SAVE THE MIDWIVES

NUMBER FOUR SPRING 1984

Your Subscription Expires With This Issue

OUR NEXT MEETING : Monday September ~~23~~, 8 pm, 24 Ashton Rd., Mt Eden,AK.

Topic:The Closure of Auckland's Maternity Hospitals:

"What Can We Do?"

All members welcome.

SAVE THE MIDWIVES

money

Save The Midwives is in financial crisis;we have $222 in the bank as of today, 22 August 1984.Our previous newsletter cost $390 to print and post 400 copies.So at our last meeting we decided to reduce the content of this next one and to raise the subscription fee . We cannot exist on the $2 fee and we think that most people can afford the new $4 sub. We have also introduced $6 and &10 subs for those of you who are willing (and able!) to pay more - we leave it to you to decide what you want to pay. Suffice it to say that we will welcome anything!
A huge thankyou must go to those people who have sent donations - approx $150 has been received so far, and without it we would not have got this far.Some members have been thanked personally and some have not - please accept this as a very appreciative acknowledgment.

magazine

We have returned to the old A4 format with this issue after several complaints that the newsletter was difficult to read. It is not actually more expensive since the type used can be smaller and the lay-out and spacing can be condensed.What took 2 pages in the last newsletter could be put on 1 in this one.However we welcome further comments on this.Also if anyone has any artistic work - cartoons, drawings, photos - we would very much like to receive them.How about photos of a birth?

members

Those of you who subscribed with the first issue will find a PINK sticker on your renewal notice this time. Please renew before November when the next issue is due out.

SAVE THE MIDWIVES POLICY STATEMENT

Save The Midwives supports and promotes midwifery as an independent profession; supports direct-entry midwifery, domiciliary midwifery, and the right of parents to information and choice in all aspects pertaining to childbirth.
At present we have 320 members nationally, 100 outside Auckland, and 70/80 of the 320 are midwives. 400 copies of the last newsletter were printed, as complimentary copies are sent to other community organisations in N.Z, and overseas, to M.P.'s, Department of Health officials, the media, etc.These complimentary copies are quite important on communicating the point of view of Save The Midwives members to the people who make decisions concerning health care in N.Z.

THE OBSTETRIC REGULATIONS

We are presently compiling a submission to be sent to the Health Department regarding the review of the 1975 Obstetric Regulations that the Department is undertaking. Plans are in the pipeline for a research study comparing procedures and outcomes in home births, small maternity hospitals and base obstetric units. The data collected by the Department at present is not sufficient for a comprehensive (and thus credible) survey to be carried out, and so we have requested the Department to also collect the following information:
mother: amniotomy? ultrasound? X ray? internal/external foetal monitoring? amniocentesis? episiotomy? tears? (with/without episiotomy?) 3rd stage-maternal effort or active management?
baby: spontaneous breathing? Apgar scores at 1 and 5 minutes? jaundice? birth injuries? A COPY OF OUR SUBMISSION IS AVAILABLE TO MEMBERS - ENCLOSE AN S.A.E.

THE STRATEGIC PLAN - THE AUCKLAND HOSPITAL BOARD

The Hospital Board recommends closure of Helensville, Howick, Papakura, and Warkworth maternity hospitals as well as St Helens base Hospital. These moves will seriously affect parents as well as midwives and we intend to send a submission.This will be the topic of discussion at our next meeting to be held at 24 Ashton Rd., Mt Eden, 8pm on Monday September 18.Everyone is welcome - you don't have to say anything, it is a great opportunity for midwives and mothers to get together , please come along!

NEWS & EVENTS

An Auckland Patient's Rights Association has been formed along the lines of the successful Christchurch organisation,by Aucklander Lynn Potter. Any enquiries can be addressed to the Association c/o 48 Killarney St., Takapuna,or phoned to Lynn on 498 884.

#The New Mothers Support Groups that have operated successfully in Wellington for some time have now begun in Auckland.The contact is Fay Habib, 120A Roseberry Ave, Birkenhead,Ak 10, phone 480 953. The Support Groups are now operating in 8 Auckland suburbs, co-led by two women who are mothers of young babies.They organise the creche and the venue, and facilitate the discussion groups which last for 8 weeks.

#Professor Dennis Bonham has resigned as Medical Advisor to Parent's Centre as a result of concern felt by Parent's Centre members over his recent publication "Whither Obstetrics", which recommends aggressive management of labour, routine ultasound and amniotomy, and free use of IV fluids, forceps and episiotomy.

#The 20th International Midwives Congress was held in Sydney,Australia,Sept 1 - 7. The event is sponsored by the International Confederation of Midwives, 57 Lower Belgrave St., London SW1 WOLR, England.

The Health Department is revising the Obstetric Regulations 1975, through a Review Subcommittee.SAVE THE MIDWIVES has been sent a circular letter inviting submissions on the subject. Copies of the Regulations are available through Government bookshops, and the contact re the revision is the Secretary, Review Subcommittee on the Obstetric Regulations, Department of Health, PO box 5013, Wellington.

#The Auckland Hospital Board has released it's 10 year "strategic plan", which gives lowest priority to maternity and neonatal services, and recommends the closure of several small maternity hospitals, as well as the closure of St Helen's base Hospital. Submissions are invited before October 3. Copies of the Plan can be obtained from the Board, Private Bag, Auckland.

#MICHEL ODENT is visiting N.Z. in 1985 - late Feb/early March.The tour is being arranged by the International Childbirth Education Association and the Federation of N.Z. Parent's Centres and more information will be available through them later in the year. ODENT is well known for the maternity hospital he runs in Pithiviers, France, where the maternity care is based on a non-interventive,woman-centred approach.The outcomes for both babies and mothers are excellent.

#A tour of Australia and N.Z. by Janet Balaskas, author of Active Birth, and one of the originators of the Active Birth movement in the U.K., is provisionally planned for late 1984. It is being arranged by ICEA and PArents Centres.

#An Auckland Childbirth Education Association has beenformed along the lines of the Otago one which began late last year.Members will each join the ICEA ($3), and the group will become a member group of ICEA. Plans are for the group to meet monthly and exchange information and ideas prepatory to setting up a Chilbirth Educators course to train professional educators. Secretary is Lynda Wilson, 16 McEntee Rd., R.D. Waitakere.

#Auckland Parents Centre is holding these classes and courses for late 1984:
Antenatal classes, 24 October, Meadowbank Family Support Unit.
Toddlers course, 12 Sept, Meadowbank (fully booked, but taking enrolments for next year). Music/Art/Drama, 1 October, 3 week workshop for 3 to 5 year olds, 10-11am Mondays. Early School Years course, 11 October, 7.30pm, 4 weeks.All bookings to Bobby Wakenell (606 467), all enquiries to Marie Alpe (767 742).

