SAVE THE MIDWIVES

FEBRUARY 1990 # 22

CONTENTS

DIRECT ENTRY - HAVE YOUR SAY

This issue includes the Direct Entry Discussion Document and Curriculum Draft Proposal for a Direct Entry course to be sited at Carrington Polytechnic in Auckland. As stated in the document itself, the DE Taskforce have actually approached a number of Techs. around the country who have expressed interest in midwifery training, but to date, only Carrington via its School of Health Studies have been prepared to take action.

This document is released with the endorsement of the NZ College of Midwives as determined at its last national executive meeting on Feb 3rd 1990.

The document is self explanatory and we would like to encourage as much input and response to it as possible. During the survey previously conducted, it was evident that there was both concern and confusion about exactly what a DE would offer, and although this is both a draft and an outline only, our hope is that it will also provide the necessary clarification.

For those who live in the Auckland area or who are able to move to attend the Carrington course, please contact the School of Health Studies to inform them of your interest. They are recording all such enquiries to further assess the level of interest and to maintain contact with potential participants.

For those of you in other areas, we hope that this document will facilitate discussion which may ultimately lead to a course in your area as well.

Looking forward to your responses and comments. Judi Strid

RELIEF HOMEBIRTH MIDWIFE REQUIRED

Whangarei & District to work with Lynley McFarland

From April for all of 1990

Active Homebirth Support Group established

Domino Contract possible

Midwives home (and dog) possible available

Ph. Feliz Barnett (089) 487-182 NOW

or write FAST POST to: 5 Armstrong Ave., Whangarei

D A T E S T O R E M E M B E R

* **FERTILITY ACTION COURSES ON WOMEN'S HEALTH ISSUES** - Auckland
  Course 1 commences 15 Feb (6 Thursday evenings)
  Course 2 commences 29 March (6 Thursday evenings)
  $100 for 1 course or $180 for both - Educ.College,Epsom Ave.
  Contact: Fertility Action,PO Box 46148,Herne Bay (09)780 357

* **DRAGON BOAT FESTIVAL** - Auckland - March 4th
  St. Helens Hospital Auckland have a team entered in this.

* **INTERNATIONAL WOMEN'S DAY** - March 8th

* **BREASTFEEDING AWARENESS WEEK** to show Breast Is Best March 29
  Contact: Jackie Gunn - ATI or Betty Jenkins - National Womens

* **COMPLEMENTARY MEDICINE & HEALTH LIFESTYLE FAIR** - 31 March
  Students Union Building Cafe, Auckland University

* **THE HEALTH PROMOTION FORUM OF NZ ANNUAL CONFERENCE** April'90
  Theme: Working Together - Health as a Social Movement
  Contact: Kim Conway,c/-Community Health Dept.Auckland Univer.

* **1990 NZ NATIONAL HOMEBIRTH CONFERENCE** - Whangarei
  May 11-13 (10th Domiciliary Midwives Day)Theme Birth Figures.
  Contact: Agnes Hermans - 24 Pah Rd, Onerahi, Whangarei

* **1990 NATIONAL NURSES FORUM** - Victoria University, Wellington
  May 18-20 Theme: Partnership in Health - The Future Is Now
  Contact: Nursing Educ.& Research Foundation,PO Box 2128,Wgtn.

* **AUSTRALIAN 11th NATIONAL HOMEBIRTH CONFERENCE** - May 19-21
  Adelaide. Theme: "Unity In Birth"
  Contact: GPO Box 703, Unley,South Australia 5016 (08)3394195

* **INTERNATIONAL WOMEN'S DAY FOR PEACE & DISARMAMENT** - May 24th

* **NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE** - Aug 17-20 1990
  Knox College - Dunedin (AGM on the Friday night)
  Enquiries: Conference Cmttee. NZ College of Mws, Otago Region
  PO Box 6243, Dunedin North. (Calling for abstracts/ideas)

* **INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS:** October 8-12 1990 Kobe, Japan
  Theme: " A Midwife's Gift - Love, Knowledge and Skill "
  Enquiries: ICM International Congress, Nursing Association
  International Relations, 8-2, 5-Chrome Jingumae,Shibuya,Tokyo
  (or to NZCOM Board of Management, PO Box 21106, Christchurch)
  Deadline on abstracts - Jan 31st 1990

* **EARTH FIRST EXPO** - Avondale Racecourse and Showgrounds
  Oct 18-22 1990. Contact: PO Box 8371, Symonds St. Auckland
  To celebrate the spirit of co-operation between the different cultures which now make up the NZ community in the search for better ways of co-existing with each other & the natural environment on which we ultimately depend.

