

NUMBER FIVE

# SAVE THE MIDWIVES



EDITORIAL	1
LETTERS	3
SAVE THE MIDWIVES	7
NEWS AND EVENTS	8
ARE SMALL HOSPITALS SAFE ?	10
RURAL MIDWIFERY	13
THE FUTURE OF BIRTH	15
MATERNITY CARE IN HOLLAND	18
ULTRASOUND IN PREGNANCY	24
SAIREY GAMP	27
APPEAL · INQUIRY · QUESTIONNAIRE	28

# editorial

Closure of four small maternity hospitals along with St Helen's Hospital is planned as part of the Auckland Hospital Board's recently released Strategic Plan. Specialist care will be provided for ALL births in Auckland, EVEN for those who elect not to use it, with no choice available to the pregnant woman. Throughout the chapter dealing with maternity services it is assumed that specialist care for all births will lower the perinatal mortality rate. Never a shred of supportive evidence is produced.

The maternity services section of the Strategic Plan closely reflects the paper "Whither Obstetrics", written in 1982 by Professor D. G. Bonham of Auckland University's Medical School. Professor Bonham recommends an aggressively managerial approach to obstetrics condoning early amniotomy, IV fluids, low forceps and episiotomy as routine.

The social and emotional aspects of birth are not touched on by this paper, and are again ignored in the Strategic Plan. Many women, at an intensely vulnerable stage of their lives, have suffered from this attitude that birth is solely a medical event. Indeed, amongst doctors following this line in obstetrics, the combination of ignorance and arrogance is almost overwhelming. It is with relief that we greet statistical evidence for the opposing point of view.

A research paper recently completed by Professor Roger Rosenblatt\*, here for a year on leave from the University of Washington at Seattle, has shown that New Zealand babies of normal birthweight have a far greater chance of survival if born in a small (level 0 or 1) hospital than if born in a specialist (level 2 or 3) unit. In addition, babies under 2500 grams, whatever their birthweights, have a better chance of surviving their first week of life if born in a level 0 or level 1 unit!

Using conservative criteria, Rosenblatt and his co-researcher, Dr Judith Reinken of the Health Department's MSRU Unit, attribute 12% of the perinatal deaths in New Zealand to preventable causes, and state that 89% of these occur in level 2 and 3 hospitals.

Their conclusion is that New Zealand's eighteen level 2 hospitals provide a service of questionable quality, and that a strong case can be made, on the grounds of both safety and economy, for the majority of births to take place in small maternity hospitals.

\* see article p. 10.

The Auckland Hospital Board has, however, completely ignored the Rosenblatt Report. Even if the Auckland Hospital Board was unaware of Rosenblatt's research, and we know they were not, the data was available to their planners. Why didn't they research it? Why didn't they base their plans for maternity care on facts, instead of on unsubstantiated opinion?

The answer lies in power, and in self-interest - power to build an obstetric empire, secure financial futures for obstetric specialists, bodies and babies on which to train medical students, as well as in the belief that women, particularly parturient women, are better off in the hands of men.

The people of Auckland must absolutely reject this philosophy. They must ensure that the Auckland Hospital Board places the highest priority on the needs of mothers and their babies. The Board must begin to actively encourage most women to choose a small maternity hospital where they will be attended by a midwife and general practitioner; in short, the Board must REVERSE its policy on maternity care. In this way will both safety and emotional satisfaction be assured.

\*\*\*\*\* Judy Larkin

The attainment of health for all by the year 2000 was the central issue of the International Conference on Primary Health Care, held at Alma-Ata in September 1978. In view of the importance of that conference for future health strategy throughout the world, the Declaration of Alma-Ata is here reproduced in part.

#### THE DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting at Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers to protect and promote the health of all the people of the world, hereby makes the following Declaration:

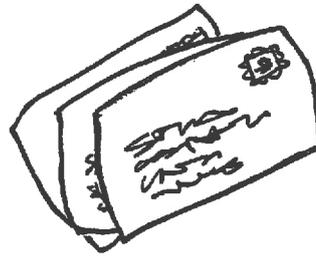
##### Paragraph I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

##### Paragraph IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

# letters



Dear Friends

Please find enclosed \$10 subscription. Thank you for your thoughtful and informative newsletters - I have received three and am always interested to read them from cover to cover. I am an RGON, trained at Wellington Public Hospital, completed in 1979. Since then I have worked in a variety of areas and in 1981 I decided to train as a midwife - and spent 1982 working in Wellington Women's Hospital as a pre-requisite for acceptance to the Polytech course. However, as the year progressed, and I spoke with student midwives, I became less keen to undertake that particular course, much as I wanted to be a midwife! I loved working at Wellington Women's Hospital and am still keen to train as a midwife.

At the beginning of 1983 I married and moved to South Taranaki, and am presently a Staff Nurse in ICU at Hawera Hospital - a 110 bed hospital. I am still very keen to train as a midwife and have applied to train at the Royal Women's in Melbourne. However, there is a 12-18 month waiting list, so I am happy to wait.

The reasons I do not want to train as a midwife in New Zealand are many. The forty week course incorporates the Diploma, which I think is at the expense of midwifery experience - it reduces the actual hours spent on things pertaining to midwifery and thus it reduces the importance of midwifery. The fact that it is not based in a hospital reduces the number of hours of actual clinical experience. Most of the women I spoke with who were student midwives were spending about 60 hours a week on the course as well as doing one night shift a week to supplement their \$27 per week income. As you can imagine, with this amount of stress, their health suffered.

So I have chosen not to train as a midwife in New Zealand. There are other reasons, which I will not go into, but I think I have covered the main points.

I am very concerned about where midwifery in New Zealand is heading and am not happy with what I see. It gives me encouragement to know that people such as yourselves have joined together in support to uphold the midwife and care of the newborn and their parents/families.

Yours sincerely  
Claire Barnett  
Manaia

Dear Sister-In-Midwifery

I wish to join the Save The Midwives Association and enclose the joining fee and a small donation. As a midwife currently working at Wellington Women's Hospital, I have become extremely concerned about the state of midwifery in New Zealand. We have, of necessity and with little acknowledgement, become educators of the student midwives studying at Wellington Polytech. Midwifery education is, I feel, at a very dangerous level. I have been very encouraged by the work of your organisation and look forward to your correspondence. I would be very happy to help you in any way you felt appropriate.

Sincerely  
Joan Skinner  
Newtown, Wellington

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Dear Ms Larkin

I have just recently joined the Northland Home Birth Group and was lent a copy of Save The Midwives which I've just finished reading. I was shocked, to say the least, at the plight of midwives when they do such a good, worthwhile job!

Please find enclosed a cheque for \$4 being the subscription to your magazine. Keep up the good work and I'll try and get more people to join.

Yours sincerely  
Casey Sumner (mother)  
Kaitaia

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Dear Editor

Our home birth group has been meeting monthly for three years now to support a domiciliary midwife, discuss natural prepared childbirth and breastfeeding, as well as providing postnatal support for homebirth families. Our midwife has been greatly appreciated and we admire and value the wonderful family-based service provided by domiciliary midwives.