#A MEETING is to be held with Deborah Farnsworth, secretary of the British Columbia Association of Midwives, on Tues September 25, 7.30 pm, at 4 St Stephens Ave, Parnell.The general topic will be midwifery, and Deborah will provide an update on the situation in Canada.(She practises there as a lay midwife.) Everybody welcome - parents and midwives alike.

#The next meeting of the Home Birth Association in Auckland is on September 18(Tues), 7.30 pm at 109 Meadowbank Rd., Meadowbank.
These meetings are open to anyone - come along and find out what it's all about.

#ICEA are negotiating with Sheila Kitzinger about a possible return tour of Australia and New Zealand, where she will be available to public groups for workshops and lectures. Sheila charges the eqivalent of 210 English pounds for a one hour lecture, and 400 pounds for a 5 hour workshop.

#BREASTFEEDING: LA Leche League branches offer a series of four meetings to pregnant women and new mothers, where practical "mother-to-mother"information is shared. The meetings cover these topics: "The Advantages of Breastfeeding", "Baby Arrives: The Family and the Breastfed Baby", "The Art of Breastfeeding and Overcoming Difficulties", "Nutrition and Weaning". Contact members for Auckland areas are:

Birkdale/Beachhaven	Bronwyn Stevenson	436 390
Birkenhead/Northcote	Christine Ball	485 673
East Coast Bays	Carol Oram	404 6204
Glenfeild	Christine Hughes	444 3938
Auckland East	Ann Owen	545 998
B/house Bay/Roskill	Sue Bickley	678 435
Green Bay	Glenda O'Halloran	817 6391
Henderson	Adrienne Peat	836 1537
Massey	Caroline May	832 5338
Mt Albert	Anne Heritage	860 752
Eden/Epsom	Sally Morison	735 162
Onehunga/Mangere	Lois Findlay	594 468
Te Atatu	Sheilagh Cave	818 7183
Titirangi	Bette Dean	872 949
Howick/Pakuranga	Jennifer Blake	534 9650
Manurewa	Sheryl Moroney	267 2395
Papakura	Debra Denny	267 6962

Tuakau/Lesley-Ann Massey/68462

Pukekohe/Keitha Jenkins/87090

Papatoetoe/Christine Ingle/278 4479

pinched from THE ASSOCIATION OF RADICAL MIDWIVES, No 22, SUMMER 1984

THE BATTLE TO BE A MIDWIFE

Is New Zealand short of midwives? Newspaper reports threaten the closure of Te Aroha Maternity Hospital should a midwife not be found. But for some people trying to register and work as a midwife is a real battle.

Many midwives write to Save the Midwives with problems but the experiences of Truus Verburgt should concern us all. Truus has agreed to let us write up her story.

Truus Verburgt was born in 1956 in the Netherlands. After high school she completed a three year training as an aneasthetic-nurse and worked in that capacity for one year. It was then that she became interested in midwifery. In September 1979 she began her midwifery training in a maternity clinic in Rotterdam. General training is not a prerequisite for midwifery in the Netherlands. Truus completed the three year course in August 1982 and was registered as a midwife. Her references are excellent.

So here we have a woman who has completed six years training and successfully passed her exams. The Midwifery Officer of the U.K. Central Council for Nursing and Midwifery, in a letter to Truus provides some idea of the standard of training. "The direct entry training in Holland did not have to be altered when the European Community Midwives Directives were implemented as it already met the requirements." Something which the U.K. course did not. There the direct entry course had to be increased from two to three years.

In 1982 Truus was making plans to immigrate to New Zealand and in May wrote to the Nursing Council seeking registration as a midwife. The Council informed her that in the terms of s.18(1) of the Nurses Act her application had been declined as her training programme was not equivalent to that of a New Zealand 'nurse' seeking registration as a midwife.

Direct entry trained midwives do register in New Zealand and work both in the domiciliary and hospital midwifery. However, since the Nurses Amendment Act was passed, direct entry trained midwives who were not registered and practising in New Zealand before 1st April 1984 can no longer register as <u>domiciliary</u> midwives. Nothing in the Act precludes them from registering and working in a hospital.

In January 1983 Truus wrote to the Council and received a reply from Pat Carroll which basically denies the right of direct entry midwives to register in New Zealand. "You ask further what supplementary courses you would take upon reaching New Zealand, in order to obtain midwifery registration. The nurses legislation is quite clear. Any person wishing to gain midwifery qualification who does not already hold a nursing registration would be required to complete the three year general/obstetric or comprehensive nursing programme and proceed on to undertake the one year Advanced Diploma of Nursing course with the midwifery/clinical option." Well, this is just not true.

Inspite of the Nursing Council decisions, Truus and her husband came to New Zealand in March 1983 and life since then has revolved

around trying to register as a midwife. Truus made a second application for registration in early 1983 but again the Council refused and advised her that she would have to complete the three year general training and obstetric nursing programme.

As Truus puts it, she had never been so angry in her life, but she was to get angrier as the saga continued. She made enquiries about training as a nurse, although the Council would make no committment to recognise her midwifery qualification should she complete the course. Ann McDonald wrote to her, "I can only confirm that the Council found no fault with the transcript of your midwifery programme at this time, nor could I imagine that it would be seen as deficient even if the requirements for the New Zealand midwifery programme were upgraded."

Truus applied for and received registration in the U.K. in November 1983 but the Council advised that this made no difference to their decision.

In November 1983 Truus reluctantly enroled in the comprehensive nursing course but understandably opted out a few months later.

The Nurses Amendment Act 1983 added a new subsection to s.18 of the Nurses Act which deals with persons qualified overseas. Section 18(3) reads, "In the application of this section in respect of any person seeking to become registered as a midwife, nothing in this section shall require that person to have successfully completed, elsewhere than in New Zealand, a course of instruction equivalent to a course of instruction leading to registration as a registered comprehensive nurse or a registered general and obstetric nurse under this Act."

Given this amendment, Truus applied again for registration in March 1984 but once again the Council refused registration on the basis of s.18, that her programme did not meet the Council's requirements.

It was at this stage that Truus heard about Save the Midwives and read our analysis of the Nurses Amendment Act. We advised her to place the matter in the hands of a lawyer which she did. Following a letter from her lawyer, the Council undertook to look at her application for the fourth time.

Once again they advised that she couldn't be registered under s.18(1) but for the first time they considered her case under s.18(2). They decided that she could register if she undertook 6 months further instruction dealing with theory and clinical practice of medical and paediatric nursing and a community nursing component. In addition she would have to satisfy language, age and character requirements. Her 6 month bridging course would have to be offered by a hospital school of nursing, technical institute department of nursing or general hospital nursing service.

