites, availability of collaboration with other institutions and sources of finance. (Chapters 4-7). Appendix 6 provides a formula for estimating the cost of proposed and current courses.

4.4 Who should be recruited? Is there an adequate recruitment pool?

The type of midwife desired and course content will naturally affect the type of trainee sought. The research indicated that the size and composition of the recruitment pool will need to be taken into consideration when designing a course. This may require changes in service delivery or educational organization, and the effects of these on the quality of care needed to be evaluated.

The report suggests ways in which the local and national supply of potential candidates can be assessed and the characteristics of this group determined. It highlights why it will be necessary to devise more active recruitment campaigns and more rigorous selection procedures, and suggests ways to do this. (Chapters 4 and 5, Appendix 7).

4.5 What are staff attitudes to direct entry?

The findings of the study indicated that the level of commitment to direct entry midwifery training will have a marked effect on the success of the project. Both managers and tutors must be convinced of its value, and prepared to spend time in staff preparation to ensure that all are ready to give direct entrants "a fair chance". (Chapter 6, and end of Chapter 3).

5. Recommendations

Positive action must be taken if the development of direct entry training is to be accelerated.

5.1 Co-ordination

A liaison group or task force representative of all bodies concerned should be given the responsibility for determining the most effective way forward for direct entry midwifery training coordinating initiatives and maintaining the impetus. (Chapters 1-8)

5.2 Support

Greater support should be given to those considering the implementation of direct entry courses. (Chapters 3,5,6, and 8)

a) An organised link should be formed between all those considering or planning a course as well as those who attempted to implement a course and did not succeed.

b) A series of study days should be run on course implementation eg. selection, curriculum , finance.

c) Additional resources should be allocated to enable the midwifery education officers to help provide the extra support which direct entry midwifery projects require.

5.3 Information

Information on all aspects of direct entry (eg. potential candidates, costing, curriculum) should be easily available from a central source. (Chapters 3-8)

5.4 Research

a) Evaluation of existing and new courses should be carried out. An independent body and the findings made widely available. (Chapters 3 and 5)

b) Each area considering a direct entry project should carry out a local feasibility study. (Chapters 4-7, Appendix 6)

5.5 Communication

Lines of communication between regions, districts and schools should be improved, as should those between them and the statutory bodies. (Chapters 3,5,6, and 8)

a) The ENB should clarify its role in the changing education environment.

b) Each region should appoint midwifery advisers to coordinate initiatives and to liaise between schools, districts, region and the statutory bodies.

5.6 Publicity

The role of the midwife and the opportunity of direct entry training should be more widely publicised.

5.7 Funding

Further research should be carried out to identify the most appropriate and effective organization of funding for midwifery education.

5.8 Rationalisation

To ensure a sound base for the development of new courses, rationalisation of the structure and provision of midwifery education is essential. (Chapters 5-7)

5.9 Strategy

The agency responsible for strategic planning should be clearly identified, and should control funding. (Chapters 3,5 and 8)

5.10 Statistics

Statistics on potential candidates for direct entry midwifery training should be gathered nationally in a standard format.

WESTERN LEADER, Thursday, January 12, 1989 Page 3

Next door neighbours, Bianca and Ariane with Joan Donley.

Coincidence for midwife

When Ariane and Bianca grow up they will have more in common to talk about than the average next door neighbours – they were both born at home, on the same day and delivered by the same midwife.

At 72 years old, Joan Donley is the "grandmother of midwifery" in the west. Bianca was the 658th baby she has delivered, Ariane the 659th.

But among all those births she says she has never come across such a string of coincidences as on January 4.

And it was far from expected.

Bianca's mum, Donna Hyslop, was not meant to give birth for two more weeks and Ariane's mum, Jenneke VandenBerg-Smith, was one day late.

"It's weird all right," says Mrs VandenBerg-Smith. "But it's pretty good to have company next door, someone in exactly the same boat. We can sympathise.

"Now they can hear our baby crying and we can hear their baby crying, it's all quite funny."

Both decided on home births because "it's no hassle, no interference and altogther more comfortable," says Donna Hyslop.

She had had her first baby delivered by Joan Donley and Jeneke decided to take Joan's help as well because it would be so convenient – though they never guessed just how convenient.

"It certainly makes a change from rushing across town to go from one birth to another," says Joan.

Elizabeth Noble

Elizabeth Noble and her partner Dr Leo Sorger inspired an Auckland workshop on Feb.4th with their in depth examination of the foundations of conventional childbirth techniques and antenatal preparation. An important message was the need to focus on a better understanding of the normal physiology of labour with an individual approach to help each woman respond spontaneously to the forces of labour and childbirth.

They emphasised that there must be no interference with the normal process of labour without good reason; and Elizabeth criticised the way women are often trained to struggle against their bodies' in the name of a particular method of childbirth preparation learned in a few weeks.