At present we are without a midwife and are unaware of any domiciliary midwives currently practising north of Auckland. However, we have been heartened by your organisation and we see pressing for better pay for domiciliary midwives and direct-entry training for midwives as vital if New Zealand women are to continue to have alternatives to technically engineered births. We find your publication an important source of information and a welcome voice keeping us in touch.

We would be delighted if with your circulation amongst midwives we could contact any midwife who would be interested in doing home deliveries in this area. There have previously been about ten to fifteen deliveries a year and our group offers a supportive working atmosphere.

Enclosed is a donation/subscription for your magazine and the great work you do - keep it up!

Thanks.

Sue Wood  
Northland Homebirth Association  
Kaitaia

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Dear Madam

While being most supportive of the aims of your organisation and of your newsletter, I was very disappointed to note that in your issue for Spring 1984 you included, without comment, an article reprinted from a California magazine called "Tips For Easing A Difficult Labour" which is replete with nutritional faddism and totally unwarranted statements. If people want to consume herbal remedies during pregnancy I see no reason why they should not do so, although I very much doubt that there is a scrap of evidence that they do other than psychological good. However, some of the more specific nutritional recommendations, and the use of mega-doses of vitamins, are certainly not only unfounded but potentially hazardous. To be specific:

1. Evening Primrose Oil

This very expensive item does indeed contain precursors of prostaglandins, but so do most other vegetable and fish oils. There is absolutely no evidence that it will affect labour as claimed.

2. "Pituitary Extracts"

These usually contain little if any active hormones and certainly oxytocin release is NOT controlled by hormones, but by a portion of the brain (the hypothalamus).

3. Megadose Vitamins

There is no evidence at all that 100mg of B Complex (whatever that is, they vary in composition) has any effect either, and one must worry about large doses of vitamins affecting the fetus. 100mg of any of the B vitamins would be a large dose, and recently serious ill effects have been found in ADULTS let alone in the fetus. 10g of Vitamin C per day is an enormous dose. Firstly much of it will not be absorbed, and it will cause diarrhoea as a consequence in a lot of people. Second, vitamin dependence has been found in infants of women taking high doses of vitamins, in other words, the

infant shows signs of deficiency on perfectly normal intake of the vitamin because s/he has become habituated to huge doses. Third and most important, contrary to claims often made there is no reason whatsoever to assume that humans ever need such huge doses which one could almost never hope to obtain from any conceivable human diet. It is strange that it should be claimed that to be healthy you have to take pills and capsules, especially by those calling themselves health FOOD promoters!! Of course the sale of those products is very lucrative.

#### 4. Calcium and Magnesium

While adequate intake of calcium and magnesium is certainly desirable, the amounts claimed are high and surely represent TOTAL intake. There is little evidence that calcium prevents cramps, and none at all that it affects pain experience.

#### 5. "Keep Your Baby Small"

The most deleterious suggestion is left till last: "keep your baby small" by doing certain things. Smaller babies have more risk of illness and death. Thus anything which tends to reduce the infant's size, such as strict dieting, is positively criminal. Fortunately their suggestions are completely crazy and would have no effect of that sort. The last thing one wants to do if you want an adequate calcium intake is to avoid dairy products: that is, unless you are trying to sell calcium tablets...

By all means let us have education about the benefits of good dietary habits in pregnancy: but copying this irrational rubbish, and without comment, can only harm your cause by identifying you with the lunatic fringe and thus repelling otherwise favourable health professional and public support.

Yours sincerely  
John Birkbeck M.B., Ch.B., F.R.C.P.C.  
Medical Advisor La Leche League  
Chairman Infant Nutrition Committee,  
Paediatric Society of New Zealand  
University of Otago  
Dunedin

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Articles and letters are customarily printed without comment. It is my opinion that the readers of this newsletter have the intelligence to accept or reject any part of any article on its merits, as they see fit. There are many shades of opinion on any topic, and to annotate an article with one, namely my own, would be presumptuous. - J.L.

# save the midwives

Save The Midwives currently has 350 members, 80 midwives and 270 parents nurses, general practitioners, physiotherapists, etc. We have done a geographical breakdown of the membership and it pans out as follows:-

## MIDWIVES

Auckland (37), Hamilton (8), Dunedin (6), Wanganui (3) and one or two each in Lumsden, Christchurch, Twizel, Blenheim, Westland, Palmerston North, Thames, Hawkes Bay, Tokoroa, Whangarei, Oamaru, Murupara, Tirau, Invercargill, Nelson and New Plymouth. 5 in Wellington.

## MOTHERS AND OTHERS

Auckland (203), Hamilton (13), Wellington (11), Northland (10), Thames area (8), Reefton (6), Christchurch (5), Hawkes Bay (5), Tauranga (3), Whakatane (6) and 3 or fewer in each of the following places; Taumaranui, Whangaparoa, Tokoroa, Arapuni, Manaia, Dunedin, Okura, Bulls, Westport, Lyttleton, Waipukurau, Wanganui, Palmerston North, Te Puna, Invercargill and New Plymouth.

We have four Australian members, one in England, one in Japan, one in California and one in Canada. These are individuals who have somehow heard of Save The Midwives and have sent a subscription from overseas. In addition, we send quite a few complimentary copies of our journal to overseas midwifery and parenting groups.

## RENEWALS

If your sub expires with this issue you will have a **RED** sticker on the back cover. Please renew before February when the next issue is due out.

Thank you to all those people who have renewed their subscriptions promptly; we cannot afford to send out a complimentary copy reminding you to re-subscribe, and we simply order the number of copies that we have paid-up subscriptions for, plus fifty extra for people who subscribe immediately after the newsletter goes out. Once those fifty have gone, thats it! So renew now - don't miss out.

## AUCKLAND HOSPITAL BOARD

Save The Midwives is currently involved in opposing the Auckland Hospital Board's plans to close Warkworth, Helensville, Papkura, Howick and St Helens Hospitals. Auckland women will be left with a choice of four hospitals, all high-tech, or a home birth, and that option will soon be closed down if we let this plan go ahead. See article on page 15.

# news and events

## \* Caesarean Support Group

A much needed support group for women who have had their babies by Caesarean Section was formed several months ago in Auckland. Calling itself simply the Caesarean Support Group, the group aims to provide emotional and practical support to Caesarean families immediately after the birth and also during subsequent pregnancies. The group also aims to act as a source of information about caesarean childbirth and to promote education in this area. At present members of the group are working on a booklet for distribution to all women who have just had a caesarean section.

Support and information are provided through telephone conversations, letters, person to person contact and regular, informal discussion groups, etc. Contact phone numbers for the group are - Philippa Rodgers 598-441 and Jane Northwood 673-790. Jane's address is Flat 2, 6 Laburnum Road, Avondale, Auckland.

\* Janet Balaskas, the author of "New Life" and "Active Birth", recently held a full day workshop in Tauranga, sponsored by ICEA, who awarded 5 "contact hours" to it. Eighteen "contact hours" are required by ICEA as part of their teacher certification programme. Janet is a counsellor for childbirth, trained by the National Childbirth Trust, and a founder of the London Birth Centre. There are now two New Zealand CEA (Childbirth Education Association) members. Auckland's secretary is Lynda Williams, 16 McEntee Road, Waitakere and Otago can be contacted through Adele Birkbeck, 25 Selkirk Street, Roslyn, Dunedin.

