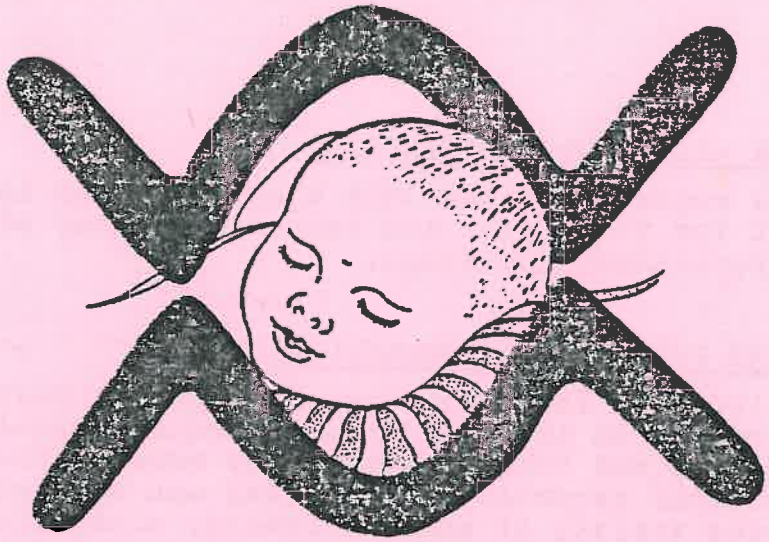
SAVE THE MIDWIVES

1985



number 8

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NEWS AND EVENTS

WHAT WOMEN WANT FROM THE MINISTRY

This final report from the 1984 Women's Forums is available on request for $1.00 from Ann Hercus, Minister of Women's Affairs, Parliament Buildings.

HEALTH CARE FOR WOMEN INTERNATIONAL

This publication, formerly "Issues in Health Care of Women", aims to provide an international interdisciplinary approach to health care and related topics for women. The editors accept research reports, and clinical and theoretical papers about a wide variety of women's health; obstetrics, gynaecology; perinatal and neonatal care; aging; alternative lifestyles; cultural differences; and psychological challenges. Original manuscripts with two photocopies and a covering letter to :

Phyllis N. Stern
Professor and Director
School of Nursing
Dalhousie University
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CANADA B3H 3J5

"Booking for Maternity Care: A Comparison of Two Systems"

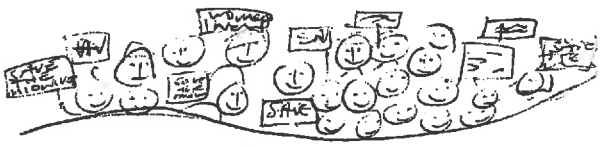
Occasional Paper 31, is available from the Publications Sales Office, Royal College of General Practitioners, 8 Queen St, Edinburgh EH2 1JE, price £3.50 including postage. Payment with order.

Professor Michael Klein of McGill University, Montreal, Canada, and Ms Diana Elbourne of the National Perinatal Epidemiology Unit, Oxford, studied the views of women experiencing general practioner obstetric care and compared them with those of a group of women experiencing consultant care, both in the Oxford area.

The findings show that women under general practitioner care saw fewer different doctors and received more consistent advice. The results are given in detail and the general conclusions are supportive to those wno are promoting general practitioner obstetrics and consider that it should have a place in a modern health system.

INTERNATIONAL SYMPOSIUM ON ULTRASOUND - London April 1985

According to AIMS (Association for Improvements in the Maternity Services) three major areas of concern were revealed: There was no evidence of the efficacy of ultrasound in reducing perinatal mortality rates or improving the outcome of pregnancies; There was nothing to support the statement that ultrasound was safe in the long term. "We do not know" was the consensus of those present (midwives, nurses, epidemiologists, radiographers, obstetricians and consumers).



WOMEN'S HEALTH COMMITTEE

The N.Z. Board of Health, which advises the Minister of Health on issues relating to health care, has a subcommittee specifically concerned with women's health. This subcommittee recently called for submissions from the public, and it has now produced a report on these. Over 235 groups and individuals sent in submissions, and the following priority areas emerged; health education, prevention, need for research, choices, community health care, well-woman clinics, women as carers, relationships with general practitioners, and the health needs of specific groups of women. A report will be issued free twice a year by the Women's Health Committee, and you can put yourself on their mailing list by writing to them at the Board of Health, PO Box 27-111, Wellington.