Women have abdicated their power over birth to the Medical Profession - along with death. Even the language of birth has been masculinised ie. a Leboyer birth, Lamaze breathing, Simms position, incompetent cervix etc.

Often the interests of the mother and baby are in conflict due to the attitude of the medical profession. Most women's potential for normal, healthy childbearing has been obscured by medical and media preoccupation with the abnormal aspects of labour and technological interference in the natural birth process. Studies have shown that the hospital is not safer than the home for low-risk births, and medical intervention with associated restrictions on midwifery care and homebirths have become widespread.

Elizabeth describes the renaissance of midwifery as an encouraging sign. An increasing number of women are comming to realize that they have a greater chance of a natural birth with a midwife...particularly one with a deep trust in the process of birth. Maternity care workers who lack sensitivity and are out of touch, are often those who have unresolved traumatic birth problems they need to deal with themselves.

She emphasises the importance of recognising that each person has their <u>own</u> experience so it is not appropriate to teach women how to breathe and what to do. More useful and appropriate preparation is in encouraging women to feel confident and trust their bodies and the birth process.

*** What people need to learn, they can't be taught ***

It is important to explore fears which are usually about loss of control, pain and death. By developing confidence, these fears can be overcome and replaced with flexibility, intuition and the ability to surrender to the birth process. Long difficult labours can be due to the fear of losing control and performance anxiety. The pain of labour - the opening up - then becomes an intense body-mind crisis as the mental "garbage" causes physical resistance. She describes pain in childbirth as <u>just another expression of lack of attunement.</u>

Elizabeth sees her role in antenatal preparation as one of facilitating her clients self exploration as teaching is inappropriate. Her feeling is, that when we are really free we just do it, and are not troubled by the need to control and direct the course of the labour and birth. Courage and confidence are things that can be built up, but there is a need to recognise various physiological aspects about the process.

For example
- being upright improves the drive angle of the uterus gravity-assisted body mechanics
- breathing patterns are unphysiological as this is trying to
  1. control an involuntary process
  2. lower awareness and increase effort and tension
  3. cause blood gas disturbances -hypo.& hyperventilation
- use of vocalisation as long as not breath-holding
- relaxation is the key to awareness and energy

She opposes instructing mothers to use strong, prolonged pushing combined with breath-holding during the second stage of labour as this is more likely to cause fetal hypoxia and acidosis than the actual length of time in second stage. She would like to see the definition of second stage changed to when the head is on the pelvic floor.

Labour like life is striking in its variability. It is a journey into the unknown so it is important to cultivate a sense of mystery that accomodates knowing oneself, developing self-reliance, insights and resourcefulness. Childbirth classes should be the map or menu. There is no right way of preparation and the technique in teaching is not important. Preparation and helping women connect with their babies can be achieved through many forums such as visualisation, music/singing, meditation, relaxation, massage, stretching/yoga, dreams, intuition, art etc. Childbearing integrates a woman's mind and body in the most intense way, forcing her to rethink the meaning of her life, and to deal with the inevitable changes of lifestyle and family roles. She may experience birth with heightened awareness & pleasure, or with fear & unresolved conflicts.

It is essential to avoid interference so labour can unfold uniquely and spontaneously. Birth is instinctive, so those present can affirm a woman who feels she's losing control simply by saying "That's it". Coaching is bad; labour support should help the woman sustain her courage, affirm her feelings and actions,and provide fluids and foods.

Keeping midwifery strong is essential as is the need to return the power of childbirth to women. She feels concern at midwifery being defined by what it isn't ie. can't do breech births, multiples and other risk factors defined by the system. There is nothing new about the way women give birth, only about the way that those around them control the birth enviroment and the experience.

BITS & PIECES:

* The Ministry of Women's Affairs has recently updated its list of women's groups and organisations throughout the country. For a copy, contact Linda Oliver at the Ministry. If you want to be on the mailing list for the Ministry's free newsletter, contact - Ministry of Women's Affairs
PO Box 10-049, Wellington.

* Unnecessary Cesarean Sections: A Rapidly Growing National Epidemic published by Public Citizen Health Research Group USA is an 80 page report which concludes that at least half of the c-sections performed annually in the US are medically unnecessary. The research group found no relation between the type of patients a hospital admits and its c-section rate. The 3 most significant contributing factors to the nation-wide increase are -
1. the continued policy of automatic repeat c-sections
2. over-diagnosis & overuse of c-section for dystocia
3. over-diagnosis of fetal distress
Maternal risk is particularly highlighted with the maternal mortality rate at 60.72 per 100,000 for c-sections.

* The American College of Obstetrics & Gynecologists (ACOG) has released a new policy on electronic fetal monitoring, recommending it not be used routinely on low risk women.