* **FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES:**
  14-17 November 1990 - Massey University, Palmerston North
  Theme: Women as Health Providers Within a Context of Culture, Society & Health Policy.
  Enquiries: Dept. of Nursing Studies, Massey University, PN.

* **AUSTRALIAN COLLEGE OF MIDWIVES 7th BIENNIAL CONFERENCE-** Perth
  16-18 September 1991 Theme: " Birthdays, Birthways "

* **2ND INTERNATIONAL HOMEBIRTH CONFERENCE** - 1992 Sydney
  Enquiries & Input: Jane Thompson,12 Thornton St.Fairlight,NSW

The Bristol third stage trial: active versus physiological management of third stage labour

W J Prendiville and others. Department of Obstetrics and Gynaecology, Bristol Maternity Hospital, Bristol, England.

Type of Study:
Prospective, randomised controlled trial.

Numbers:
Of 4709 women delivered vaginally in Bristol Maternity Hospital between 1st January 1986 and 31st January 1987, 1965 were admitted to the trial. (95% of those eligible to participate in the trial did so).

Purpose:
To compare the effects of routine active management of the third stage of labour with those of physiological management on maternal and fetal morbidity; in particular to see whether active management reduces the incidence of postpartum haemorrhage (blood loss 500 ml) compared with physiological management.

Methods:
1695 women entered the trial on admission to labour ward and were randomly allocated to either active (846) or physiological (849) management groups just before vaginal delivery. The women in the two groups were comparable at entry to the study.

Criteria for exclusion from the trial were: refusal; antepartum haemorrhage, heart disease, breech presentation, multiple pregnancy, intrauterine death. After a preliminary analysis of the data (by an independent data monitoring committee) to check whether there was evidence of any clinically important adverse effects in either treatment group, three additional criteria were added in May 1986: ritodrine given two hours before delivery, anticoagulant treatment, and any condition requiring specific management of the third stage. The management of any woman allocated to the physiological group became active whenever necessary. The study was approved by an ethics committee.

A number of outcome measures were recorded:
(a) Maternal variables - blood loss; length of third stage; the need for therapeutic oxytocics; the need for manual removal of the placenta and evacuation of retained produces of conception; side effects of oxytocics such as nausea and headaches.

(b) Neonatal variables - Apgar score; packed cell volumes (0.50 or 0.65); admissions to special care nursery; presence of jaundice; whether breastfeeding at time of discharge.

Results:
99 per cent of the women allocated to the active group received all three main components of active management (i.e. a prophylactic oxytocic, cord clamping before delivery of placenta and cord traction). Only one-fifth of the physiological management group were given a prophylactic oxytocic, two-fifths had cord traction, and just over one half had the cord clamped before placental delivery. Thus, nearly half the women in the physiological group (n = 403) achieved a physiological third stage whilst about 17% of the women allocated to the physiological group received as much active management as those allocated to the active group. The study was highly controlled: the protocol clearly specified the circumstances in which a deviation was permitted and detailed reasons were always provided for any differences between the management allocated and that received.

By April 1986 concern had been expressed about the high incidence of postpartum haemorrhage in the physiological group and a preliminary analysis of the data from 425 deliveries showed considerably higher rates of postpartum haemorrhage (16.5% v. 3.8%). Therefore, in May 1986 the independent data monitoring group recommended that whilst there was insufficient evidence to conclude that active management produced unequivocally better outcomes, the trial protocol needed to be amended by adding the three further exemption criteria listed under "Methods" above.

Detailed statistical analysis of the data was carried out. For the 849 women allocated to the physiological management group between January 1 1986 and January 31 1987 the incidence of postpartum haemorrhage was 17.9% compared with 5.9% in the active management group. A similar difference was also seen in other indices of blood loss as detailed below. The third stage of labour was longer in the physiological group (median length 15 minutes v. 5 minutes), and more women needed therapeutic oxytocics (29.7% v. 6.4%).