MIDWIVES CONFERENCE

It becomes more and more evident that the New Zealand Nurses Association (NZNA) does not represent the interests of midwives. The only political representation the NZ midwives have is a Section of the NZNA, which costs them $72.80 for the NZNA sub plus a further $20 annual sub to the Midwives Section. Despite this hefty sub to the NZNA it has refused to fund two midwives to attend the ICM Pacific Regional Conference in Indonesia in November. The two delegates, Carol Hoskins, National President of the Midwives Section, and Ann McQueen, Past President, have had to go begging. The Effie Redwood Trust has given Ann $2000. Otago Hospital Board has provided $600 towards Carols expenses - the balance had to be raised elsewhere. Great support from the NZNA!

Furthermore, Julie Foley, NZNA nominee on the Women's Health Committee (see above), is there to represent midwives, yet she is not a member of the Midwives Section! She is currently preparing a Position Paper on midwifery education, yet to date she has not conferred with any members of the Midwives Section. In fact, it was news to them that she was preparing this paper!

AUCKLAND MIDWIVES SECTION

The NZNA's Auckland Midwives Section has recently held its AGM to elect its new officers. We would like to congratulate Sarah Hodgetts, the new Chairperson, on her election. As a midwife, Sarah has always been extremely supportive of mothers, and is a strong and articulate advocate of the rights of parents. She was involved in the formation of Maternity Action, representing East Auckland Parents Centre, and joined Save The Midwives at its inception.

We would also like to thank Ann McQueen, retiring Chairperson of the Auckland Section, for her deep caring and support. Ann has been responsible for much of the increased awareness amongst Auckland midwives of just how threatened their profession is, and as immediate Past President of the NZ Midwives Section, has strongly promoted midwifery.

SUZANNE ARMS

...,the author of "Immaculate Deception," flew into Auckland recently for two days. She spoke to the Home Birth Association Committee, visited National Women's Hospital, and addressed a meeting of the Home Birth Midwives' and Doctors' Group. She feels two things are necessary for us to improve maternity care in New Zealand; we must have specialist (direct entry) training for midwives so that midwifery cannot be subsumed by nursing, and we must support general practitioners, who are the natural allies of midwives. There is a legal requirement for all births in NZ to be covered by a doctor, and G.P.s are far more likely than obstetricians to provide holistic, family centred maternity care.

Why Midwifery?

By G. J. Kloosterman, M.D.

This lecture by Dr. Kloosterman was given in Toronto, November 2, 1984, at the Second Annual Conference of the Midwives' Alliance of North America. Dr. Kloosterman was the Director of the Midwives' Academy in Amsterdam from 1947-1957. He has recently retired from the position of Professor of Obstetrics and Gynaecology at the University of Amsterdam.

From time immemorial, giving assistance to a woman in labour has been as female a task as parturition itself. This statement holds good for all cultures on this planet, and up till the 17th century, it was also universally accepted in our western culture. Smellie, the founding father of British obstetrics, wrote in the preface of his famous treatise on the theory and practice of midwifery in 1752, in a somewhat condescending way: "It is natural to suppose that while the simplicity of the early ages remained, women would have recourse to none but persons of their own sex, in diseases peculiar to it; men were only employed but in the utmost extremity."

But in the 16th and 17th centuries, the centuries of the great discoveries, of the discovery of our planet, of our solar system, of anatomy of the human body, of the circulation of our blood, the secret realm of women had to be explored as well, and the acceptance of the male surgeon-accoucheur as superior to the midwife was the result. This happened first in France, the country where Ambroise Pare (1510-1590) had acquired immortal merit, as the founder of obstetric science. A century later, Louis Quatorze, the Sun-King, took a male accoucheur, first for his two mistresses and finally, in 1682, also for his legal wife. From this moment on, it was more fashionable, at least in France, to be helped by a doctor-accoucheur than by a midwife. In the next century, this example was followed in the other countries of Europe. Although at first, this tendency was attributed to French immorality and deprivation, at the end of the 18th century, the superiority of the male surgeon-accoucheur was accepted everywhere in Europe. After that period, it became common practice to picture the midwife of past and present as careless, meddlesome, dirty and stupid. The important contributions to midwifery made by experienced and learned midwives like Louise Bourgeois and Justine Dittrichs, called Sigemund, are not mentioned at all in the elaborate historical introduction of seventy-two pages in Smellie's book on midwifery.