* In 1984, the minimum expenditure on ultrasound examinations alone in the UK amounted to some £5,000,000 per annum (AIMS)

* There is cicumstantial evidence that the bonding of mothers and babies is disrupted by early separation. There is a higher incidence of battering among babies born prematurely and separated from their mothers for as long as they need intensive care. Even the short separation while the mother recovers from the anaesthetic she is given if the baby has to be delivered by caesarean section surgery, makes a dramatic difference to the likelihood that the baby will later suffer physical abuse. Abuse is 10 times more likely for a baby born by caerarean section. (Jane London/Health)

* The 1988 Parents Centre National Conference passed remits supporting both the introduction of a 3 year Direct Entry Midwifery Course to train midwives, plus the establishment of a separate midwifery course for nursing graduates.

* The 1988 annual Labour Party Conference passed a remit calling for the training and retraining of midwives to be given priority in health services to increase the birthing options for women.

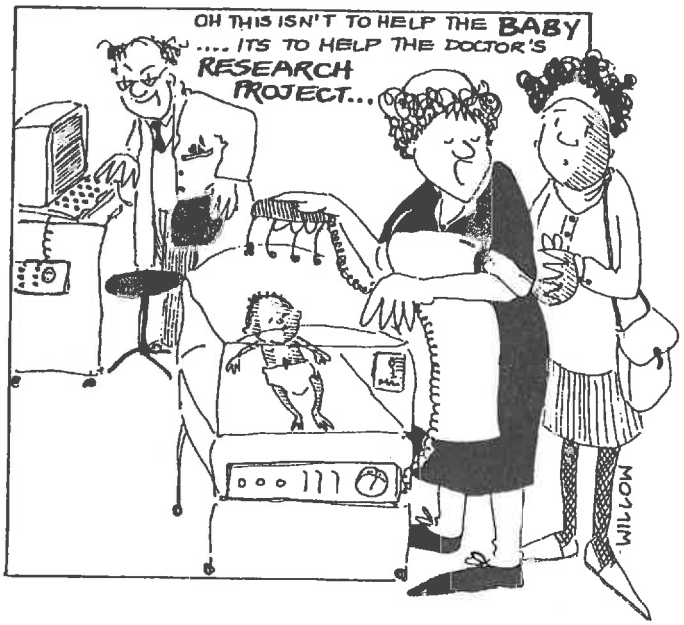
Research and Ethics

Following in the wake of the Cartwright Inquiry, the Health Department has set researchers a stringent set of guidelines. The new standard proceeds on the premise that the patients' rights are to be paramount and lays down rules for gaining approval for research projects, as well as the requirement that written consent is required from all patients involved in research. The performance of the ethics committee at National Womens' Hospital was attacked on the grounds that it demonstrated a lack of comprehension of the importance of providing information to patients.

Patient rights also assume a large role in the policy of the Waikato Hospital Board. The Planning Manager, Dr Alan Sinclair, has been reported as advocating a national consent form which would apply to all services offered by the Hospital Board. He suggested in addition that there was a need for consumer input and that this perspective may well become one of the most important aspects of hospital board policy over the next few years. He went on, "for that reason we need to get it right."

It seems that the issue has not only arisen in New Zealand, although its local manifestation has taken a much more specific form. SYNAPSE, the Canadian journal of biomedical ethics, has also commented on the difficulty presented by what actually constitutes research. This is due to the fact that the traditional definition of research as a scholarly activity distinct from teaching, consultation and other forms of professional practice is not applicable to fields such as biomedical ethics in which theory and practice are intimately linked. The answer, it is said, lies in a multidisciplinary approach with a more pragmatic and mundane emphasis on aspects such as casual conversation or formal or informal consultation. The magazine emphasises that what is needed is a network for communication among researchers to avoid needless duplication and to "signal important topics in danger of neglect."

It makes a difference if it's your decision



Foresight

The Association For the Promotion of Pre-Conceptual Care.

aims to take steps to secure optimal health & nutritional status in both prospective parents, prior to the conception of the baby; and to instigate research aimed at the identification and removal of potential health hazards to foetal development, in the external enviroment in which the mother will carry the child.

"Foresight" believes much can be done with nutrition and education of the parents to reduce perinatal deaths and cngenital deformities. The work of Dr Weston Price & Dr Frank Pottenger proved conclusively that many disorders formerly thought to be genetic, could be reproduced or eliminated at will by dietary manipulation. They found that where people were living on natural, whole, unprocessed foods, the children were born with no disadvantage. However the children of the first generation to change to tinned & processed foods were prone to tooth decay, dental arch & allergic syndromes. Later births showed skeletal anomalies along with brain and central nervous system damage.

"Nutrition Against Disease" by Dr Roger Williams states " If all human mothers could be fed as expertly as prospective animal mothers in the laboratory, spontaneous abortions, stillbirths and premature births would disappear; the birth of deformed and mentally retarded babies would be largely a thing of the past."