Likewise, a secondary analysis showed that the outcome for the 403 women in the physiological group who actually received physiological management was notably less beneficial when compared with the active management group. Analysis of the neonatal variables did not reveal any significant differences between the two groups except that the mean birth weight of babies in the physiological groups was significantly higher and they also had a significantly higher mean packed cell volume when compared with babies in the active group.

The researchers had been concerned that systematic bias might have affected clinical estimates of blood loss since the trial was not double blind and the observer knew the management allocated. They therefore studied three additional maternal haematological variables which could be objectively measured: postpartum (24-28 hours) haemoglobin concentration < 90g/1; mean postpartum packed cell volume; mean change in haemoglobin concentration between 34 weeks gestation and postpartum. Each of these measures supported the more subjective clinical estimates.

Authors' Comments:
The authors conclude that active management of the third stage of labour reduces the incidence of postpartum haemorrhage, shortens the third stage and results in reduced neonatal packed cell volume. Moreover, they state that the results of the secondary analysis showed that active management of the third stage was preferable regardless of first and second stage criteria. They write: "Contrary to prior expectations, the advantage of active management was consistently greater in women defined as being at low risk". The authors also discuss possible reasons for the relatively low rate of "successful" physiological management.

Abstracted with permission from British Medical Journal, vol 297, no 6659, 19 November 1988, pp 1295-1300.

THE BRISTOL THIRD-STAGE TRIAL:
A Critical Review by Dr John Stevenson

> If you set out to compare a policy of intensive precipitous intervention with a policy of sitting back & watching the patient bleed, obviously the rush-in-and rip-it-out policy will be seen to be safer. This is not what the proponents of optimal birth are contending. The whole trial, based on false premises, is completely misleading, & numerous other criteria are mistaken, misunderstood, or misinterpreted.

The British Medical Journal of 19.11.88 published a 6 page report of an important trial concerning active versus physiological management of third stage labour. The stated objective was to compare the effects on foetal & maternal morbidity of routine active management with expectant or physiological management, particularly regarding post-partum haemorrhage. The trial was discontinued early because of excessive incidence of serious haemorrhages in the physiologically managed group. Analysis of the results showed that the policy of active management not only reduces haemorrhages, but has the additional benefits of shortening third stage & reducing neo-natal packed-cell volume. So this trial appears to be completely disastrous for the proponents of restrained management.

This research report is important because of its far-reaching implications. From now on, obstetricians all over the world will tell their patients that they will not stand any nonsence about third-stage management, because a carefully planned, expertly structured, & thoroughly monitored trial in Bristol Maternity Hospital has proved conclusively that the customary routine management of third stage is safe & efficient, whereas the unorthodox requests of the minority of nuisance patients have been proved to be dangerous, so much that the trial had to be stopped before it got half-way through its planned course. Any patient who wants to continue arguing will be referred to this report, where she will get bogged down amongst overpowering rationalizing & scientific jargon.

The trial was planned & set up by the Academic Dept. of Obstetrics & Gynaecology (whose members would be expert at obstetrical intervention), with the help of a research midwife, & a social statistician. It was a progressive randomised trial in which women who were expected to deliver vaginally were allocated randomly to either active or physiological management As each woman approaced delivery, a sealed envelope was opened, revealing which group she was allocated to. Active management consisted of injection of oxytocin as the anterior shoulder was delivered; immediate clamping & cutting of the cord; & delivery of the placenta by cord traction. The physiological group was managed by NOT giving oxytocic prophylactically; by leaving the cord intact until the placenta was delivered; no cord traction nor any manual interference with the fundus; encouragement of early breast feeding & encouragement of a posture favourable for placental delivery.

In explaining the purpose of the trial, the authors refer to some reports published in medical journals, in which the scientific bases of certain obstetrical routines were questioned, so the trial was designed to test those contentions. Note that the challenges did not come from patients! The obvious alternative to active management is passive management, to see whether a woman's body can cope without assistance; that should settle the matter conclusively. Here is a very common blunder in logic, to go from the sublime to the ridiculous; to justify on inordinate extreme by ridiculing the opposite inordinate extreme, & I have indicated exactly this error in my introduction.