A very important and perhaps unique document containing information on the obstetric results of a midwife around 1700 is the diary of Catherine Schrader, a Dutch midwife who lived from 1656 till 1746 and who practiced in the province of Frisia, in the north of the Netherlands. She made notes after every delivery, and these notes form a manuscript of 544 pages —her diary or "Memoryboeck" of the women. She assisted 3060 women; there were 70 twin pregnancies and 2 sets of triplets. There were 6 cases of placenta praevia totalis, whereby she performed a manual removal of the placenta followed by version and extraction of the child, that in all these cases presented in transverse position. She performed 88 breech extractions and/or version and extractions for transverse positions or head presentations with prolapse of the umbilical cord (2.9%). Her overall maternal mortality was 7%, but in 43 cases, her help was called in by other midwives or doctors and, in these cases, the patient was sometimes already dead or dying as she entered the house. In these 43 cases, 7 women died. **This means that she herself delivered 3017 women with a maternal mortality of 5%, that is, less than the figure reached in the U.S.A. in 1936.**

If we look at the period of three centuries (from 1550 till 1850) in which the first great achievements of obstetric art took place, then we must admit that the male invasion into the delivery room has been followed by many scientific achievements. But these proud achievements were partly reached by and gave rise to many internal examinations of women, and at the end of the 18th and espe-

The Practicing Midwife/Spring 1985

with thanks to The Practicing Midwife.

cially in the beginning of the 19th century, this evoked unsuspected and, at first, completely neglected catastrophic consequences. In the University Clinic in Vienna, maternal mortality rose from 12.5% around 1800 to 99% in the period 1841-1847. The great killer was childbirth fever.

As early as 1795, Alexander Gordon in Aberdeen drew attention to the contagiousness of puerperal fever. He wrote: "In short, I had evident proofs of its infectious nature and that the infection was as readily communicated as that of smallpox or measles. It is a disagreeable declaration for me to mention that I myself was the means of carrying the infection to a great number of women."

In Boston in 1843, Oliver Wendell Holmes read his paper entitled, "The contagiousness of puerperal fever". In a brilliant review of the experience with childbed fever in several European centres, he stated, "it would seem incredible that any should be found too prejudiced or indolent to accept the solemn truth knelled into their ears by the funeral bells both sides of the ocean, the plain conclusion that the physician and the disease entered hand in hand into the chamber of the unsuspecting patient". And in conclusion he wrote, "the time is come when the existence of a private pestilence in the sphere of a single physician should be looked upon not as a misfortune but a crime."

In 1847 in Vienna, Ignaz Philipp Semmelweis proved more convincingly than ever before the contagiousness of puerperal fever. He also showed (and that is his immortal merit), that the disease was caused by performing an internal examination with unclean hands and that infection could be avoided by washing hands in chlorinated lime water.

How did the members of the obstetric profession react to these accusations and discoveries? With few exceptions, very negatively. In the U.S.A., Meigs called the paper of Holmes: "the jejune and fizzless vaporings of sophomore writers". And in 1848, Meigs wrote in his book on Females and their diseases: "Having practiced midwifery a great many years and having been concerned in the visitation of the sick labouring under puerperal fever....visiting the same cases with those who have been so cruelly abused, as performing the part of a walking pestilence, scattering death and desolation where they desired only to do good — and seeing that I could never convict myself of being the means of spreading the contagion, I remain incredulous as to the contagiousness of the malady".

Another famous American obstetrician, Hodge, rejected the message of Holmes, because it was too terrible to believe. In Europe, where Semmelweis had given overwhelming statistical evidence that by his method many thousands of mothers could be saved, the reaction of the obstetrical establishment was the same, and it took the discovery of Pasteur and Lister to convince at last every obstetrician. All this is strong proof that discussions on childbirth give rise to strong emotions and that male obstetricians have been very sensitive to criticism and sometimes react with emotional outbursts and the expression of hurt feelings to overwhelming statistical and scientific evidence.