This organisation offers a number of publications for sale (further details available from pamphlets in our library). The annual subscription is £5 - The Secretary, The Old Vicarage, Church Lane, Witley, Surrey, GU8 5PN, UK.

Thanks to Taya van Roon for this contribution

A Feminist Perspective in Midwifery

MAVIS KIRKHAM

(From Feminist practice in women's health care. Ed.C.Webb)

The word **midwife** seems to me to mean in concrete terms exactly what **feminist** means ideologically: with women. I want the women I care for to have confidence and faith in their own bodies, and really to "tune in" to their selves and their children. They need to take responsibility from the start for the great responsibility of parenthood. Our society does not help women to trust their bodies, so as feminist midwives we need to offer a setting where women can learn a great deal and feel confident to make choices, knowing that we will support them.

A midwife brings her technical skills to care for a mother and her baby, but the essence of these skills is the very quiet art of ensuring that the woman is safe and strong. Often the important thing is not to act, but to be there to ensure that the woman feels safe to do what she feels best. Perhaps the difference between being the ring-master and being the safety net is really the difference between doctors and midwives.

Woes of the hospital midwife

Midwifery is defined as care during and around normal birth. The midwife is with the woman at crucial points in pregnancy and throughout labour. She helps the woman to give birth and she supports her later as she gains confidence and strength to care for her baby and resume her life.

Midwifery has a long and proud but largely unwritten history, although much was written to malign midwives by the rising male doctors who saw them as a great threat (Donnison 1977). Today, I feel that a crucial part of a feminist midwife's work is the defence of normality in the face of male-dominated obstetrics and its attendant technology and medical ideology.

Women still have a right to choose the place of birth of their children, and if we lose that right many other choices in childbirth will be lost too. Feminist midwives inevitably work to maintain that right in reality, and to support women in their choices. I find I do this mainly through women's groups outside my actual job.

The vast majority of births in this country (UK) now take place in hospital, and I work in a hospital. Hospitals are strongly hierarchial institutions and in such a setting the place of women, whether as staff or patients, is usually at the bottom. The underlying values which led to the centralisation of maternity care in hospitals largely dictate their structure, and therefore give rise to the problems of women within that structure. Hospitals exist to centralise medical expertise (largely male) and equipment (expensive & largely male-designed) for maximum efficiency, and women come (at whatever cost) to the experts (often in order to be told to rest). The woman is the consultant's "patient" and he controls the "care" of "his" patient, although he may never see her. Such a

hierarchy of institutional expertise limits the autonomy of its workers as well as those it serves.

Midwives still cherish their description as practitioners in their own right but as normal birth moved into hospital the reality behind the definitions changed. Previously all pregnancies were seen as normal until judged otherwise, a judgement usually made initially by the midwife. The reverse is now true, as all pregnancies now fall under medical management and are "normal only in retrospect". By this logic, the midwife as practitioner in her own right is defined out of existance. The hospital midwife's work therefore becomes either obstetric nursing or what medical staff define as provisionally normal and are therefore prepared to delegate. Fortunately, in practice, it also embraces the vast areas of work which doctors either do not have the time for or do not see as important. Doctors are expensive and in a hurry but pregnancy and labour are long, as is the real work of the midwife.

Nursing and midwifery, too, have strongly hierarchical power structures. The way the nurse or midwife feels her position within this structure greatly affects those she cares for. As Sheahan (1972) observed of American nursing, "If power corrupts, so much more so does powerlessness. It corrupts by changing our perceptions of ourselves....being too subordinate, too alienated or too weak to effect change." Our training within hospitals and our socialisation as women make it all too easy to accept the constraints imposed upon us. Yet by our example we teach the pregnant women to accept them too. We are the ones who spend time with the women, and it is our actions which teach patients to be patient and to accept the system. We do not have to do this. We know it is not healthy.

We who are with women can listen to them and encourage them to listen first to their own bodies and their babies. There is immense scope to do what we believe to be healthy within the National Health Service despite its structure and, ironically, the present cuts give us more scope whilst giving us much more work.

We are there to care for these women and therefore we must work to improve the system, but never in a way that will hurt the women it serves. I feel that confrontation between midwives and doctors usually falls into this potentially hurtful category. I have often seen a confrontation between doctor and midwife acted out, sometimes years later, on the body of a woman who was not part of the original confrontation. This poses terrible dilemmas, but together we must be able to find wiser ways of moving towards real change. Through our own research and teaching we can alter attitudes, and a wide range of political channels are open to us as women and as midwives.

I believe that change will come through struggling at the level of everyday life as a midwife.

Setting up a Domino Scheme

by Lilian Mecran, SRN, SCM, ADM,
Senior Midwife, St. George's Hospital, London

A description of how the scheme was set up in a London hospital.