\* "The Role of the Family in the Education of the Child" is the title of a seminar being planned for April 1985 by the Centre For Continuing Education, Victoria University of Wellington. Amongst other things, consideration will be given to such questions as "where does the responsibility lie for educating children? What support services should be available to parents? How can cultural values be respected? Attendance at the seminar is by invitation, approximate cost is \$120. More information can be obtained from Beverley Morris, Centre For Continuing Education, Victoria University, Private Bag, Wellington.

\* Auckland Parent's Centre's A.G.M. is to be held Thursday 28 February, 1985, at 8 pm. Wine and Cheese evening, 30 Aratonga Ave, Greenlane.

\*A request for an increase in the salary of domiciliary midwives, to bring them into line with hospital-employed midwives, was one of the remits passed at the NZ Federation of Parents Centres' 1984 Conference.

\* The Federation has organised, in conjunction with the Correspondence School, a Pregnancy and Childbirth course. It consists of 5 booklets;

1. Having a Baby
2. Labour and Delivery
3. Postnatal
4. Feeding and Care
5. Baby Development

It is designed for people unable to attend antenatal classes, costs \$15, and is available from the Registrar, The Correspondence School, Private Bag, Wellington.

\*The Home Birth Association is having its annual "get-together" on February 10. This will be held at Cornwall Park by the Kauri stand,

\*The tour of NZ planned by Michel Odent has been cancelled. He was to have spent 5 days here in February 1985, but has cancelled his tour due to committments elsewhere.

## wanted

DIRECTOR - DEPARTMENT OF MYTHOLOGY

### Auckland Hospital Board

This newly-created position is available within the Auckland Hospital Board for a professional person of unusual abilities.

Ideally the applicant should have attained a satisfactory educational level, be experienced in promoting what the Minister of Women's Affairs has so aptly termed "the edifice complex", and prepared to expect a challenging role in promoting the Board's policies, particularly in the area of maternity services.

While previous selling experience would be an advantage, it is not essential, as we provide a comprehensive Training Course in Hospital Board Myths and Legends.

Masterminding management of public response to Board Policy is the imperative: Considerable emphasis is to be placed on the obstetric service in particular. Consequently the ability to influence both the media and the public of Auckland to ignore the recent Rosenblatt Report would be a decided advantage. Any additional skills in promoting the Obstetrician/Childbirth-As-Emergency theme in contrast to the Midwife-G.P./Birth As A Natural Phenomenon theme will certainly promote the applicant's chances.

Drive, energy and cynicism (although a rare combination) will be necessary in view of well-founded opposition to Board policy in this area by Auckland's Parenting Organisations. However the successful applicant will receive a competitive employment package with better-than-normal benefits, and will in addition have the distinction of setting a rather surprising precedent.

To be First in this Field, contact

The Chief Executive  
The Auckland Hospital Board  
Wellesley St  
Auckland 1

# HOW SAFE IS BIRTH IN SMALL HOSPITALS ?

"OBSTETRIC PRACTICE APPEARS TO BE VERY SAFE IN SMALL NEW ZEALAND MATERNITY HOSPITALS, AND FURTHER CLOSURES CANNOT BE JUSTIFIED ON THE BASIS OF QUALITY" -

so concludes a research study into NZ's maternity services, completed in July 1984 by Professor Roger Rosenblatt, on a year's sabbatical leave from the University of Washington at Seattle, and Dr Judith Reinken, a research scientist with the Department of Health in Wellington.\*

Save The Midwives has a copy of the draft report of this study, which, particularly in view of the proposed closures of small maternity hospitals in Auckland and the Waikato, makes very interesting reading. Of particular interest is Chapter 6 ; Quality of Care and Regionalisation: Is Obstetrics Safe In Small Hospitals? Space does not permit us a full discussion of the report here, but you can contact the Department of Health in order to obtain a copy\*. In Chapter 6, Rosenblatt and Reinken look at the birthweight-specific perinatal mortality rates of the Level 0, 1, 2, & 3 hospitals in NZ (Level 0 and 1 hospitals are staffed entirely by midwives and G.P.'s), including all hospital births from 1978-81 in their data.

Birth weight specific rates allow an evaluation of how well hospitals of different size and sophistication perform with respect to infants of similar birthweight. They also allow an identification of those hospitals where preventable deaths are occurring. The authors chose 5 birth weight categories - under 1000g, 1000-1500g, 1500-2000g, 2000-2500g, over 2500g, the last category being regarded as normal birth weight babies.

## BIRTHS IN AUCKLAND

The Auckland Hospital Board area was used as an example in chapter 6, although only the crude perinatal mortality rates were used. There were few or no deaths in the smaller hospitals, the rate rising with the size and sophistication of the maternity unit, which is what one would expect in a regionalised system, where high-risk births take place in Level 2 and 3 units. However one must keep in mind that a substantial proportion of births in these hospitals are potentially normal births.

When the birth weight specific rates were calculated, and this was done for the country as a whole, it was found that, IN EVERY WEIGHT CATEGORY, LEVEL 1 HOSPITALS HAD THE LOWEST BIRTH WEIGHT SPECIFIC MORTALITY RATES. Level 2 hospitals had significantly higher rates than Level 3 units for low birth weight babies. (See Fig 6.8 below). To quote the study - "Level 1 hospitals in NZ have extremely good outcomes, as measured by perinatal mortality, for infants of all birth weights. The very low crude and birth weight specific perinatal mortality rates in Level 1 hospitals should be further analysed. The number of births under 2500g in these hospitals is relatively small in our four year sample, so it is possible, but unlikely, that the observed differences occurred by chance. However there are a statistically significant number of normal weight births in Level 1 hospitals, and in this large group LEVEL 1 RATES ARE MORE THAN 40% LOWER THAN RATES IN LEVEL 2 OR 3 HOSPITALS.

A second possible methodological explanation for the observed pattern would be the transfer of mothers whose babies died in utero before or during transfer; these deaths would then mistakenly be attributed to the hospital receiving the transfer. Although this must happen occasionally, it seems unlikely that it would account for the differences observed."

The authors also suggest that, because of the very low perinatal mortality rates in the Level 1 hospitals, and the relatively high rates in the Level 2 units, unnecessary referral may be occurring, and that many of the women being referred to the more sophisticated units could be safely delivered in smaller hospitals. "Given the fact that most excess deaths appear to be occurring in the Level 2 hospitals, it is possible that the overall outcome could improve if a less sensitive but more specific antenatal screening protocol were used in the Level 1 hospitals." - p109 \*

**PREVENTABLE DEATHS**

There were 2399 hospital perinatal deaths during the years 1977-1981. The authors ascertained the causes of these deaths from the death certificates, and each death was assigned to one of two mutually exclusive categories, "probably preventable" and "probably non-preventable". Two analyses were undertaken, the first using deliberately conservative criteria, the second using more liberal standards.