Truus, you may remember, had specifically requested information on supplementary courses in January 1983 and been given no assistance.

Well, the bridging course sounds like a solution, doesn't it.? But it is not offered anywhere in New Zealand and the local Hawkes Bay Hospital Board has refused to be involved in such a course. (We have advised Truus to seek an Ombudsman investigation into this. Unfortunately the Nursing Council is not subject to investigation in this way.)

As Truus, in her excellent English says, "I feel very strongly that the Council deliberately wants to prevent me from practising as a midwife for reasons I still don't understand."

Before this decision was made, Truus and her lawyer had filed an appeal to the High Court. The Council told Truus's lawyer that at the meeting which would decide her fourth application for registration the Council was going to review the whole question of criteria for admission of midwives and that once they were established they would deal with her case. Well, the bridging solution came out of that meeting. Save the Midwives have written to the Council seeking information on these criteria.

The High Court action is likely to cost in the vicinity of $1,500. We Believe that the future of midwifery in New Zealand is dependent on women with determination and enthusiasm such as Truus has so amply demonstrated.

We would like to ask readers on her behalf to make donations towards her legal costs should she be unable to arrange a suitable 6 months course acceptable to the Nursing Council. She will then proceed with the High Court appeal. Donations will be refunded, less postage, (indicating <u>our</u> financial crisis) if the appeal does not proceed.

Truus wrote to us recently, "Thank you once again for all the support. since it is very difficult for me to keep my spirits up. It is like fighting against a big wall."

The Appeal Fund,
11 Manapau Street,
Meadowbank,
AUCKLAND 5

Barbara Macfarlane

WHY DIRECT-ENTRY MIDWIVES?

This is an account of the post-graduate work,over a period of one year, of a recently trained British direct-entry midwife.

The object of this account is to shine a light on the actual qualification,capabilities and experience, that modern-day direct-entry midwives have. Direct-entry midwives are now trained only in the U.K. and Holland,and in those third-world countries where they are equally experienced, if not so well-qualified.

Rather than giving a detailed descripton of the content ad syllabus of direct-entry training,it seems simpler and more illustrative to describe to you the three positions I held as a staff midwife in the maternity hospitals where I worked in Britain. With one year ahead of me before returning to New Zealand, I decided to gain as much varied experience as I could. The jobs which I applied for and secured were vacancies for state-certified midwives,with absolutely no discrimination towards midwives with or without the state-registered nursing training.

ACUTE POST-NATAL

My first job was as a staff midwife in the acute post-natal ward in a busy consultant maternity hospital.I usually worked in sole charge with the help of one nursing aide nd one nursery nurse.(A nursery nurse is trained specifically in the care of infants). There were 25 mothers and their babies and this post-natal ward catered for those whose births had not been normal,i.e. forceps and caesarean section births and those patients with medical problems - diabetes, epilepsy, asthma, multiple sclerosis, post partum haemorrhages and the subsequent transfusions. This work required not only midwifery skills but also much nursing care.It was not unusual to have 8 to 10 patients recovering from caesarean sections with all the post-surgical nursing care involved, as well as insulin regimes for the diabetics and so forth. The direct-entry training proved adequate to deal with the demands of such "abnormal" situations.

COTTAGE HOSPITAL

I then moved to a smaller and quieter cottage hospital, or General Practitioner Unit, where the most tecnical piece of equipment was a Sonicaid - a 10 bed unit giving total antenatal, intrapartum and post natal care to the local people of a small rural district. The nearest consultant unit was 7 miles away and it was there that we referred patients with problems of any kind.
The quality of the midwifery work in Gowborough was excellent. Again, each duty was staffed with only one midwife and an assistant nursing aide.We conducted midwive's antenatal clinics, called the G.P.'s only for the second stage of labour if necessary and happily enjoyed the early days of mother and babe before they went home. The atmosphere was very friendly, relaxed and open, and the midwifery work very enjoyable with great continuity of care for each woman.

TEACHING DOCTORS

Before leaving the U.K. I worked at University College Hospital, London, an obstetric training hospital for doctors.Here the pace was hectic, to say the least, and on the labour ward it was not unusual to deliver 2 or 3 babies in any one shift.(With 60 million people in Britain there is no shortage of birthing going on.)
Here there were many inductions, epidurals, and high-risk patients.As midwives we conducted and monitored all the labours, set up the fetal monitoring equipment, attached fetal scalp electrodes, set up intravenous infusions ourselves and

assisted the doctors for all abnormal births as well as scrubbing in theatre for caearean sections. Also it was our work to train and to supervise medical students in the art of normal birth.

RETURN TO NEW ZEALAND

I felt very happy to return to N.Z. and was lokking forward to working here very much. Also there were reports of a national shortage of midwives here,as in Britain. However, I found that only nurse-midwives could practise here as a rule. Nevertheless I applied to the Nursing Council for New Zealand registration and after a delay of 8 worrying months I am happy to say that two of us, both New Zealanders who trained in the U.K. as direct-entry midwives, now have N.Z. midwifery registration.
It was frustrating and in a way humiliating to have our British "modern-day" training and recent work experience that can be compared to the best in any country, doubted and at worst denied.

To conclude, we seek support and demand recognition for direct-entry midwives in this country.We hope that this door which was eventually opened to us will remain open to others in the future, and especially that no ill-fated wind will close it again.Thanks to Save The Midwives and to all who are giving direct-entry midwives such encouragement and active support.

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MIDWIFERY OVERSEAS

MIDWIFE Joan Donley recently travelled to the U.S.A. and Canada on holiday, and took the opportunity of talking to midwives and parents while she was there.The following two articles update the situation in those two countries for midwives.

CALIFORNIA, U.S.A.

In the State of California 3.6% of births took place outside of hospital in 1979 and the trend is increasing. Today there are 339 certified nurses-midwives (CNM) and over 350 "lay" midwives delivering babies at home.

There are three CNM training programmes in California which require a Bachelors degree in nursing, but some preference is given to nurses with a Masters degree. These midwives practice legally, being registered with the Board of Nursing;they are not popular with the medical community.
The lay midwives, on the other hand, practise without benefit of licensure - overtly or covertly depending on the medical response which ranges from tolerance to hostility.Since 1974,27 of these midwives have been charged with practising medicine without a license. Two have been convicted. The California Association of Midwives (CAM) has prepared a resume of all these cases entitled "Midwives and Other Outlaws".(Copy held by the Editor of STM).