The Domino (Domiciliary In and Out) Scheme enables women to be delivered in hospital but go home as soon as possible, usually between six and 24 hours after delivery. An important component of the scheme is that women recieve care from community midwives throughout the antenatal, labour, delivery and postnatal periods. This enables the individual needs of the mother to be met through more personalised care. Ideally each woman would have a single midwife assigned to her and responsible for all her care but in practice this is rarely achievable and a team approach which facilitates the development of relationships of trust and understanding has been adopted.

Domino schemes were introduced in the late 1960's at a time when there was an increasing trend towards hospital confinements. Up until 1960 approximately 60 per cent of women delivered at home but this decreased dramatically following recommendations supporting hospital confinement in 1959. The justifications for this recommendation were that the risk of death to mother and infant was lower in obstetric hospitals, and that the advantage of hospital confinement is so great that it should override any disadvantages such as the distress it may cause to the mother or the physiological or psychological morbidity which mothers or babies may suffer as a result[1].

In response to pressure from women the Domino scheme was offered as a compromise between home and hospital confinement, operating initially in general practitioner units.

Hospital deliveries at St. George's Hospital were approaching 3,500 per year in 1985 and in order to relieve pressure on beds whilst providing a high standard of maternity care a modified Domino scheme for women resident in Wandsworth was proposed.

The aims of the scheme were stated as being:

1. to give mothers more personalised care in which individual needs could be identified and met,
2. to provide continuity care,
3. to give the midwife the opportunity to use all her midwifery skills in caring for the woman antenatally, in labour, during delivery, and postnatally.

In addition it was anticipated that job satisfaction for midwives would be enhanced.

Women who were to be considered as being suitable for the Domino scheme were those in the lowest risk groups. It was agreed that this could include primiparous women.

Antenatal care would be provided in a variety of ways. Community midwives could undertake shared care with the GP either at the surgery or more informally in the client's home. Care could also be shared by the community midwife and the hospital consultant either at a peripheral clinic or again in the client's home. All mothers would attend the hospital for booking and again at 34–36 weeks gestation.

During labour and delivery mothers would be looked after by the community midwife in St. George's Hospital. Provided that the delivery was normal and both mother and baby were well they could be transferred home to the care of the community midwife within six to 12 hours of delivery.

A six-month pilot scheme was begun in October 1985. During this time community midwives provided care for, and delivered, 45 women. Clients were recruited mostly in one of three ways: during booking and history taking by the community midwife in the client's home; referral by the consultants from the booking or antenatal clinics; from peripheral antenatal clinics which are staffed only by midwives.

During the pilot scheme a number of problems arose. Staff in the maternity department were unsure how the scheme worked and there was confusion between the function of the peripheral clinics in relation to the Domino scheme. Some general practitioners thought that the scheme would work on the same principle as in a GP unit and that they would be called to attend for labour and delivery. In response, meetings were held with midwives, hospital doctors and general practitioners in which these and other problems were discussed and the scheme clarified.

At an early stage it was recognised that it was not going to be possible to guarantee that a particular midwife would be present during a mother's labour and delivery. Instead a team approach was introduced whereby a team of six midwives known to the mother provided care antenatally, during labour and delivery, and postnatally. Tea parties were held once a month in the community midwifery base to introduce mothers to midwives.

Following the six-month pilot period it was agreed that the Domino Scheme should continue and by the end of 1986, 120 mothers had been involved in the scheme. Although the Community midwives were continually assessing how the scheme was progressing and how it could be improved to meet the needs of the mothers, it was felt that this was an appropriate time to undertake a more formal evaluation. A self completion question-

Reproduced with permission from Midwife, Health Visitor and Community Nurse, vol 25, no 6, June 1988, pp 231-232.

naire was compiled and sent out to all mothers who had been delivered on the Domino scheme in 1986. We were concerned to find out the view of mothers as we knew that some mothers had been disappointed to be attended by a community midwife not known to them during delivery, and there had been instances when no community midwife had been able to be present. Were we being unrealistic in the number of mothers we were booking on to the scheme in relation to the number of community midwives available?

The response to our evaluation survey was good with 80 per cent of clients returning completed questionnaires. We were gratified to find that 88 per cent of clients said that the scheme had met their needs, with 97 per cent saying that they would use the scheme again. This was in spite of findings which suggested that we had not been totally successful in achieving our original aims.

Sixty-seven per cent of mothers recorded that the majority of their antenatal care had been provided by a community midwife with just 50 per cent recording that they had a birth plan. During labour and delivery 64 per cent were attended by a community midwife but for almost 50 per cent of these women it was not a midwife they had met before. All those mothers who knew the attending midwife felt that this made a positive difference as to how they coped with labour and to their feelings throughout this very important time.