In the conservative category, all stillbirths were considered non-preventable as were all deaths in babies weighing less than 1500g at birth. (Even though some NZ hospitals routinely save infants under this weight). The intent was to focus on a group of deaths where the likelihood was very high that death could have been prevented. They discovered that 89% of the preventable deaths actually occurred in Level 2 and 3 hospitals. The major preventable cause of death was Respiratory Distress Syndrome, "a well defined clinical entity that should rarely have a fatal outcome in infants weighing more than 1500g" \*.

Using more liberal criteria, (babies under 1000g being assigned to the "probably preventable" category), 91.3% of preventable deaths occurred in Level 2 and 3 hospitals, and 18% of all perinatal deaths were in this category. Most preventable deaths occur in the Level 2 hospitals. In order to get an estimate of the number of deaths that might be prevented by higher obstetric standards or better referral patterns in Level 2 hospitals, the authors calculated the excess deaths using the rates achieved by the Level 3 hospitals. The results are displayed in Table 6.5. (see below). It is notable that the differences are particularly marked for infants weighing between 1000 and 2500g, the high-risk group that these hospitals are intended to save.

**TABLE 6.5: EXCESS PERINATAL DEATHS IN NEW ZEALAND MATERNITY HOSPITALS, BY HOSPITAL LEVEL AND BIRTH WEIGHT CATEGORIES, USING RATES ACHIEVED IN LEVEL III HOSPITALS, 1978-1981.**

Hospital Level	Birth Weight Category (in grams)			Totals
	< 1500	1500-2499	> 2500	
G (n=63)	0	0	0	0
I (n=14)	7	0	0	7
II (n=15)	68	62	0	130
III (n= 3)	0	0	0	0
<b>Totals</b>	<b>75</b>	<b>62</b>	<b>0</b>	<b>137</b>

The authors offer two possible explanations for this - 1, that unnecessary referrals from Level 1 hospitals may be overloading the Level 2 units, forcing them to divert their attention from the medium risk mothers and babies for whom they were designed. 2, Level 2 hospitals may be holding on to patients who would be better treated in Level 3 facilities. The average Level 2 hospital has fewer than one birth a month of a baby weighing less than 1500g. It is possible that the Level 2 staff do not have enough truly high risk cases to maintain their competence. They mention, in addition, that some Level 2 hospitals have only one paediatrician, and that very sick neonates require 24 hour care which they would only receive in a hospital with more paediatric staff.

To conclude, the authors state that their results "offer strong support for an obstetrical system in which general practitioners and midwives, working in settings with low technological intensity handle the majority of deliveries, and specialist obstetricians concentrate their efforts on high risk deliveries."

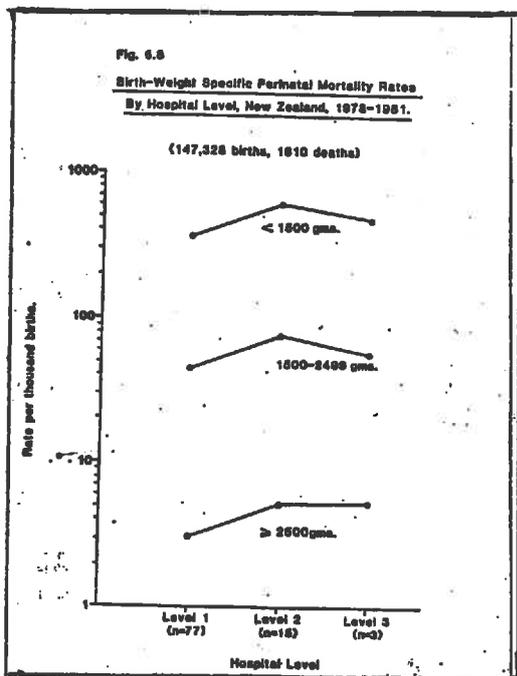
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\*Regionalisation of Obstetric and Perinatal Care in New Zealand - A Health Services Analysis, (July 1984), by Professor Roger Rosenblatt, MD, MPH, Associate Professor of Family Medicine, University of Washington School of Medicine at Seattle, Washington, U.S.A., and Dr Judith Reinken, Research Scientist, Department of Health, Management Services and Research Unit, Wellington, NZ.

This report is being prepared for publication by the Department of Health. All enquiries should be directed to the Director-General, Dept of Health, PO Box 5013, Wellington. We should note that the Department was unwilling to give us a copy requested under the Official Information Act, and in fact Dr Salmond, the Deputy Director-General, included a "concrete gumboots" paragraph in his reply - "premature citing of the report could misrepresent the findings, and the opinions of the authors, could influence any possible action arising from it, and could ultimately prove contrary to the interests of the persons who quoted from it", he wrote.

So we're checking our shoes every morning, but would urge those people interested in the report to request a copy; there's nothing that says such research has to be pre-digested by the Department of Health before the public of New Zealand can make sense of it.

Judy Larkin



# a rural midwife's work

Maureen Tracy

I am writing to tell you how impressed I am with the amount of work being done by Save The Midwives group and the enjoyment I get from the articles in your newsletter.

Because of the isolation of the area in which I work prevents me from taking an active part in your campaign, I can only wish you every success and give you my whole-hearted support.

Because of the publicity in recent months about home births and hospital births and the closing of small maternity hospitals, I am enclosing a resume of the work that I am doing with the hope that it might encourage some midwives to accept positions at the smaller rural hospitals and help to ease the present situation that exists.

Before I start though, I must say that it is my personal opinion that small hospitals need experienced midwives who are used to making decisions and handling emergencies and are willing to become part of the community. They also need to be willing to give more than just eight hours a day, because to me, job satisfaction is more important than anything else.

I am the Principal Nurse at Murupara Maternity Hospital and the only midwife, so I am on call twenty-four hours a day, seven days a week, except when I get relief from my base hospital, which works out at about three to four days a month. More frequent relief is not possible because of the shortage of midwives.

We deliver approximately ninety babies a year and have about one hundred and fifty admissions a year - patients on bed rest for urinary infections, toxemia, etc. We would transfer about fourteen patients a year to base hospital for delivery, mostly premature labours or severe toxemia patients and following delivery our patients are returned to us for post-natal care.

I work with a husband and wife GP team who have been in the area for a number of years. We cover all aspects of obstetric care - antenatal, antenatal classes, labour and delivery, post natal care and continuing mothercraft sessions.

One of the joys of a small hospital is that you are able to get to know the patients long before delivery. You become a friend long before you become their midwife and that friendship continues long after the patient has left hospital. If you stay in the area for some time you are delivering second and third babies and by that time you have got to know the family well.

In the four and a half years I have been here, we have had only one stillbirth and this was a young girl who had had no antenatal care before delivery - we have only had to actively resuscitate two babies.

We have made the hospital as relaxed and homely as possible. When patients in labour are admitted, they are encouraged to walk around the garden, watch television or talk with the other patients. The majority of our patients, including the primigravidas, only lie down for the last half hour or so before delivery.

The use of pain relief during labour is minimal because of the atmosphere in the hospital and the fact that they are never left alone means that the need for drugs is almost eliminated. I am with the patient from admission throughout labour no matter how long and then care for mother and baby post partum. The Plunket Nurse's clinic is attached to the hospital and so my patients come to show how their babies are growing and sit down and have a cup of tea.

Included in my work is counselling and education of parents and family groups and school children within the community. I am also involved with family planning and continuing child care.