Physiological Management is a contradiction in terms; you don't "manage" the physiology of the body. To devise the protocol for physiological management, because there is no standard definition of it, the research midwife took advice from "certain midwives known to practice it", and then trained the labour-ward midwives before the trial commenced. I question whether a research midwife from the hospital establishment could faithfully obtain a clear assessment of methods used by midwives outside the system who respect the wishes of their clients, & then responsibly reduce those methods to protocol rules & teach them to sceptical labour-ward staff in the hospital setting. Those "certain midwives known to practice it" were not called in to check the finalized protocol for "physiological management".

The patients' wishes were another missing factor, as the trial was planned & controlled by experts without ANY input from ANY patient at ANY time. We must also distinguish between two quite distinct issues in the complaint against maximal hasty intervention. One is that women want less haste & less intervention, but not to the extent of permitting excessive bleeding. The other is that they need consultation, explanation, & agreement, regarding obstetrical procedures which can be painful & frightening. The correct & valid basis for this trial should have been patient participation; one group wanting a share in the decision-making, & the other group content to leave all decisions to the staff.

By what right should the patient have any say?
The obstetrician spends years in medical school learning all the answers to every possible problem; he must know what to do & how to do it. This is a specious but spurious argument; there are plenty of things done by doctors & other experts without enough logical basis, & not necessarily producing the results expected or promised. In a free country, the mother definitely has the right to call the shots. But she also has a very basic perogative. She has grown this child within her body, & when born will nourish the child at her breast, worrying about the best foods for the child after weaning. This care & concern continues through illness, the teaching of various skills, the achievements, through school & into adult

life. Of all the notable events in the life of her child, the momentous is the birth. She needs & deserves attendants who are sympathetically involved, emotionally supportive, & respect fully helpful; & this especially concerns her medical assistants. If she does not want the placenta ripped out straight after birth, surely that wish should be respected & honoured. It is a thoughtless bureaucratic mentality which says "EITHER we drag it out this minute, OR we leave it until you have bled so much that you are in trouble". The reason why homebirth is so safe is because we use common-sense rather than rule-of-thumb, & we tackle haemorrhages in good time but by gentle methods which we have learned by respecting the patients' wishes. The organisers of this trial could & should have seen that it was wrongly conceived, & would need to be stopped because of disasterous results.

A pilot study was conducted for 6 weeks in Nov-Dec 1985 to ensure that the management was feasible, & to train the staff. The trial proper was commenced in Jan'86. By May'86 excessive haemorrhages in the physiological group (PM) caused the management committee to modify the protocol by increasing the criteria for exclusion from the trial; clarifying the conditions for transfer from the physiological to the active management group (AM); & increasing encouragement of attempts at early breast-feeding. However the data monitoring committee became increasingly concerned about the alarming haemorrhages in the PM group, until in Jan'87 they recommended that the trial be stopped.

Virtually all the women allocated to AM received it, but less than half the women allocated to PM were successful, the rest needin intervention. Even when the patients were re-classified as low-risk if labour was spontaneous, duration less than than 12 hrs, & delivery spontaneous; but high-risk if induction, augmentation, or epidural were "necessary" & if labour were longer & "needed" assistance, the results of further analysis showed that AM was "preferable" regardless of first & second stage criteria. In fact, contrary to prior expectation, the advantage of active management was consistently greater in the low-risk group.

None of the women in the AM group was transfered to the other group. Of those allocated to the PM group, many failed when the cord was clamped & cut immediately either because it was tight around baby's neck, or because the liquor was meconium-stained. I believe the cord should not be cut for either of these indications. In the rare event of a baby needing resuscitation, it can be done effectively & efficiently without cutting the cord. The cord should never be cut until it is empty & has ceased pulsating. However it is not necessarily left intact until the placenta is delivered; a few mothers want that, most do not. A mother may want to put the baby to the breast at once, but it is unusual for a baby to suck in the first half-hour, although I have occasionally seen immediate sucking.

RESULTS:	ACTIVE MANAGEMENT (AM)	PHYSIOLOGICAL MANAGEMENT (PM)
Haemorrhage over 500mls	Almost 6%	Almost 18%
Haemorrhage over 1 litre	Almost 1%	3%
Oxytocic inject.prohylactic	100%	20%
Oxytocic inject.therapeutic	6.4%	Almost 30%
Vomited	12%	6%
Serious Problems*	About 8%	21%

*Defined as haemorrhages, transfusions, manual removal or evacuation of retained products.