The lay midwives practise without legal sanction, lack physician back-up, have difficulty in obtaining hospital admission for transfers, lack access to laboratory testing, have no third party reimbursement, have no Standards for Practice, and face prosecution.They have considerable, and growing, consumer support, and are presently working with consumers to define the scope of midwifery in statute, to increase accessibility to midwifery training, to establish Standards of Practice and to make provision to certify lay midwives.

I found the dedication and caring of these young midwives to be truly inspiring and I feel priveleged to have met some of them.

Joan Donley.

CANADA

In Ontario, as in all other provinces of Canada, it is illegal for midwives to deliver babies - in hospital or at home! Michael Dixon, registrar of the Ontario College of Physicians and Surgeons has said he does not consider it proper for midwives to be involved in birth either at home or in hospital! (I wonder if it's O.K. for women to be involved?). He said, "It would certainly be our position that midwifery is part of obstetrics and is therefore part of the pracice of medicine as defined in the provincial Health Disciplines Act...". The College warned it's members that " It is professional misconduct for a member to permit, counsel or assist any person not licensed as a physician to engage in the practice of medicine".(1)

Later, the chairman of the College's Ad Hoc Committee on Out Of Hospital Births,Ray Bechett, MD, FRCS(C), asked for a brief on "where midwives fit into the birth process"!

However, homebirth midwifery at least is supported by a number of progressive doctors. The Medical Reform Group,(Ontario), formed in 1980, passed a resolution in support of safe alternatives in childbirth and the legalisation of midwifery.But the College of Physicians and Surgeons stated in March 1983, that "out of hospital births should be discouraged because of the additional risks to mother and baby...patients are encouraged to discuss their views regarding childbirth with their doctors...a physician should not however, be expected to compromise his position, or to accept conditions which would make it impossible to maintain the standards of practice of the profession...". The "Toronto Star"'s reply was that " Home births are no more dangerous than hospital births and there has been no epidemic of tragedies.But to win your support in it's power play against midwives, the medical profession wants you to think that having a baby at home is the selfish whim of hippy dippies who care more about vibes than healthy newborns." The author, Michele Landsberg, pointed out that while there were decent individual doctors, "the organised medical establishment is something else: it defends it's own turf with the paranoia of a street gang, and it's monopolistic bully boy tactics make a group of tough Teamsters look like a convention of creampuffs." She claimed that "Canada's intransigence about midwifery puts it, ignominiously, among the most backward nations of the world...in feudal backwaters like Burundi and El Salvador...because women's health means big bucks - thats what it's all about."This, she claimed, is why doctors feel threatened by about 25 midwives working in Ontario.

Another article in the "Kitchener Record" quoted Dr Dorothy Hall who said that claims by the medical doctors that home birth was unsafe was " a lot of rot" and that the doctors are "selling the Canadian public a Bill of Goods".Dorothy Hall recently retired from W.H.O. after directing nursing education for nine years.

The Ontario Association of Midwives responded to the College of Physicians and Surgeons by compiling a bibliography of recent medical literature on homebirth for distribution to doctors and legislators.It also advised the College that since it did not reveal the sources of information on which it based it's conclusions, OAM considered these conclusions untenable and questioned the College's motives. OAM also rejected the College's use of Britain as a model because of the way the British statistics were compiled, and because of the different political, social and economic factors involved.

Currently there is a move to eliminate the supportive homebirth doctors through insurance fees. A doctor in Guelph has decided to discontinue coverage for homebirth because his medical insurance fees for this cover have been "increased out of all reason".

midwives

Most of the midwives in Canada were trained elsewhere. Although there are three Canadian nurse-midwifery courses training 16 to 24 miwives a year, these are primarily to train midwives for outpost nursing, that is, above the 60th parallel in the frozen north where doctors won't go.

Despite these anomalies, Canada is a member of the ICM. The Ontario Nurse-Midwives Association are sending a delegate,Lil Dunn, to the ICM Conference in Sydney in September. Lil did her midwifery training in Scotland and is currently working in Blenheim, N.Z.She came here hoping to gain midwifery experience!

In general a spirit of unity and co-operation pervades the relationship between the lay and nurses midwives in both Ontario and British Columbia.Since the struggle throughout Canada is for the legalisation of midwifery the nurse midwives need the support of the numerous lay midwives who have strong consumer support.

"labour of love"

Louise Mangan points out that "the medicalisation of midwifery in other parts of the world has jeopardised the status, role and skill of the midwife, that international experience shows that a nursing background is not necessary to quality care and that the status of the nurse midwife in the United States has been threatened by traditional doctor-nurse relationships."
Louise is past chairperson of the Interdisciplinary Midwifery Task Force (B.C.), which along with the Midwives Association of British Columbia is working towards legalisation of midwifery in British Columbia.They are also developing criteria for the education and licensure of midwives.

Much of the unity among the Canadian midwives can be credited to MABC. In British Columbia they have had success in uniting both formally trained and self-trained midwives to work towards their common goal.In their second "Labour of Love" Conference in 1983 the dominant theme was a union of the profession of midwifery undivided by categories - "unqualified midwifery".

Their conference called for :

1) recognition of midwifery as a distinct and valuable profession;

2) midwives as independent practitioners working in consultation with physicians rather than supervised by them;

3) creation of a separate "Midwifery Act" rather than subsuming midwives under the Nursing Practices Act;

4) separate and distinct midwifery training leading to highly skilled practitioners;

5) midwives should be self-regulated professionals with an advisory board which might also include nurses, physicians and consumers.

Following this conference, Karen May, a direct-entry midwife, U.K., and a founding member of MABC, attended the National Action Committee on the Status of Women Conference in Ottawa. The National Action Committee is the " most powerful lobby for women in Canada ". It passed the following resolutions:

Endorsed the International Definition of midwifery

Supported legalisation of midwifery services in Canada

Supported the coverage of midwifery services by provincial medical insurance programmes

Supported the inclusion of midwifery services in the extended insured services in the new Canada Health Act 1983, which consolidates health services under the Federal Government instead of the provincial governments.

All this energy culminated in the formation of a National Association of Canadian Midwives - a network of midwifery organisations across Canada who keep each other informed on midwifery status and who act as a basis for unity of purpose and support.