I am fortunate that I work with two doctors who appreciate the skills and knowledge that I have acquired over years of practising as a midwife and support me fully in all facets of my work. Because of this trust and understanding, my patients have total midwife care including delivery and because of this they feel safe and secure throughout the whole birthing process and they leave the hospital with happy memories.

I have worked in all the large hospitals in Auckland over the years as a midwife but in my small hospital I have found the complete job satisfaction that I was looking for. I feel that all trainee midwives and house surgeons could gain a lot of valuable knowledge and experience from working in a small hospital.

I get very upset when I read articles about how small hospitals are inadequate; we have all the necessary equipment and knowledge to cope with any obstetrical emergency except caesarian and with good antenatal screening, at risk patients are referred early - long before an emergency situation arises. The doctors and myself keep up to date by reading and we attend continuing education courses at large base hospitals.

Small hospitals play a very important role in the life style of the community; the maternity hospital is not just regarded as the place where they go to have their babies, it is the one place where they can always find help and comfort. They know they can always just pick up the phone day or night and someone will always answer them with the offer of help or advice if needed. Yet these are the hospitals that they want to close down - surely it is the right of every woman to choose where she wants to have her baby and who she wants to have take care of her during pregnancy, labour and delivery!

Maureen Tracy  
Murupara Hospital  
Oregon Drive Murupara

# the future of birth

The Auckland Hospital Board recently released a "Strategic Plan" for the future of Auckland's health services over the next ten years. Chapter 7.3 deals with maternity and neonatal services. In short, it suggests that specialist care at Board expense, be provided for ALL births in Auckland; that Waitakere and North Shore Hospitals join Middlemore Hospital as high technology Level 2 hospitals and that Howick, Papakura, Warkworth, Helensville and St Helens Hospitals close.

The Plan assumes that the high technology care provided by Level 2 and Level 3 hospitals will lower the perinatal mortality rate. No evidence is produced to substantiate this view. In fact, both overseas and New Zealand research shows the opposite to be true. Low technology care is that provided by general practitioners and midwives delivering babies in Level 0 and Level 1 hospitals. These two professional groups have been shown, time and time again, to produce better outcomes for mothers who have experienced a normal pregnancy. A recent study of New Zealand's maternity services has shown that babies, whatever their birthweight, are more likely to survive their first week of life if they are born in a Level 0 or Level 1 hospital (see article on page ).

The Auckland Hospital Board has chosen to ignore this data when drawing up its Strategic Plan. Why? Who will benefit more from the proposed specialist maternity services - mothers and babies or specialists? The Royal College of Obstetricians and Gynaecologists stated in 1970 that New Zealand needed one obstetric specialist for every 750 live births in New Zealand, which indicated a need for 70 specialists. However, in 1969 there were already 83 on the Register. Very likely there are more than 100 now. If the Strategic Plan is implemented, many more specialists will be required to provide high technology care for every mother and baby.

To quote from Chapter 7.3 - "clearly a decision to provide capacity for all births in units with specialist facilities within a limited budgetary framework implies that other options will not be readily available. By some, this will be seen as a curtailment of individual freedom of choice, but the trends noted (in paragraph 7.3.16 and table 19) are evidence that the numbers who wish to use these other options are steadily diminishing. In a very real sense, the collective decision has been in favour of births in specialist units."

This implies that it is women who have made the decision in favour of confinement in specialist units rather than in the small maternity hospitals. Very few women make an informed decision about where they will give birth. Most go wherever their doctor recommends or books them, without

discussion of the alternatives. General practitioners are under considerable pressure from the obstetric hierarchy to book women into specialist units. With this in mind it would seem that the "collective decision" referred to is that of those who provide maternity care rather than that of the women who use it.

## what can you do?

- (1) You can acquaint yourself with the Rosenblatt Report. Professor Roger Rosenblatt of the University of Washington at Seattle, was recently in New Zealand on a year's sabbatical leave, and along with Dr Judith Remken of the Health Department, he researched safety in small maternity hospitals in New Zealand. Their recommendation was that New Zealand, in the interests of both safety and economy, return to a policy of encouraging women into Level 0 and Level 1 hospitals to give birth. They suggest that a large number of unnecessary referrals to Level 2 and 3 hospitals are occurring and they find the quality of care in our Level 2 hospitals to be somewhat questionable. They state that "further closure of small maternity hospitals cannot be justified on the basis of quality." For more information about the Rosenblatt Report, read the article on page 10 of this issue.
- (2) You can talk to your local Hospital Board member. There are 14 persons on the Auckland Hospital Board which is structured as a "ward" system - that is you have a representative for your particular area of Auckland. Write to them or better still, go to see them and leave them with a written summary of your objections to the Strategic Plan. A list of their names and addresses are at the end of this article.
- (3) Go to the Hospital Board meetings. These are open to the public and are held every three weeks at 4 p.m. on a Monday in the Auckland Hospital Board Building, Wellesley Street (near the Art Gallery). These meetings are quite an eye-opener, to say the least, and will give you a good idea of whether the person representing your area is worthy of re-election. If a significant number of people begin attending the Board meetings with the maternity services as their primary interest, the Board members may well take more notice of public comment in this area.

## who decides?

All submissions, which were due by October 1, will be summarised by the Board's administrative staff and presented to the 14 elected members of the Board in that form. The Strategic Plan will be revised in the light of submissions, and then the Board will vote on whether to accept the revised

Strategic Plan. If they do accept it, it becomes the blueprint for the next ten years. We have no way of knowing how the draft Strategic Plan will be altered. The same group of people who wrote the draft plan are summarising the submissions, which introduces substantial opportunity for bias, and they will be the people who write the revised Strategic Plan.

However, the Hospital Board members can reject the revised Strategic Plan if they feel it is not in the best interests of Auckland mothers and babies. It is up to us to make them aware of what we consider acceptable, and we can best do that by contacting them directly.

Brenda Hinton &  
Judy Larkin

**A U C K L A N D   H O S P I T A L   B O A R D   M E M B E R S**

One Tree Hill, Mt Wellington Onehunga, Ellerslie	}	Mrs Olive Manning 80 Campbell Road, One Tree Hill
Northcote, Birkenhead Takapuna, Devonport East Coast Bays	}	Mr Duncan MacLean 5 Heaton Grove, Birkenhead Mrs Connie Purdue 21 Sylvan Avenue, Northcote
Mt Roskill, New Lynn Mt Albert, Newmarket Mt Eden	}	Mrs Shirley Barrett 59 Balmoral Road, Mt Eden Mr Douglas Brebner 56 Cormack Street, Mt Roskill
Papatoetoe City Manukau City, Otahuhu Howick	}	Mr Peter Carter 7 Palmers Road, Weymouth Dr Frank Rutter 153 Great South Road, Papatoetoe Dr Alison Riddell 133 Point View Drive, Papatoetoe
Waitemata, Rodney Great Barrier Island Glen Eden, Henderson Helensville	}	Lady Haliburton 27 Old North Road, Orewa Mrs Judith Bassett 17 Stillwell Road, Mt Albert
Auckland City Waiheke Island	}	Dr Bruce Faris 197 Victoria Avenue, Remuera Dr William Manchester 97 Remuera Road, Remuera Mr John Bridgman 157 Portland Road, Remuera
Franklin, Pukekohe Waiuku, Tuakau, Papakura	}	Mr Bruce Hopkins c/o Otara Spinal Unit, Otara

**MEETINGS TO WHICH THE PUBLIC ARE WELCOME: Feb 11, March 4, 25, April 22, May 13, June 4, 24, July 15, August 5, 26, Sept 16, October 7, 29, November 18, December 9.**

# maternity care in the netherlands

PART 1

Obstetrical care in the Netherlands has a unique position in Europe thanks to its organisation and obstetrical results. It is the only country with very low perinatal mortality rates (11.2%)\*, where a substantial amount of home deliveries (35%) is part of the obstetrical organisation. Compared with a country like Sweden, for example, which also has one of the lowest perinatal mortality rates, we notice that about 100% of the deliveries take place in well-equipped hospitals.