Almost 40 per cent of mothers went home within 12 hours of delivery with 70 per cent going home within 24 hours. Just 17 per cent remained in hospital for longer than 48 hours. More than three-quarters of mothers went home within the time they requested. Some of the reasons given for having to stay longer were instrumental deliveries, babies needing intensive care or mothers choosing to remain in hospital for a longer period.

Mothers emphasised the importance of continuity of care especially in the delivery and postnatal periods in enabling them to cope better. Postnatal follow-up care proved to be the area where most improvement is required if we are to achieve this. Only 35 per cent of the mothers were visited postnatally by a midwife they knew whilst almost all felt that knowing the midwife affected postnatal care.

In response to the findings of the evaluation study there have been changes in duty rotas and more staff have been allocated to the community to cope with the workload. We are confident that more mothers are now being followed through from antenatal to postnatal by midwives whom they know. We are continuing to recruit mothers to the Domino scheme and requests to join the scheme continue to increase.

We will continue to assess our performance and look for areas where we can do better. One example of this is, at the present time the community midwives are informed when the mother arrives at the hospital in labour. We are working towards the community midwife being able to assess the mother's progress in labour in her own home so that the time spent in the labour ward can be reduced. This is seen as being desirable by both mothers and midwives.

A recent study[2] showed that the clinical skills and judgment of many midwives in relation to the assessment of pregnancy were not being used fully. As midwives we are aware that the client's expectations in the performance of her care are increasing. She wants to be informed, to have a choice, and more than anything else wants continuity of care throughout pregnancy, labour and the postnatal period. However, it has been demonstrated that the role of the midwife is still not recognised among our medical and nursing colleagues, as well as the general public, so that many midwives feel frustrated with the fragmented pattern of maternity care which they experience[3].

We as midwives still have a long way to go in order to meet fully the expectations and demands of our clients. Judging from the response of our clients the Domino scheme appears to be one way in which this could be achieved. With the continued commitment of the community midwives to this concept of care there is no reason why the Domino scheme should not continue to enlarge and provide appropriate individualised care for an increasing number of women.

Acknowledgements

I should like to thank all the community midwives for their continued commitment and support for the Domino scheme.

My thanks also go the Chris Hoare, Nurse Advisor Research and Quality Assurance, Wandsworth Health Authority, for her help and advice both with the evaluation project and the preparation of this paper.

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Nurses' training fund gets big boost

WELLINGTON. — The Government will invest an additional $25 million in nurse training over the next five years, Associate Education Minister Phil Goff and Health Minister David Caygill announced yesterday.

The funding will provide 176 extra comprehensive nursing course places from next year, which will see 477 additional nurses in training by 1991.

"The increase in places will allow New Zealanders to fill highly trained nursing positions for which, because of shortages in recent years, New Zealand has had to rely on importing nurses with the necessary skills," Mr Goff said in a statement.

The new training positions will be available at polytechnics from February. There will be 64 new places available at Carrington Polytechnic, 32 at Waikato, 16 at Parumoana, 48 at Wellington and 16 at Christchurch.

Mr Caygill said the additional training places would increase numbers to meet workforce requirements forecast by the Department of Health.

Government approval of the extra training places also signalled the completion of the transfer, begun in 1973, of the three-year nursing programme from hospital schools to polytechnics, the ministers said.

• MR CAYGILL also announced domiciliary midwives would receive a 50 percent increase in fees and other payment increases.

He said the Government recognised home births as a genuine option for women.

Wellington Homebirth Association spokeswoman Madeline Gooda said the increases were extremely impressive.

It would be a big improvement for midwives who, under the old pay regime, had to supervise 60 home births a year to obtain an income of about $21,000.

The association had been campaigning for at least six years for improvements to midwives' payment, she said. There were still places in the country where obstetricians opposed home births, so there was a lot of educating to be done yet.

Mr Caygill said the fee for supervising labour and delivery for a six hour period would increase to $250.

Time beyond the six hours would be paid at $37.50 an hour.

Mr Caygill has also agreed to support an additional number of antenatal and postnatal visits.

Up to six additonal visits will qualify for funding at the current fee of $16 per visit.

Mr Caygill said the increase in fees would be backdated to the start of August.

Domiciliary midwives are contracted with the Health Department.

MICHEL ODENT

Bestselling author of
BIRTH REBORN

.....addressed an Auckland workshop Dec 10th on
CHILDBIRTH - A TURNING POINT

Odent is well known for his outspoken criticisms of modern maternity care, questioning the need for much of the medical intervention that takes place. His years at Pithiviers Hospital in France where he initiated dramatic changes to the childbirth enviroment showed clearly that the less interference there was during labour, the less likely problems would develop with the birth.