This organisation was born across Canada on Mother's Day, May 8, this year.What a positive way to celebrate Mother's Day! Across Canada midwifery is rising from the ashes. It is becoming a force to be reckoned with - legal or illegal.So much so that the Canada Council Explorations Programme has awarded a 6-month grant to research a book about the re-emergence of the midwife in Canada.

midwives unite

The Midwives Association of British Columbia are sending delegates to the International Confederation of Midwives conference in Sydney in September. Their delegates are sponsoring a remit to encourage the unity of all midwives - lay, direct-entry, and nurse-midwives. To date they are supported in this by the Dutch midwives and the American College of Nurse Midwives.Dorothea Lang. president of the latter, has said that "North America is being looked upon as setting new trends in midwifery.There is an obligation to set an example for other nations to follow". She recommended that the Midwives Association of North America (MANA) work towards joining ICM. Perhaps American support for this remit will influence midwives from other countries to also endorse it. Let's hope so! In New Zealand the Midwives Section of the NZNA certainly came out in support of the direct-entry midwives at the time of the Nurses Amendment Bill. In fact this was the reason that the NZNA would not let the midwives submission go forward to the Select Committee considering the Bill - it contradicted the NZNA POlicy Statement that midwifery is merely a post-graduate course of nursing, not a profession in its own right.

Midwifery IS a profession in its own right.If midwifery is going to make a come-back, this premise is fundamental. Let's hope that countries where midwifery is recognised can come to terms with their nursing elitism and recognise that midwives adequately trained outside the nursing/hospital setting are also midwives. The World Health Organisation Definition of a Midwife says " A midwife is a person who..." i.e. she is not necessarily a nurse!

USEFUL ADRESSES

CAM - California Association of Midwives, PO Box 3306, San Jose, CA 95156,USA.

MOM - Mothers and Others For Midwives, 5481 Santa Catalina Avenue, Garden Grove, CA92645

MOTHERING magazine - PO Box 2208, Albuquerque, New Mexico 87103,USA.(Sub $US 15.00p.a.)

BAGOM - Bay Area Guild of Midwives, c/o Melanie Austin, CNM,3054 22nd St.,San Francisco, CA,USA.

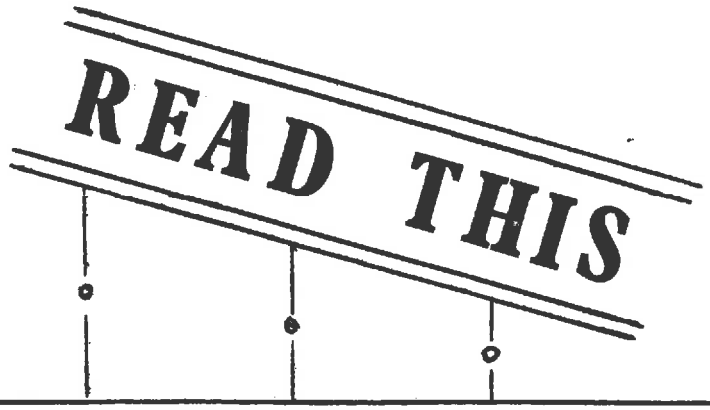
MANA - Midwives Alliance of North America, c/o Concord Midwifery Service, 30 South Main St., Concord, N.H. 03301.

Medical Reform Group of Ontario, c/o B. Lent, 929 Waterloo St., London, Ont N6A 3X2

MABC - Midwives Association of British Columbia, PO Box 46698,Stn G, Vancouver V6R 4K8.

IMPROVING THE OUTCOME OF PREGNANCY THROUGH INCREASED UTILIZATION OF MIDWIVES*

Doris Haire



Several comments were received after the last newsletter that the excellence of this article was obscured by the small size of the print.So here it is again, twice the size, and we urge ALL MIDWIVES to read it.It provides sound evidence for the thesis that maternity care for normal childbirth is best provided by MIDWIVES!

ABSTRACT

"Current research makes it obvious that aggressive management of human parturition is not, in general, in the best interests of the vast majority of mothers and babies. Practices such as the enforced confinement of the mother to bed during labour, amniotomy, administration of drugs that depress the central nervous system of both the mother and her newborn infant, forceps extraction, etc., are potentially detrimental to both mother and infant. If the outcome of pregnancy is to be improved, the number of nurse-midwives must be increased and their services expanded. Efforts aimed at reducing infant mortality by concentrating on the expansion of neonatal intensive care units are secondary, not primary."

During my years as President of the International Childbirth Education Association, the National Women's Health Network, and the American Foundation for Maternal and Child Health, I have visited hundreds of maternity hospitals throughout the world: in Great Britain, Western Europe, Russia, Asia, Australia, New Zealand, the South Pacific, the Americas, and Africa. During my visits I was privileged to observe obstetric techniques and procedures and to interview physicians, professional midwives and parents in the various countries. My companion on many of my visits was Dorothea Lang, C.N.M., Director of Midwifery for the New York City Department of Health and Past President of the American College of Nurse-Midwives. Miss Lang's experience as both a midwife and former head nurse of the labor and delivery unit of the New York Hospital-Cornell Medical Center, made her a particularly well qualified observer and companion. As we traveled from country to country, certain patterns of care and infant outcome soon became evident. For one, in those countries that enjoy an incidence of infant mortality significantly lower than that of the United States the major proportion of family planning services and obstetric care is provided by highly trained midwives. In these countries the medical expertise of the physician is called on only when the expectant mother is ill during pregnancy or when labor or birth is anticipated to be, or is found to be, abnormal. Under this system the high-risk mother, the one who is most likely to bear an impaired or stillborn child, has a better opportunity to obtain in-depth medical attention than is possible under our existing American system of obstetrical care, in which the obstetrician is also called on to serve as both midwife and physician.

Evidence is accumulating rapidly that our basic system of providing obstetric care is not in the best interests of normal pregnant and parturient women and their offspring, nor, in many cases, in the best interests of high-risk mothers and their offspring.

Roberto Caldeyro-Barcia, President of the International Federation of Gynecologists and Obstetricians (F.I.G.O.) from 1976 to 1979, commented on the adverse effects of obstetric intervention on maternal and infant outcome by saying:

> In the last 40 years many artificial practices have been introduced which have changed childbirth from a physiological event to a very complicated medical procedure in which all kinds of drugs are used and procedures carried out, sometimes unnecessarily, and many of them potentially damaging for the baby and even for the mother.[1]

Obstetric residents and practicing physicians have been so pressed to keep up with technology that they

* This article was adapted from the author's testimony presented at a Public Hearing sponsored by the Mayor's Blue Ribbon Commission on Infant Mortality, Washington, D.C., February 14, 1980.

from the American Journal of Nurse-Midwifery, Vol 26, No 1.

have not developed or have lost their skills to perceive and interpret human factors and their contribution to the intricate checks and balances which comprise human parturition. Residents and practicing physicians have increasingly turned to electronic and ultrasonic devices to determine the status of the fetus. Yet the F.D.A. has recently cautioned that

> Increasing concern has arisen regarding the fetal safety of widely used diagnostic ultrasound in obstetrics. Animal studies have been reported to reveal delayed neuromuscular development, altered emotional behavior, EEG changes, anomalies and decreased survival. Genetic alterations have also been demonstrated in in-vitro systems.[2] (For more details on diagnostic ultrasound see *Federal Register*, Tuesday February 13, 1979, part 3, pp. 9542–9545.)