The Dutch obstetrical care system is characterized by five points:

- 1) an independent highly qualified training for midwives
- 2) a substantial number of independent practising midwives
- 3) highly competent maternity nurses
- 4) a generally accepted screening system for risk pregnancies
- 5) choice between home or hospital confinement for women with good prenatal care and low risk pregnancies

Successively I will discuss these five points with you, after which I would like to present a study, dating from 1981, in which the obstetrical care system has been evaluated on its efficacy and safety.

## 1. The Education Programme For Midwives

The first point I mentioned before was an independent highly qualified training for midwives.

By Act of Parliament, dating from 1865, and with some adaptations to newer circumstances, the midwife is given legal sanction to practice and to provide obstetrical care to women with uncomplicated pregnancies, delivery and postnatal period, without intervention by the obstetrician. The midwife belongs to the medical profession, together with the general practitioners, specialists, dentists and pharmaceutical chemists. They have the right to practice on their own and their actions are under control of the Medical Audit Board.

The educational programme consists of a three year post-graduate training, given in three midwife schools in Holland. The requirements for the educational programme as well as for the examinations are regulated by the Government.\*\*

In contrast to most of the other countries, the midwife training in Holland is not linked in any way to the nurses programme. This accentuates once more the position of the midwife as independent and equal to the physicians role.

Briefly I will point out to you the contents of the student midwives curriculum.

The first year is dedicated to normal physiology of pregnancy, birth and puerperium. Twenty-one weeks are to be spent in clinical rotations, mainly at the maternity ward where the student midwives take the responsibility for the young mother and her newborn. Other rotations are spent at the delivery room, outpatient clinic and pregnancy ward.

The second year the student midwife starts to attend her own deliveries, under the supervision of a midwife. For this purpose she spends seven days and nights continuously in the hospital, in order to see and attend a birth from the beginning until the end. She will also take care of the postnatal period of the women whose deliveries she conducted. In the outpatient clinic the student midwife learns how to perform prenatal examinations. Two rotations of two weeks are spent respectively on the gynecology ward and the neonatal intensive care unit. At the end of the first two years a National Board Examination is held.

In the third and final year the student is prepared for working in her own practice. For four weeks she participates in a private practice of a midwife and attends a number of home deliveries. During her training a student midwife has attended at least forty deliveries.

In the third year an essay has to be written, that will be published in the professional journals. At the end of the third year an oral examination is held in order to be certified. The members from the examination committee are representatives of the Ministry of Health and of the University.

<u>Review Of Clinical Rotations In Weeks</u>			
	<u>1st Year</u>	<u>2nd Year</u>	<u>3rd Year</u>
Maternity ward	13	5	
Delivery room	4	8	14
Outpatient clinic	2	2	10
Pregnancy ward	2	6	8
Gynecology		2	
Neonatal intensive care		2	2
Midwife practice			4

Review Of Theoretical Courses In Hours

	<u>1st Year</u>	<u>2nd Year</u>	<u>3rd Year</u>
Chemistry	65		
Anatomy	105		
Physiology	100	50	
Obstetrics	220	300	140
Gynecology		20	
Pediatrics	5	50	25
Pathology		80	
Dietetics	15		
Pharmacology		10	
Social science		30	30
Birth control			14
Ethics			5
History of obstetrics	10		
Psychology		25	50
Total	<u>510</u>	<u>535</u>	<u>264</u>

2. The Position Of The Midwife

In 1982 930 midwives were registered, of whom 75% were working in their own private practices and 25% for a hospital. Data from the Ministry of Health show that the amount of obstetrical care provided by midwives has not changed in the last decennium, while the amount of care provided by general practitioners has greatly diminished. Especially in the big cities the role of the general practitioner has been reduced to a great extent, whereas his role in rural areas is still considerable. In Fig. 1 the distribution of obstetrical care in the Netherlands is shown:

	<u>Midwife</u>	<u>General Practitioner</u>	<u>Obstetrician</u>
1970	37%	37%	26%
1975	38%	28%	34%
1979	38%	18%	43%

Fig. 1 - distribution of obstetrical care \*

The aim of the midwives training is to teach her to take care of a pregnant woman in both a technical, social and psychological manner. During prenatal visits, she will build up a confidential relationship with the woman. She will provide a lot of information and answer questions

about manner and place of delivery, nutrition, prenatal courses and complaints.

If the delivery takes place at home, the midwife is like a guest, adapting herself to the particular circumstances, answering the needs of the woman and coaching her through the birth process. The postnatal period will also be spent in the woman's own environment. When problems arise the midwife will seek for a solution within the family setting and try to prevent the separation of mother and child.

During the last decennium the midwives' curriculum and the authorities of the midwife have been adapted to the modern developments and demands of obstetrics. The extension of her activities includes amongst others:\*\*\*

- to draw blood for bloodgroup and haemoglobine determination, German measles and luesserology
- to make Pap smears
- to correct a breech position during pregnancy
- to prescribe certain drugs during pregnancy
- to administer pitocin and ermetrine after delivery
- to administer local anaesthesia
- to repair an episiotomy and a second degree tear
- to administer anti-D immunoglobuline
- to perform echoscopy in use of unknown amenoerrhoea in the first half of pregnancy

Some prominent gynecologists, like Professor Kloosterman have greatly stimulated the position and education of the midwives. They promoted midwives to do research and to publish their own articles. Professor Kloosterman has insisted on the development of an independent master organisation for midwives to replace the former religious and politically coloured groups. Nowadays a good functioning labour union exists, which promotes the interests of the midwives like regulations about their fees, continuous education, and which maintains the contacts with the insurance companies and the Ministry of Health. In co-operation with the latter a standardised registration of the prenatal visits and the deliveries has been developed.

### 3. The Maternity Nurse

The institute of maternity nursing as it functions in the Netherlands is unique in Europe. The maternity nurse is specialised in taking care of the young mother and her new-born during the postnatal period when spent at home. The delivery can take place at home or in the hospital. In the latter case the woman will go home shortly after birth (short term hospitalisation). When a woman spends the post natal period in the hospital (long-term hospitalisation) the personnel of the maternity ward will take care of her and her child.

The duties of the maternity nurse consists of:

- assisting the delivery
- taking care of mother and newborn
- giving information and instruction to the family
- helping in the household

By assisting at birth and taking care of the family in the postnatal period, she will provide an optimal integration of the new world citizen in his or her family.