He emphasised the need to observe 3 very important rules
- Don't distub the mother in labour
- Don't disturb the first contact between mother & baby
- Don't disturb breastfeeding

Then there is the need to question the various childbirth practices used. For instance, research (Lancet Dec'87) has found that foetal electronic monitoring creates a worse outcome with a higher c-section & forceps rate. However, the medical profession is trained to answer some questions and avoid others.

Cultural behaviour with nutrition and particular eating/food traditions may actually have a biochemical basis that we should consider and ask questions about. For instance, in certain countries fish is not to be eaten in particular situations. There are some fatty acids which influence the synthesis which is involved in childbirth, and these fatty acids are found in fish oils. A report (Lancet 1986) on childbirth in the Faroe Islands (north of Scotland) showed a very low rate of prematurity but a higher mortality rate. The main diet is fish and the average baby is overdue and overweight with difficulty in being born. As fish oil seems to postpone labour, this raises lots of questions about the value of using fish oils to 37wks to avoid prematurity, stopping in time to avoid postmaturity.

Enviromental factors also have a profound affect on labour and research on mammals (US scientist Newton) to discover how to make their labour longer and more difficult showed that the following will achieve this:-

1. Put the labouring animal in an unfamiliar place.
2. Move the labouring animal from place to place.
3. Put in a transparent glass cage to be observed.

Undisturbed animals seek a dark private place and as humans are mammals this is a fundamental need for them too. At Pithiviers they endeavoured to make the hospital a familiar place by involving women in an activity there - a singing group. Privacy was achieved with a small birthing room. Many people have overlooked the importance of the size of birthing rooms, and most are too big.

Darkness is important too as light is a strong and powerful stimulant. The sense of sight is the most intellectual sense whereas during childbirth the active part of the brain is the primitive part. Inhibitions come from the optic side so there is a need to reduce this type of stimulation which inhibits the process of birth. Darkness gives more of a feeling of privacy and being unobserved and is easy to introduce for birthing women.

Human Enviroment is also significant and primitive women still go bush isolating themselves and protecting themselves from men. Traditionally birth is definately only women's business. The presence of the baby's father at the birth is a very new phenomena that coincided with the increase in hopitalised birth, reduction in family size, and the change in social structure ie. midwives diminished role, less support from women and more fragmented family life which leaves only the couple plus the practical need of the fathers role in transporting the woman to hospital. Odent stresses the need for more time to consider and understand all the implications of men at birth - there is no simple conclusion. In 1940 Gantly Dick Read observed that men may transmit fear during labour and are therefore a negative pressence.

Now it is the couple giving birth rather than the woman. If the man is actively involved and in front coaching, labour will be long and difficult. When the woman is ready to "go to another planet" the man wants to maintain eye to eye contact. This is very inhibiting and disruptive. He has seen women lock themselves in the toilet to ensure privacy, and if he sees the man preoccupying the woman, he suggests she go to the toilet. The more involved the man, the longer the labour.

Women are best left alone

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New Insights Into The Physiology Of Labour:

Midwives of the greatest value are those who are able to take a back seat role. Vaginal examinations are an intrusion of privacy and an experienced midwife should not need a finger to know what is happening.

The end of the first stage is characterised by the need to grasp. The first stage is a passive one so at the end of this stage more adrenalin is secreted so more blood is going to the muscles and changes are easy to observe. An ecstatic state indicates a high level of endorphins so the hormonal state can also be an indicator. Dilated pupils, a dry mouth and wanting a glass of water is due to a high level of adrenalin which signals the muscles are being prepared for pushing. The behaviour and hormonal balance are far more significant than the state of the cervix. The need to grasp is the real key.

Women need the best possible enviroment for the birth, but just at the special moment following birth - someone wants to do something....catch the mothers eye, congratulate, ring on the

phone, give a medical check, talk loudly.....all while the mother is trying to establish eye to eye contact with her baby. Important not to disturb the mother at this time as she is still on "another planet" and knows instinctively how best to hold the baby for breastfeeding if left undisturbed at this critical point. The baby needs her touch, so don't wrap it up, and look out for the man who is interfering with "what about me" messages.

3rd Stage - is the time to avoid detachment of the placenta until the right time. Again, the need for privacy and darkness helps the mother secrete oxytocin so the process happens undisturbed. Women will spontaneously choose an upright position that won't compress the vena cava (big blood vessel), so important to not interfere with this too.

The Value of Water - can be very helpful for women who find the hospital inhibiting to isolate themselves. Water has a lower level of gravity and less stimulation, but is most effective after mid-dilatation. Women find the contractions easier and more efficient and are better able to relax in the water. However many will leave the water when they feel the birth is close and the move to a cooler place stimulates additional adrenalin so the birth follows very soon after.