Amniotomy (the artificial rupture of membranes), which is frequently carried out to insert the monitoring electrodes into the fetal scalp, is a procedure shown by Caldeyro-Barcia, Gabbe, and others to increase the risk of umbilical cord compression,[2] cord prolapse, and increased pressure on the fetal brain.[3] Amniotomy causes the baby's head, rather than the intact amniotic wedge, to serve as a battering ram to open up the birth canal.

I recently attended the Tokyo Congress of the International Federation of Gynecologists and Obstetricians. The research data presented by Doctors Caldeyro-Barcia, Flynn, and others demonstrated that American obstetric practices are frequently detrimental to maternal and infant outcome.

Doris Haire is the President of the American Foundation for Maternal and Child Health. In addition, she is the Chair of the Committee on Health Law and Regulation of the National Women's Health Network. She also serves on the Advisory Board of JNM, representing Consumer Affairs.

For example, several researchers showed that merely confining a mother to bed during labor tends to significantly[4]

1. Prolong labor by 2.5 hr
2. Increase the mother's need for pain-relieving drugs and uterine stimulants
3. Increase the need for forceps extraction of the infant
4. Increase the incidence of abnormal fetal heart rates and poor Apgar scores in the neonates.

Despite evidence that ambulation during labor improves the mother's comfort and the immediate and probably the long-term outcome of the pregnancy, the vast majority of obstetric patients in the United States are routinely confined to bed.

Drugs are used frequently as a substitute for quality care. Yet neither physicians nor other hospital personnel appear to be fulfilling their legal obligation to inform their obstetric patients that

1. There is no obstetric drug that has been proven safe for unborn children
2. The drugs offered to them during labor and delivery can depress their infant's cardiovascular, respiratory, and thermoregulatory mechanisms
3. No one knows whether the brain circuitry of the infant may be permanently affected by the drugs offered to them during labor and delivery.

Perhaps some mothers would not care about this, but their indifference does not remove the health professional's legal obligation to inform the patient of the risks involved in the treatment and of alternative treatments that do not involve those risks.

The improvement in the outcome of pregnancy resulting from the greater use of well-trained midwives was made evident in 1971 by Levy, who reported that during a 2-year medically directed nurse–midwifery program in California, the number of prenatal visits doubled and the incidence of infant deaths decreased significantly.[5]

Across the continent, the success of the California nurse-midwifery program in improving infant outcome has been essentially duplicated by the Frontier Nursing Service in remote Leslie County, KY, one of the poorest counties in Appalachia; in Su Clinica Familia, located in the Mexican border town of Raymondville, Texas; and at the North Central Bronx Hospital in New York.

NORTH CENTRAL BRONX HOSPITAL

I recently obtained data from the obstetric service at North Central Bronx Hospital in New York that demonstrates clearly that educating mothers for the childbearing experience, permitting one or two of the mother's loved ones to provide her with strong emotional support during labor and delivery, and avoiding unnecessary intervention in the birth processes can significantly improve the outcome of pregnancy, even when two-thirds of the obstetric population would be considered high risk or at risk.

It is appropriate to this discussion to describe the obstetric service of the North Central Bronx Hospital because it is a city hospital, serving one of the more sociologically depressed areas of New York. The mothers cared for at North Central Bronx Hospital are primarily black and Hispanic, with a smattering of whites. Thirty percent of the mothers are clearly medically high risk. An additional equal percentage of mothers would probably be considered at risk in most institutions.

The maternal and infant outcome at North Central Bronx Hospital in 1978 and 1979 is outstanding by any criteria. Given the 30% incidence of high-risk mothers it is truly remarkable. This good outcome is the result of the skilled and tender care of certified nurse-midwives who, with ap-

propriate medical consultation, essentially run the obstetric service. The care of high-risk mothers and at-risk mothers is essentially the same as for low-risk mothers unless there is a medical indication for intervention. If a mother or infant requires medical attention, it is provided by a board-certified obstetrician rather than by a resident. If a premature, low birth weight or sick infant is anticipated, the chief pediatric resident and a first- or second-year pediatric resident are in attendance at delivery. The intensive care nursery is under the direct supervision of a board-certified neonatologist 24 hr a day.

The midwives practice nonintervention obstetrics in keeping with the latest scientific research. The results of their efforts refute the premise that it is the mother alone, not the management of her pregnancy, labor, and delivery, that determines the infant outcome of her pregnancy.

A review of the records of approximately 2608 births carried out from January 1 to December 31, 1979 at North Central Bronx Hospital reveals the following enviable statistics:

- Every mother admitted to the obstetric service, whether low-risk or high-risk, and regardless of age, was cared for by midwives. With the exception of severely Rh-sensitized expectant mothers, obstetric patients were not transferred to another hospital.
- Eighty-eight percent of the deliveries were normal, spontaneous vaginal deliveries (without fundal pressure).
- Eighty-three percent of the total population of mothers were successfully delivered by midwives.
- Ninety-three percent of the infants over 1000 g born in the obstetric service had Apgar scores of 7 or above at 1 min of life; at 5 mins, the rate was 98.3%.
- Analgesia and anesthetic drugs were used in fewer than 30% of all labors.

Unless there is a specific medical contraindication, mothers are encouraged to walk around during labor to shorten labor (by 2.5 hr on average) and reduce the discomfort of contractions.

- The incidence of instrumental delivery was 2.34% (low forceps 1.57%; mid forceps 0.5%; vacuum extractor 0.15%.)
- The neonatal mortality rate among infants 1000 g or over was 4.2/1000; at 750 g or over it was 7.6/1000.
- The perinatal mortality rate among infants 750 g or over was 14.5/1000. (The overall rate for New York City was 15.9; for all other municipal hospitals in the city the rate was 20.6. Statistics are not available for more than 1000 g.)
- The overall cesarean section rate was 9% (7% primary and 2% repeat).

All mothers who had experienced a previous Cesarean section were allowed to experience spontaneous labor. Of these, 37% gave birth vaginally.

- There were no elective inductions of labor.
- Uterine stimulants such as oxytocin were employed in only 3% of mothers' labors and only when there was a medical indication.
- Vaginal examinations are kept to a minimum (three to five times) during labor to avoid causing the mother unnecessary discomfort, to avoid the inadvertent rupture of the mother's membranes, and to avoid an increased likelihood of maternal infection.

Great care is taken by the midwives to avoid the inadvertent or intentional rupture of the mother's membranes during internal examinations of the mother during labor.