Recently the maternity nurse curriculum has been prolonged to three years. In these three years broad attention is given to a general theoretical background and to practical oriented rotations. A summary of the theoretical training (in hours) is as follows:

- Dutch and foreign languages	200
- physical education	80
- sociology	160
- dynamics of social psychology	320
- music and arts	200
- housekeeping	320
- health education	240

Under supervision of a qualified maternity nurse, the student learns practical work by working in different families. This period lasts for forty weeks.

The pregnant woman who wants to make use of the maternity nurse facilities, has to apply for a nurse at a maternity nurse centre. Two options exist:

- a maternity nurse who helps all day
- a maternity nurse who comes in twice a day

In both cases maternity care will last for ten days. Maternity care is insured by both National Health and private insurance companies.

In 1979 the number of home deliveries followed by maternity care was 91,621 and for out-patient deliveries (short-term hospitalisation) 34,811. These figures amount to the following percentages:

- home delivery with a maternity nurse	32.3%
- home delivery without a maternity nurse	3.1%
- hospital delivery followed by postnatal period at home with a maternity nurse	19.8%
- delivery and postnatal period in hospital	44.8%

\*\*\*\*\*

Part II Of this article will be printed in our next newsletter. This was written by M.Ris, a Dutch midwife, and sent to us by Veronika Muller, midwife, member of STM.

# Beter Bevallen

Amsterdam, the Netherlands  
August 25th, 1984

To all of those who feel concerned about obstetrics and who are interested in active birth, Holland must seem a paradise:

- women are able to choose the place of birth and about one third of all deliveries actually are homebirths;
- midwives work independently and are highly respected;
- hospitals must compete with all the advantages of the home situation; compared to other countries, they usually have a non-aggressive approach to childbirth;
- the rate of perinatal death is low; it ranges among the lowest in the world.

However, also in the Netherlands, developments are taking place that will eventually block the possibilities for active birth. It seems as if Holland wants to get rid of its 'backwardness' as fast as possible: gynaecologists overtly comment on homebirth as being obsolete; chemicals are more and more used in the treatment of pain; the number of artificial deliveries is rising, and the percentage of home-deliveries over the past 10 years has drastically declined.

Consumers and midwives concerned about these developments started the 'Beter Bevallen' movement. Last January we held a conference which proved to be a great succes and which was extensively covered by the media. Talking to participants, especially women from other countries, we realised that consumers everywhere are making themselves heard. In the field of obstetrics their influence is being clearly felt. In countries all over the world women are standing up, demanding birth with dignity, and a delivery they can really call their own.

This is the reason why we want to organise an international platform where consumers, midwives and movements fighting for the possibility of active birth can meet and inspire each other.

**place:** Amsterdam, the Netherlands

**time and date:** a few days before the international conference of midwives, which will be held in August 1987, in The Hague, Holland. Our meeting will not overlap the midwives' conference.

If you feel just as excited about this idea as we do, please let us know. Send us your papers, pamphlets, your ideas—and keep in contact. We need you to make this plan come true.

Jetske Spanjer  
on behalf of **Beter Bevallen**  
Prinsengracht 375  
1016 HL Amsterdam  
the Netherlands

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*Thanks to Clare Hutchinson  
for sending this in.*

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# ultrasound in pregnancy

Diony Young

reprinted from ICEA News May 1984

The United States National Institutes of Health (NIH) Consensus Conference on "Use of Diagnostic Ultrasound Imaging in Pregnancy", after reviewing the evidence, has come to the following major conclusions:

- \* that no consensus exists to show "that routine ultrasound examinations for all pregnancies improved perinatal outcome or decreased morbidity or mortality."
- \* that "ultrasound examination in pregnancy should be performed for a specific medical indication."
- \* that "ultrasound evaluation can improve the outcome of high-risk or complicated pregnancies."
- \* that the recommendation by the Consensus Panel is that "routine ultrasound screening is not indicated at this time." \*

The Consensus statement by the NIH Consensus Conference Panel was reached following one year of deliberations and a 2½ day conference in Bethesda, Maryland, February 6 to 8, 1984. Representatives from several childbirth, women's and professional organisations and individuals gave formal statements to the Panel during the Conference. These included ICEA, the National Women's Health Network, C/SEC Inc. and the American Academy of Husband-Coached Childbirth.

The use of ultrasound in obstetrics has risen dramatically in recent years, and concern has been expressed about its safety and about whether all use of the procedure is necessary or appropriate. The Consensus Panel was therefore asked to review the scientific literature and research to develop a report that addressed the following five questions:

- \* What types of ultrasound scanning are currently used in obstetric practice? How extensive is this use? What is known about the dose/exposure to the fetus and the mother from each type?
- \* For what purpose is ultrasound now used in pregnancy? For each use what is the evidence that ultrasound improves patient management and/or outcome of pregnancy?
- \* What are the theoretical risks of ultrasound to the fetus and the mother? What evidence exists from animal, tissue culture and human studies on the actual extent of the risk?
- \* Based on the available evidence, what are the appropriate indications for and limitations on the use of ultrasound in obstetrics today?

\* What further studies are needed of efficacy and safety of use of ultrasound in pregnancy?

The Report points out that "lack of risk has been assumed because no adverse effects have been demonstrated clearly in humans." However, the report continues that "other evidence dictates that a hypothetical risk must be presumed with ultrasound." Similarly, its value "in improving the management and outcome of pregnancy also has been assumed rather than demonstrated, especially its value as a routine screening procedure."

The data indicates that currently in the United States 15% to 40% of pregnant women are exposed to at least one ultrasound examination. But the report points out that "there is reason to believe that all of these data sources seriously underestimate the true extent of exposure to ultrasound since they do not necessarily include exposure via Doppler devices (e.g. electronic fetal monitors, Doptone)". For this reason, the Panel recommends recording specific exposure by Doppler devices. In addition, two scientists and researchers, Dr Wesley Nyborg and Dr A. Roy Williams, suggested the need to record output levels of the devices and length of labour time when electronic fetal monitoring is used.

The report lists a total of 27 medical circumstances for which the Panel believes ultrasound use would be of benefit. These include its use to assess gestational age and fetal growth, to detect abnormalities in the mother or fetus, to determine fetal position, to recognise multiple pregnancies and for many other purposes.

The report described studies that have examined the safety of ultrasound use in human beings as "inadequate", and although no harmful effects to mother or fetus have been reported in more than 20 years of use, "it is likely that any ill effects would be subtle and delayed in expression."

Several participants at the Conference mentioned the recently reported association between dyslexia and ultrasound exposure.\*\* One of the invited scientific commentators on the Report, Dr Paul Gross, summed up the uncertainty about ultrasound effects with the statement that, "Any input of energy to a living cell is certain to disturb something when it is energy different from that to which the cell is usually exposed." He observed that any questions of risk are questions of development, and at the present time, there is no answer to the issue of risk in ultrasound use.

Some animal and cell culture studies have suggested that ultrasound exposure can retard fetal growth, impair the immune response, and produce cell damage and chromosomal

changes. Although some of these findings could not be reproduced by other investigators, the Panel notes that the reported effects cannot be ignored.