No reason is stated why prophylactic oxytocin was given to 20% of the PM group. Maybe the labour-ward midwives weren't concentrating, & most of the "failures" in this group obviously occurred because those midwives were so experienced & confident with AM. The authors predictably conclude that the policy of active management is justified in preventing blood loss exceeding 500mls including the increased risk where loss is greater than 1 litre, the "need" for blood transfusions, longer third stage & raised neo-natal packed-cell volume.

1. Physiological Management Causes Third Stage to Last Longer -more than half an hour in 25% of cases. How dreadful, in terms of doctor's valuable time! Homebirth practitioners perceive baby & the birth process to be far more valuable than Drs time, doing other things while watching out for haemorrhage. They consider the mothers comfort, write up their notes & admire the baby. Why is 3rd stage longer than 2 minutes deemed a disadvantage? The policy of the College of Obstetricians is delivery of babies safely & efficiently. We argue that their concept of efficiency is incompatible with safety, because it boils down to saving the Drs valuable time, which seems to me what this trial is all about. I suggest that the superior safety of homebirth is precisely due to our policy of patience & careful restraint, which the researchers should investigate & evaluate.

2. Excessive Haemorrhages
This report states blood loss in volume catagories as though it were a bad thing. This assumes the human body is so bably designed that it needs obstetricians to apply the dreadful ritual of AM to save women's lives. Whilst we flatly object to their AM & their so-called PM used in the Bristol trial, we also disagree with their assessment of blood loss as though it were always bad. A woman's body produces over a litre of extra blood during pregnancy, & a loss of 2-3 decilitres with no disability is quite normal. Some women lose a litre without disability. However, there is not a single mention in this report of how a patient was affected by blood loss, nor of the criteria on which a transfusion was deemed necessary.

When there is minimal bleeding, or none at all, there is very good reason not to disturb the placenta. Besides allowing the parents to contemplate, caress & bond with the bay undistracted, it is important to remember that the uterus underlying the placenta is consolidating & becomming less likely to bleed, so that after half an hour haemorrhage becomes so unlikely that one could regard it as effectively prevented. As a very basic safety measure, this principle could be formulated: In the absence of significant bleeding or expulsive contractions or cervical discomfort, the placenta should be left undisturbed for a good half-hour. After that, it can be delivered when the mother wishes.

When a haemorrhage threatens, the correct policy is first deliver the placenta, then help the uterus contract by massaging it directly. Third & lastly, oxytocic injections, rarely needed.

At the first convenient opportunity after the birth, the underpad should be changed, so that liquor & meconium are removed, & any blood loss will be obvious. If bleeding occurs, it should be scooped up & placed in a measuring jug, & when the cumulative loss approaches half a litre, it is time to warn the mother that the placenta needs delivering. The reason for instigating action before the loss reaches 500mls is that by the time the placenta is delivered, particularly if stbborn, & when the blood in the membranes is included, the total loss is considerably more. The authors comment that post-partum haemorrhage is usually under-estimated. This is largely true & I have yet to meet anyone (apart from the midwives I have trained) who meticulously measures the loss in a measuring-jug.

In this trial however, I suggest the haemorrhage in the PM group could well have been over-estimated, due to the general anxiety & expectation of failure pervading Bristl Hospital as everyone became horrified by the predominence of haemorrhages in the group being managed "wrongly" in the view of the staff.

3. The Problem of Increased Neo-natal Packed Cell Volume
-implies the baby's circulation is overloaded with too many red cells. The PM group babies averaged 85gms heavier than those of the active group, & 3 times as many had a packed cell volume of over 0.65 , & they were much more likely to have blood specimens taken to check for polycythaemia or jaundice.

When the cord is not clamped immediately, allowing the placenta to drain, baby receives about half to one cupful OF ITS OWN BLOOD as drainage from the placenta. The experts feel they are doing the baby a favour by depriving it of this extra blood, thus reducing jaundice, & possibly other advantages, especially saving time. Mild or moderate physiological jaundice is absolutely no threat to a healthy breast-fed baby. Ultra-violet lights are unnecessary, & I am sure the baby makes good use of that extra blood - a valuable body substance. There is also a glaring inconsistancy in the way obstetrical experts view baby's surplus blood from the placenta (which they blithely discard) compared with mother's surplus generated during pregnancy but redundant once baby is born (which they strain to conserve).