- Fewer than 50% of mothers (including the 30% who were high risk) were monitored electronically. Many of the mothers who are monitored are monitored only intermittently to minimize the fetus's exposure to the potential risks of ultrasound.

To avoid maternal exhaustion during labor, mothers who are not high risk are allowed to eat and drink during labor. This practice has not resulted in a single case of aspiration of vomitus in the 2 years since the institution of the practice.

The mother's pelvis and perineum are not "prepped" (shaved and washed with an antiseptic solution). Enemas are not given.

Throughout their labor and delivery mothers are accompanied by one or two companions of their choosing.

Sixty-four percent of the mothers gave birth in their labor beds in the labor rooms. Twenty-one percent gave birth in labor beds that had been moved to the delivery room because of indication that the mother may need an assisted delivery or that the assistance of a pediatrician may be required. In only 15% of births were mothers moved to the delivery table for delivery.

- Eighty-five percent of mothers gave birth in the semisitting position without stirrups.
- Almost half (45%) of the mothers gave birth over an intact perineum. Episiotomy was performed in only 26% of births. Twenty-six percent of the mothers experienced first or second degree tears. Most first degree tears did not require sutures and all healed without complication. Three percent of the mothers experienced third degree lacerations, and 1% experienced fourth degree lacerations. These lacerations were extensions of episiotomies and occurred after the application of forceps by the obstetrician.

Premature and low-birth-weight infants are delivered over an intact perineum unless there is insufficient stretch to the mother's perineum.

The midwives at North Central Bronx Hospital have demonstrated that even high-risk mothers and their

offspring benefit from a policy of nonintervention unless there is a clear medical indication for such intervention.

I appreciate the skills of the neonatologist in saving very premature, ill, and defective infants. However, there is no doubt in my mind that ultimately the midwife will be recognized as the health professional most capable of improving the outcome of pregnancy throughout the United States. It is obvious from the good infant outcome of infants delivered at the North Central Bronx Hospital and other midwifery services in the United States that we could reduce the numbers of newborn infants requiring intensive care by increasing the number of midwives and expanding the services offered by them nationwide.

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Questionnaire Results

Answers received to our questionnaire, reprinted in this issue, make interesting reading. Would midwives please respond, who have not yet done so.

From the responses we have, midwives clearly joined Save the Midwives because they were concerned about the future of midwifery in New Zealand, the status of midwives and because it is a "professional duty" to support the Association.

None of the respondents felt that the Nurses Association properly represents midwives. "As a midwife, I do not feel represented at all through the NZNA. The result is the state of affairs at present. Midwives would probably become extinct before long, if the government had its way." All supported the establishment of a College of Midwives. There was some difference in ideas for the responsibility of the College but most felt, "surely midwives are best at deciding the highest requirements and standards for midwifery training" and "Its our training and we should be responsible to our 'own'".

The attitude to direct entry training ranged from full support to reservations. But all agreed that midwifery training in New Zealand at present is unacceptable. Similarly, all midwives were dissatisfied with the role of the midwife in New Zealand. "We are nothing more than a doctor's handmaiden"; we "should be given more autonomy, regarded as a professional"; and we find "medical profession patronising and sceptical of midwifery skills".

All agreed that the Save the Midwives newsletters were "most helpful" and outlined activities that we should undertake including "annual fee could be increased to cover costs", which we have been forced to do. Our thanks to the 12 who have responded to date.

Questionnaire repeated p.18

Auckland Hospital Board Strategic Plan

Midwives will be interested in this Plan which supports the closure of five maternity units in the region and the provision of facilities for all births to occur in obstetric units with specialist obstetric services. Interesting too to note that National Women's has 36% of the region's births and 24% of babies are admitted to the Intensive Care Unit. At St Helens 40% of babies are admitted to intensive care. Copies of the report are available from the Chief Executive, A.H.B..

Tips For Easing A Difficult Labour

from the California Association of Midwives' newsletter, Spring 1984.

BEFORE LABOUR BEGINS:

1) 3 weeks before birth, take Blue Cohosh daily to tone the uterus (in tea, tablet form, capsules, or as herbal tincture.

   Instructions for making a proper medicinal tea: Do not let the herbs or herb water touch metal! Place desired amount (1 teaspoon is plenty, usually) of fresh or dried herbs in a 2 pint jar, then pour in boiling water. Let steep and cool. Sip throughout the day to keep the essence of the herb in the body all the time.

2) Drink Red Raspberry teaonce a day throughout pregnancy, then in the last month drink it 3 - 4 times a day. A classic tea formula, used by our grandmothers in the last month of pregnancy, which can be added to the Red Raspberry and drunk 3 - 4 times a day is:

   Black Cohosh Root
   Squaw Vine (Mitchella repens or partridge berry)
   Blessed Thistle
   Lobelia
   Pennyroyal

   Mix herbs in a 1:1 ratio, store in a tight glass jar in the dark, and make tea daily as directed above. You will experience more intense Braxton-Hicks contractions after sipping the tea. Don't panic. The herbs won't trigger labour, they just tone or stimulate the uterus so that when labour begins, you will be ready for it. (Like priming the pump!). The more work your body does before labour, the more effaced you are, the easier the actual labour will be. Making the teas and drinking them on a daily basis is also like a positive mantra or meditation. It's affirming your positive intentions and affirming the power of the natural process by making and using Mother Nature's simple remedies. It takes an extra effort to use the teas, and as you drink them, you whisper to yourself the positive affirmations which will bring you the results you desire.

3) Take Evening Primrose Oil (available in Health Food stores) 3 times a day beginning 3 weeks before the baby is due. This oil has in it the precursors of prostaglandins, the hormone which causes the cervical connective tissue fibers to soften and give.

4) Take pituitary extract tablets 3 times a day, with meals, 3 weeks or so before baby is due along with 100mg of the Vit=B complex. This will stimulate the pituitary gland to produce enough oxytocin during labour, and the B vitamins will strengthen the liver, which needs to break down this hormone to promote rhythmic surges of oxytocin release. CAUTION: some physicians think this practice is questionable. Nan doesn't think that store-bought pituitary is that strong.

5) Emotional preparation is important, especially so that you don't repeat a previously bad experience. Some suggestions are visualisation, yoga, meditation, exercise, written affirmations, diet.

6) It is very important for women who have had previous C-sections to take the vitamins to keep their tissue strong and healthy and eliminate any possibility of tears or rupture. Vitamin E - 800 IU a day, and Vitamin C - up to 10,000 mg per day before the birth, then return to taking about 2000 to 4000 mg per ady during nursing. 2000 mg of calcium and 1000 mg of magnesium are also important to prevent muscle cramping and to reduce the amount of pain you experience.