The Consensus Panel was given a copy of the "ICEA Position Paper: Diagnostic Ultrasound in Obstetrics"\*\*\*, and the ICEA position on ultrasound use was presented by Diony Young at the Conference. In direct response to statements by ICEA and other childbirth and women's organisations and individuals, important new recommendations were added to the Report concerning education of pregnant women about ultrasound use. These additions read as follows:

"Prior to an ultrasound examination, patients should be informed of the clinical indication for ultrasound, specific benefit, potential risk and alternatives, if any. In addition, the patient should be supplied with information about the exposure time and intensity, if requested. A written form may expedite this process in some cases. Patient access to educational materials regarding ultrasound is strongly encouraged."\*

A "Certification and Consent Form for Ultrasound Exposure" was presented to the Panel by Doris Haire, representing the National Women's Health Network.\*\*\*\* Copies will shortly be available from the Network. It is suggested that three copies of the form be made - one to be retained by the mother, the second copy by the physician or midwife and the third by the hospital or office where the ultrasound examination occurred.

In conclusion, the Panel recommends that much more research be undertaken to help answer questions about the safety of ultrasound. In particular, there need to be animal studies to detect the long-term effects of in utero ultrasound exposure, study of the fundamental mechanisms leading to bioeffects, and a long-term, following up study of infants involved in a randomised clinical trial to help clarify the effects of ultrasound on development in human beings.

Copies of the NIH Consensus Report can be obtained by writing to:

Michaela P. Richardson  
Chief, Office of Research Reporting  
National Institute of Child Health and Human Development  
Department of Health and Human Services  
National Institutes of Health  
Bethesda, Maryland, 20205, U.S.A.

#### References:

- \* "The Use of Diagnostic Ultrasound Imaging in Pregnancy" Draft Report, National Institutes of Health Consensus Conference, Feb. 6-8, 1984.
- \*\* Stark, C. R., et al.: Short and long-term risks after

exposure to diagnostic ultrasound in utero, "Obstet. Gynecol. 63(2): 194-200, 1984.

\*\*\* ICEA Position Paper: "Diagnostic Ultrasound in Obstetrics", Minneapolis, 1983, International Child-birth Education Association.

\*\*\*\* National Women's Health Network: "Certification and Consent Form for Ultrasound Exposure", Washington, D.C. 1984.

Copies of the ICEA Position Paper: "Diagnostic Ultrasound in Obstetrics" can be obtained from:

ICEA Bookcentre  
P.O. Box 20048  
Minneapolis, Minnesota 55420-0048, U.S.A.

Cost: US\$1.15

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## Sairey Gamp

When British midwives were at their lowest ebb they were personified by Dickens in "Sairey Gamp". How it delighted me to read in Jean Donnison's "Midwives and Medical Men" that gin-sodden Sairey was, in fact, a monthly nurse! She combined midwifery with sick nursing and laying out the dead. The real midwife spent years working as a 'deputy' to an experienced midwife. Sairey, on the other hand, was a 'monthly nurse' - trained in one of the charitable lying-in hospitals. There she would have learned to care for women in labour, calling the doctor in time to do the delivery thus saving his time.

Things haven't changed much in 140 years, have they?

These 'monthly nurses' were the forerunners of the modern day obstetric nurse. They developed as the barber surgeons with their forceps took over childbirth. When British nurses were fighting for registration they tried to persuade the independent midwives, who were also fighting for registration, to join forces with them and be labelled 'midwifery nurses'. The midwives would not have a biscuit of that and went on to gain registration in 1902 - 17 years before British nurses did.

Midwives in Europe had higher status. The growth of male practitioners was much slower in Europe, while French and German midwives were recognised and regulated by their governments with their training subsidised.

Some pretty interesting historical parallels here!!!

Joan Donley

# appeal

We would like to thank the groups and individuals who have made donations to the Appeal Fund which will assist Truus Verburgt in her appeal to the High Court against the decisions of the Nursing Council. I have forwarded your letters and cheques to Truus and she asks me to thank you all. The appeal is certainly going forward though Truus has arranged to fulfil the six months requirements at the Southland Hospital. As Truus writes, "you will understand that I'm fighting for my own future in the first place but I'm very concerned about the future of direct-entry midwives from Britain as well as Holland because the courses are now equivalent."

Interestingly, in all the responses to our questionnaire, only two midwives have been opposed to direct-entry midwifery with a three year course.

# inquiry

Our inquiry about practice on unconscious patients have brought some interesting replies. The majority of midwives are not aware of such practice on patients, which is as one would expect, since they do not assist with gynaecological care. But several doctors confirmed this, and to quote one reply, "women who had come for IUD insertion and had been given a D&C and general anaesthetic were practised on by many doctors - putting the IUD in and out, in and out".

This is an area where we should all observe carefully on behalf of the women we care for. Staff should be prepared to lay complaints with the Medical Superintendent and the Disciplinary Committee of the New Zealand Medical Association. The latter can be contacted through the Secretary, F.O. Box 156, Wellington. The Committee is duty bound to investigate a complaint. Any comments that readers have on complaint procedures and outcomes would be welcome.

As one midwife replied, "I have seen great invasions of privacy against mothers giving birth in delivery suite at National Women's - e.g. a film crew of at least three men ushered in to watch a birth take place before the actual one they were to film for a documentary. Their presence and profession were not explained to the young mother or her husband, and this was just to prepare them for what they were to film - criminal in my mind and I would be horrified if it happened to me."

We would appreciate any further information concerning this practice, especially from medical students and doctors.

# questionnaire

The responses to the questionnaire are still coming in and

still welcome. All have been very positive on the value of midwifery and extremely critical of male obstetric interference in normal birth and the increasing reliance on high technology care. One midwife joined Save The Midwives "to help to prevent the extinction of the midwifery profession, and thus leave the medical profession totally in charge of vulnerable pregnant women and their babies". The majority commented that midwifery as a profession was threatened.

Responses to work experience in relation to the WHO definition were generally negative. "I have become increasingly frustrated in recent years with the lack of opportunity to practice midwifery 'independently' due to increasing numbers of medical students and house surgeons needing experience."

All midwives who were satisfied with their role were employed in small hospitals. "I am one of the lucky ones working in a small hospital who is allowed to use my years of experience and knowledge to its fullest potential."

Of the 15 responses received since the last newsletter, 14 were extremely critical of the N.Z.N.A.; 14 are deeply concerned with current midwifery training ("It's appalling"); 14 support direct-entry midwifery with a three year training course and most comment that they would like to see a training scheme established in New Zealand; all 15 would like to see the establishment of a college of midwifery although the role of such a body is variously seen; none are completely satisfied with the current role of the midwife in New Zealand. "We are not seen to have any skills above those of a registered nurse and unfortunately I think this is becoming more accurate as our role is diminished successfully by the hospitals, N.Z.N.A., doctors and more importantly, ourselves."

If the midwife, a branch council member of the N.Z.N.A. who replied on lined paper, but did not enclose a name or address, would like to contact me, we could discuss your ideas on the positive aspects of the current midwifery training programme, N.Z.N.A., etc. for a short article in a future newsletter.

Barbara MacFarlane