The Bristol Third-Stage Trial, conceived & executed by "experts" with no patient input, is very bad news for proponents of gentle optimal birth. It rationalizes & justifies the alleged safety & efficiency of the horrendous "active management" of 3rd stage, as I suspect it was designed to do. We must point out that all their rationalizations fall far short of reasonable logic. No woman who has experienced, witnessed or read about careful & gentle 3rd stage would agree with the standard AM, but the authors were not concerned about informed choice. They were dealing with women who had no information & no choice. The medical attendant does not need to be a genius to routinely give an injection with the anterior shoulder, clamp & cut the cord, & pull the placenta out quickly; but they must be sensitive, sympathetic, responsive & dedicated, to leave things alone but be ready to act when the need is perceived. Good mothering is enhanced & facilitated by inner peace, confidence, & bonding to the baby, & these are not favoured by thoughtless hasty obstetrical routines.

···· With thanks to Dr Stevenson & Maggie Lecky Tompson ····
···· Editor of Independently Practising Midwives Communique ····

L E T T E R S:

I am interested in working in NZ as a midwife. My plan is to try & organise an exchange job for one year from June 1991. At present I am in full time work as a community midwife in Dunfermline. I am also interested in independent midwifery & would like any information that would help with my plans.

Elizabeth Paitington
Kenya Cottage,
49 Mid Beveridgewell,
Dunfermline, Fife KY12 9ES
SCOTLAND

In the Winter issue of Save the Midwives you quote me as saying that "the 3 greatest threats to modern obstetrics are consumerism, feminism and midwives".

That is a distortion of what I said about the future of obstetrics and you were quite wrong to put the statement in quotation marks. I described consumerism, feminism and changes to the status of midwifes amongst a number of other influences on obstetrics and of course these 3 have been positive influences for the most part. At no time did I talk about "threats to modern obstetrics".

I ask you to publish this letter in your next issue with an apology.

Yours sincerely

M.A.H. BAIRD.

Everything You Ever Wanted to Know About Research But Were Afraid to Ask

by Linda Corson Jones 12/IJCE/August 1989

Fifty Research Questions

Want to do a research project but you're not sure what to study? An exciting new book, *Childbirth Education: Practice, Research and Theory* (1988: W.B. Saunders Co.) by Francine H. Nichols and Sharron Smith Humenick (available from the ICEA Bookcenter), contains numerous questions for future research. These cover a wide range of topics related to pregnancy, childbirth (CB) education and early parenting. Fifty key questions from this book are identified below. Wouldn't it be wonderful if several of these questions were addressed by researchers each year?