Birth Under Water - is a possibility and it is important to accept this. Where there is a pool it will happen at some stage although he is opposed to planning the course of labour. Water is best for hard painful labour, not good for re-establishing labour where the woman is best left by herself in the dark to sleep. The first breathe is triggered by the first contact with the air so just bring the baby gently to the surface. There is no reason to panic and rush in with hands. The best rule to remember is to keep hands in pockets. Water birth after rupture of membranes is not a problem; there is greater risk of infection from germs in the throats of Drs and from vaginal examinations. He recommends the use of a transportable pool with disposable plastic liners. The magic of water helps express emotions and is a traditional feminine symbol.

Technology is a masculine symbol but we must learn to use it in a more positive way. People with the technical knowledge don't understand how to use it. The role of the O&G should be only when needed, and c-section should only be a rescue process for babies in distress.

The Process of Labour is often diagnosed too soon which can affect the whole course of the labour and birth. Be relaxed about it and avoid vaginal examinations. The mother is unlikely to need ecbolics or other substitutes if left alone. The question to ask if there is a problem, is what in the enviroment is making the mother unable to do this. Best to forget the clock for length of labour and to consider the physiological time and affect on mother and baby.

Screening is more appropriate during the first stage when he can observe the effect on the mother and baby. He never refuses anyone for a homebirth for medical reasons.

Postmaturity - may need to recalculate due date as this doesn't usually consider the woman's private life or her cycles. He advises against interference unless signs of distress, and that fetal distress related to pstmaturity is not as common as we think. Daily amnioscopy can be done to check vernix and fluid, but he suggests overdue women ring him when they count 10 kicks, and if they ring by noon everything is OK.
Cord Check is unnecessary as the baby will find some way to be born - then unwrap the cord. If the woman is in a good position and nobody gives her orders the perinium doesn't need support.

Advice is something he generally doesn't give as he has a policy of non-interference. However he does encourage the man not to disturb the woman and not to be too anxious to do things. Men often have difficulty understanding this. Where the culture is for women to isolate themselves birth is usually easy and fast. For the occassional birth that is difficult the young people stand around yelling and shouting. This triggers the birth by the increase in adrenalin. (Re.Canadian Indians)

Vitamin K is not necessary to be administered to the normal baby. There is no rational reason why it would be deficient in this precise vitamin. There is a correlation between vitamin K and jaundice and he feels the medical profession have become attached to practices such as this for no logical reason. There are early signs anyway if a baby does require vitamin K.

Ultrasound scanning is something he doesn't use as he operates on the basis of "what are you expecting of a test and will it change your attitude?" (otherwise why use it). He acknowledges it is a way of being curious but the data doesn't change anything and we don't know if it is safe so why risk it. We now know that ultrasound interferes with metabolic pathways/enzymes but the long term effects are unknown. It could be a way of reducing life expectancy, or increasing the likelihood of cancer etc....nobody knows and there are too many unanswered questions. He won't use the scan until the year 2030 when he considers he will be informed enough to make the decision. His advice to Drs is to ask women what they eat. This provides far more useful and important information than a scan.

Childbirth Education Classes - are the modern substitutes for the traditional birthing education and wisdom passed down generations of women. As well as the isolation of the nuclear family, there are now knowledge gaps as the last generation discouraged breastfeeding, picking up crying babies etc. which can be replaced by classes. Pregnant and breastfeeding women also have a strong need to be with other women yet so often they are isolated at this time; but for the day of the birth when they need privacy, "everyone" is there!

Sunday Star 11/12/88

Doctor promotes natural births

BY ELIZABETH MITCHELL

French home-birth advocate Michel Odent offers obstetricians and midwives unusual advice.

The former surgeon, in New Zealand this week to speak to health professionals, tells colleagues to keep their hands in their pockets during births, and let the mother get on with it.

In the 1970s, annoyed by the power technology was having over pregnant women, Dr Odent started his own clinic in Pithiviers Hospital in France. He now writes books and travels the world teaching how to "give birth back" to mothers.

His methods include getting rid of the bright lights and the surgical feel of modern delivery rooms, letting women give birth where they want, and keeping as far as possible from the use of forceps and Caesarean births.

Dr Odent says even the vocabulary of birth has to change before attitudes can.

"When someone asks me if I've delivered that baby I say 'No, the mother gave birth.'"

"Obstetrician comes from the same word as obstacle. We have to make sure we don't disturb the first contact between mother and baby.

All other mammals give birth in the dark and it is the natural place for it," Dr Odent says.

The "primal room" at the French hospital which has seen 1000 women a year give birth in a dark environment has an adjoining room with a pool for women who choose a water birth.

No research has been done into whether babies fare better under the Odent method but he says they will be as well off as their mothers. "You can't separate mothers and babies. What's good for the mother is good for both of them."

Dr Odent will hold workshops in Auckland, Tauranga, Wellington, Christchurch and Dunedin.

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