7) Lastly, a wonderful preparation for a vaginal birth after a Caesarean is to massage your abdomen twice daily at the scar site to improve circulation to the area and prevent rupture. Keep some vegetable oil by your bedside and vigorously massage your stomach, focusing on where you feel the ridge of tissue down by your pubic hair. Then rub some oil on to your vagina to help keep you from tearing. When you massage your abdomen, don't rub hard enough to hurt yourself or set off contractions, just hard enough to stimulate the blood flow to the area.

8) Keep your baby small by avoiding dairy products (no cow's milk) , drinking teas and eating seeds, nuts and dried fruits for snacks.

READ "Nature's Children" by Juliette De Baracli Levy.

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New Ways to Teach Nurses

In starting a new school of nursing in Baltimore, the John Hopkins University and two co-operating Baltimore hospitals may be re-inventing the wheel, in part. It probably needs re-inventing.

With the demise over the past decade of many hospital-run, three year certificate programs, nursing education has suffered from a degree of disarray. Everyone agrees nurses need more technical background as medicine becomes more complex. But four-year baccalaureate nursing programs at universities sometimes stress academics at the expense of clinical training, while two-year community college programs don't offer enough of either.Moreover colleges and universities have not always been flexible enough in giving practising nurses credit for work experience and courses they took under the old three-year system.Nurses too often have been stymied in earning degrees and thus in advancing in their careers.

Hopkins University and Hospital, in co-operation with Sinai and Church Hospitals, plans to start a two-year program leading to Bachelor of Nursing degrees for students with two years of pre-nursing training.The emphasis will be strongly clinical,with training in research and the latest technologies and with opportunities to specialise.A key feature;much of the training will be in hospitals, not classrooms. The new school is partly a re-incarnation of the old three-year, hospital-based program, with some additional aspects (such as the research emphasis and the Hopkins connection) that will make it more of an elite institution.

The Hopkins program is not the only new nursing education program in Baltimore. Three surviving three-year diploma schools -at St Josephs, Union Memorial and Maryland General Hospitals-have joined wth the College of Notre Dame in an "articulation program under which students will first earn three-year diplomas at the hospitals (while also taking courses at Notre Dame) and then spend an additional year fulltime at Notre DAme to earn baccalaureate degrees. These two programs are creative approaches to providing technical background for nurses while at the same time retaining a strong clinical emphasis.We have high hopes for both.

from...

THE SUN

17 A 18 BALTIMORE, FRIDAY, FEBRUARY 25, 1983

JAMES I. HOUCK, Managing Editor • REG MURPHY, Publisher • J.R.L. STERNE, Editorial Page Editor

SAVE THE MIDWIVES POLICY QUESTIONNAIRE : MIDWIFERY

Please use extra paper if necessary.

1) Why did you join the Save The Midwives Association?

2) If you are a midwife, are you satisfied with the representation you receive through the New Zealand Nurses' Association?
Comment?

3) Would you support the formation of an association for midwives along the lines of the British Royal College of Midwives?

4) Should such a College of Midwifery undertake full responsibility for midwifery training?

5) What is your attitude to direct-entry midwifery training in the light of the three-year U.K. course?

6)Do you think that current midwifery training in NZ is the best that it could be?

7) Are you a)personally and b)generally satisfied with the current role of the midwife in N.Z?

8) The W.H.O.'s Definition of a Midwife is "a midwife is a person who is qualified to practise midwifery. She is trained to give the necessary care, supervision and dvice to women during pregnancy, labour and the post-natal period, to conduct deliveries on her own responsibility and to care for the newly born infant. This care includes preventive measures and the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the abscence of medical help. She has an important task in health counselling and education, not only for the parents but also within the family and the community. The work should include antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care".

Does you work experience place you within that definition?

SAVE THE MIDWIVES was formed in response to a crisis in midwifery. The crisis looks as if it may be permanent. We would like your suggestions on the role and future of Save The Midwives.

PLEASE RETURN TO : Barbara McFarlane, 11 Manapau St., Meadowbank, Auckland.
NAME_____ _____Are you a midwife_____parent_____

If a midwife, are you employed in a base bospital____small hospital_____

domiciliary_____retired(temporarily or otherwise) _____

Unconscious patients 'used for practice'

LONDON, Monday. — Unconscious women patients are being used by medical students to practise intimate medical examinations without their consent, says the magazine *World Medicine*.

It quoted a leading doctor as saying some women, if they knew what had happened to them under anaesthetic, might feel as if they had been raped.

Doctors justified the system by saying it was the only way young doctors could learn and that, in a teaching hospital, the patient would already have consented, or not objected, to being examined in other circumstances.

"But that needs to be balanced against a clear invasion of the privacy and integrity of the women," Professor Ian Kennedy, professor of medical law and ethics at Kings College, London, told the magazine.

"It can be said it doesn't harm her, and at one level it doesn't," he said. "But what if, for example, she finds out and feels she's been figuratively raped?

"If she complained it might be the doctor would be found not only to have acted unethically, but also illegally. It would be assault. If she had not been asked in advance she could not have consented."

World Medicine suggested that even from the point of view of educating doctors, an unconscious woman was not the best subject.

British medicine, said the magazine, should take a leaf out of the American book and hire the professional patient — "an informed, experienced, relaxed and live mannequin, ready to tell the students what they should feel, whether it hurts and, above all, whether the student's manner is going to put the patient at ease."

NZPA—PA

AUCKLAND STAR early 1984

Does this happen in New Zealand hospitals?

Have any members seen vaginal exams performed by medical students on women under general anaesthesia?

We would appreciate any comments about the relevance of this article to the N.Z. situation. Send them to the Secretary, STM, 24 Ashton Rd., Mt Eden, AK 3.

SAVE THE MIDWIVES ASSOCIATION
24 Ashton Rd, Mt Eden, AK 3. ph 602-301

NAME _____

ADDRESS _____

_____

mother____ midwife____ other____

SUB p.a. $4____ $6____ $10____ (your choice)

new____ renew____

Australia $NZ10 International $NZ15

The Togetherness that Saves Lives

If low birth-weight babies are carried against their mother's breast kangaroo-style, they are more likely to survive than in an incubator. Two Colombian doctors are encouraging this method along with breast feeding to ensure natural mother-child bonding. They noticed a drop in gastro-intestinal infections and in the death rate among these babies. The babies stay warm, gain the immunological protection of their mother through her milk, and are likely to develop motor co-ordination earlier than unstimulated infants.

Three years ago half the babies born under 2000g (4.4 lb) in one Bogota hospital died, but today 95% survive with this method. Incubators cost between US$2,000 and $12,000 and hospital stays are expensive, so this low-cost low-tech approach is relevant in both developing and developed countries.

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