1. What are the benefits of teaching expectant parents to use assertive communication and to make responsible choices?
2. Does expectant parents' knowledge about options and choices for CB influence the nature of the birth experience?
3. What constitutes a satisfying CB experience?
4. Are CB classes cost effective?
5. What teaching strategies are most efficacious and for which kinds of class participants?
6. How does attending CB education classes influence parenting ability?
7. What are the short and long term effects of CB pain on the woman as well as her baby?
8. Do women in labor respond better to a female or male voice?
9. How effective are group teaching sessions of relaxation training when compared with training done on an individual basis?
10. Is there a difference between general and specific relaxation response in men and women?
11. Do biofeedback trained women maintain a higher degree of relaxation during CB than women who do not receive such training?
12. Can a labor companion or CB educator learn to determine the state of relaxation as effectively as biofeedback equipment?
13. How does therapeutic touch influence the responses of women during pregnancy and CB?
14. What is the effect of therapeutic touch on the sleep and rest patterns of the newborn?
15. Do individuals who are trained to use therapeutic touch continue to use it as a life skill following CB?
16. To what extent can expectant parents be taught to use acupressure effectively during pregnancy and CB?
17. How effective is acupressure in decreasing pain during CB?
18. Which pressure points are most effective in decreasing pain during CB?
19. How beneficial is imagery in CB education?
20. How extensively or frequently do expectant parents experience negative aspects or problems with visualization in CB education classes?
21. Can imagery be used to induce overdue labor?
22. Can imagery be used to delay preterm labor?
23. Are combined right-brain, left-brain imagery exercises more effective than a single strategy?
24. To what extent does music enhance relaxation?
25. Are some styles of music better for use in labor than others?
26. Is music more useful in certain phases and stages of labor than others?
27. What is the effectiveness of different paced breathing patterns in increasing relaxation and decreasing pain of the laboring woman?
28. How much home practice time is needed for women to become proficient in executing paced breathing patterns?
29. Can paced breathing patterns be taught effectively to untrained women during labor?
30. What effects do variations of positions have on labor progress?
31. What is the safety and efficacy of upright positions in second stage labor?
32. What is the cost-to-benefit ratio of single unit labor/delivery/postpartum rooms as compared to traditional birthing units?
33. How much CB education is needed for a labor companion to effectively function during CB?
34. What types of practice skills in class promote effective coaching behaviors?
35. What are the most common fears and concerns that expectant parents have about analgesia and anesthesia for CB?
36. How does CB education influence the resources and perceptions of parents to cope with a stressor event and avert a crisis?
37. Do parents retain information presented to them regarding a variety of potential unexpected birth outcomes?
38. What influence does nutrition information received in CB education classes have on parents' healthy nutritional habits?
39. What is the effect of exercise on birth and maternal recovery?
40. What is the influence of social support on expectant and new fathers?
41. Under what circumstances does receiving social support provide stress for expectant and new parents?
42. If a pregnant woman remains sexually active during the third trimester, will uterine contractions gradually efface and dilate the cervix, facilitating a shorter labor?
43. Is endogenous oxytocin produced by sexual stimulation an effective alternative to drugs for inducing or augmenting labor?
44. How does the organizational setting (health care agency versus independent classes) influence class outcomes?
45. Does the influence of CB education classes extend beyond the CB experience?
46. What are the unique problems, such as fatigue and needing child care for other children, of learners in CB education classes?
47. What are the characteristics of the CB educator who is seen as a "master teacher?"
48. What types of evaluation are used most frequently by CB educators?
49. What is the most effective way to stimulate more participatory health consumer behavior?
50. Is computer-assisted instruction as effective as traditional teaching methods for the presentation of factual content in CB education classes?

HOMEBIRTH AUSTRALIA NEWSLETTER

CONSENT ISSUES IN CHILDBIRTH - THE CONSUMER'S EXPERIENCE

This is a summarised version of a paper given by Hilda Bastian at a seminar on *The Legal, Ethical and Social Issues Pertaining to Pregnancy and Childbirth*, Cumberland College of Health Sciences, in October 1988.

An individual's right to maintain physical integrity and a measure of control over his or her life is an important feature of personal autonomy. Self-determination is particularly crucial during pregnancy and childbirth care, when the woman and her family have to live with the consequences of any action or inaction for the rest of their lives.

The role of the healthcare professional should be to provide advice and expertise, not assume the decision-making role unless specifically requested. In practice, a woman's right to make her own decisions disappear in the face of basic professional advantage and control : she is offered a choice which is no choice - "do this or you/your baby will die". The word consent implies agreement to choice made by someone else. (WHO, 1985 p115)

Making an informed choice requires an effective communication process and access to choice and information is dependent on, and limited by, the personal values and skills of the caregiver. Even the choice of practitioner may be limited.

Professional prejudices and preferences for particular treatment and approaches to care can have a controlling influence in the way choices are presented with the favoured option being glowingly described and the alternative sounding far less ideal. A practitioner has great scope in deciding what are the risks and benefits, according to which criteria and which data source suits him or her best. The lack of reliable data has not prevented obstetrians and midwives from confidently asserting the advantages and disadvantages of various procedures based either on prevailing popular opinion or personal belief. As well, some doctors and midwives will also neglect to mention quite a range of side effects which they may not consider important, but which may well have great bearing on a woman's decision to accept a procedure. Indeed, there are many procedures that some would not even consider consent necessary eg administering oxytocic drug in third stage, administering or not administering Vitamin K to the newborn.

There is also great variation between practitioners in the amount of time they are willing to spend in communication with women who wish to make their own decisions - and on what issues.

Women's choices are further limited by inflexible hospital policies and routines of which she may not even be aware. While new obstetric trends are quickly incorporated into clinical practice whether or not they have been adequatelyevaluated, consumer demands must typically run a gauntlet of years of lobbying and negotiation to reach any level of acceptance within an institution.

Choices are limited by the prevailing medical system generally: while you may be "allowed" a choice between a number of regular pharmaceutical preparations, or even a choice of no drugs at all, you are not likely to be offered the choice of herbal, homeopathic or acupuncture treatment. Nor is access restricted only in the area of what may be regarded as "fringe" alternatives: access to personal , continuous midwifery services - the traditional form of maternity care - is severely limited in Australia . Midwives are rarely granted visiting privileges in Australian hospitals.

Most aspects of the maternity care system have been developed without the informed consent of the community generally. Despite the fact that maternity services are funded by the community, there has been little direct community involvement in the evolution of professional, institutional, and governmental policies and protocols, the allocations of resources, research, or training of relevant healthcare professionals.

The rights of consumers should not be subordinated to professional and institutional needs without their consent, no matter how compelling these needs may seem to be to the professionals involved. In the case of research for example, it is often argued that there is no compulsion to honour the doctrine of informed consent; but women have the right to know the basis upon which an obstetrician or midwife is recommending a particular course of action - whether it is because they believe it is the best option, or whether it is because he or she would just like to know "what would happen if.... ". Pregnancy and childbirth care is suited to the informed choice process, as there are several months of preparation time in which the carer and the woman, in conjunction with other advisors such as childbirth educators, can develop an understanding and respect for the woman's preferences, whether informally or formally in a birth plan.

The right of women to informed consent is also often

personal records cannot be regarded as freely available when it requires a complicated freedom of information process to unearth the documents; information cannot be regarded as adequate when it is incomplete, biased or incorrect; and informed consent has limited value when at the same time it is not accompanied by true choice. At the present time, for childbearing women in particular, informed consent ultimately implies only that a woman has the right to agree with prevailing medical opinion: no matter how informed an individual might be, her choices are limited to those which are regarded as "acceptable" by her medical advisors. In fact, while there is at least some right to informed consent, there is very little scope for might be called "informed dissent".

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Hospital and continued his research into the physiology of childbirth.

His book "Natural Childbirth" was published in 1933. This was severely criticised and ridiculed by many of the medical profession, though interest was shown by the Regius Professor of Obstetrics and Gynaecology, F.J. Browne and Dr Joseph de Lee of Chicago. They encouraged Dick-Read to persevere and subsequently he contributed a chapter to Prof. Browne's textbook "Antenatal and Postnatal Care".

"Revelation of Childbirth" was published in 1942, it became universally known by the American title "Childbirth Without Fear" (1944).

Then followed "Motherhood in the Post War World", "Birth of a Child", "Introduction to Motherhood" and a revision of "Childbirth Without Fear"(1953) and "Antenatal Illustrated"(1955).

In 1947, Dr Grantly Dick-Read was invited to lecture by the Maternity Center Association of New York and the Clinique Tarnier in Paris. He lectured throughout the United Kingdom and South Africa in 1948.

After a battle for registration, he practiced in South Africa till his retirement from active practice in 1953. He filmed the last four European cases he delivered and then made a safari with his wife through the Belgian Congo, Central and East Africa to investigate childbirth amongst the unwesternised Africans in their villages. The story of this safari is told in travelogue form in "No Time for Fear"(1955).

By 1956, his works were translated into twelve languages and extracted in many more, his film "Childbirth Without Fear" was released throughout the world except South African (at the request of the women involved) and in April, 1956 a long-playing record of a baby's birth, delivered in Dick-Read's house was produced.

On the 26th of October, 1956, Pope Pius XII granted a private audience to Dr Dick-Read and his wife, at the Summer Palace. He was presented with the Silver Papal Spoon in recognition of the moral and scientific value of his principles.

In February 1957, lecture tours commenced in Germany and Switzerland covering many countries of the world, including France, Italy, Australia and America. He was in Australia in September, 1957.

A biography of Dr Grantly Dick-Read under the title "Doctor Courageous" by A. Noyes Thomas was published in England followed by a serialised autobiography in the British magazine "Woman". This was a beginning for the public to get to know the truth of a man whose life was devoted to mothers, babiesand the family unit, physically, mentally and spiritually. Dr Dick-Read died on June 11, 1959 in Norfolk.

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