But, many will say, what has this to do with present day obstetrics? We got the message: the dangers, provoked by internal manipulations have been recognized and are now almost nonexistent, thanks to prevention and powerful medication. Never before in the history of mankind has childbirth been so safe for mother and child. In the last 40 years, maternal mortality dropped more than 98%, perinatal mortality by more than 75%.

But how is this reached? By prevention, by augmenting the general health of the population and by powerful methods to treat the still existing pathologies such as placenta praevia, abruptio placentae, toxemia, malpresentations and contracted pelvis.

By no means have we been able to improve spontaneous labour in healthy woman.

Spontaneous and normal labour is a process, marked by a series of events so perfectly attuned to one another that any interference only deflects them from their optimum course. For healthy, normal women able to set their children into this world under their own power, all proud achievements of modern obstetrics are only a reassuring thought — but that is all the profit they have from it.

That the majority of all women always have been able to bring a healthy child into the world without any assistance is a fact recognized from time immemorial.

In 1701, the famous Dutch obstetrician, Hendrik van Deventer, defined a natural or easy birth as a birth accomplished by nature alone, without any interference or assistance; a birth, not in need of any help of midwife or doctor. He even compared one of his clients with a waffle-iron from which the children rolled out as easily as waffles from an iron. In 1752, William Smellie wrote, "I call that a natural labour in which the head presents and the woman is delivered by her pains and the assistance commonly given." Smellie also gave statistical data. He estimated that 92% of all

births could be called natural.

Statistical data can also be derived from the diary of Catherine Schrader, the Dutch midwife I mentioned before, who practiced from 1693 till 1745. Natural spontaneous childbirth occurred in her practice in 94%. This figure is the more striking since her practice contained more pathology than in a random sample of the population could be expected (multiple pregnancy occurred in 2.4%; placenta praevia totalis in 2%, etc.).

If, 250 years ago, more than 90% of all women with full term pregnancies were able to bring their children into the world spontaneously without any other assistance than sympathy and encouragement, it seems utterly improbable that this power nowadays should be lost in women, who, without any doubt, are in a better state of general health.

In many textbooks on obstetrics, this fact is recognized by stating that, in principle, pregnancy and labour are normal, physiological periods in a woman's life that only exceptionally can give rise to pathological and dangerous situations. But at the same time, obstetricians seem to agree that all children should be born in hospitals where doctors can cope with almost all sorts of emergencies and in the last 20 years hospitalization and highly specialized supervision by obstetricians is strived at and often achieved in almost all countries of the industrialized world on both sides of the iron curtain.

But, once again, our profession is accused by strong pressure groups of women, supported by representatives of several scientific and learned societies, that we are looking too much at one aspect of childbirth and are neglecting others. The accusation is that doctors look at pregnancy and childbirth as mild diseases, that have to be handled in huge hospitals; that modern obstetrics is crisis-oriented and that all attention is focussed on disasters that can happen. By doing so, we teach women to trust in medical science but we diminish the belief in self-reliance and in the possibility to perform the act of parturition under ones own power. These opponents of the obstetrical establishment stress the importance of childbirth as a creative act, performed by the young mother herself in a self chosen setting and without unnecessary medical interference.

Once again there is strong scientific and statistical evidence that modern western obstetrics is perverting the physiology of human parturition.

And once again, many obstetricians are defending themselves with emotional outbursts without trying to oppose the accusations with scientific arguments, as happened in the 19th century against the accusations made by Holmes and Semmelweis.

Whereas many obstetricians attribute the undeniable and great progress in obstetric results to the disappearance of the independent midwife and the disappearance of home confinements, a growing protest is heard among the public, among the consumers, against the restricted sterile conditions of the labour, and the very rooms in hospitals, the immense gadgetry and the ever-increasing caesarean section rate.

Some women go so far that they turn their backs to the obstetric profession, stay at home and accept the attendance of unqualified and sometimes undertrained women to escape the strict rules of hospitals. In doing so, they accept a risk for themselves and their children. The bad results of these non-institutionalized home confinements are (mis)used by the profession to justify their stark type of obstetric organization, whereas it would be much better to accept that many healthy and self-confident women wish to experience childbirth as a natural, creative act without unnecessary interference.

Whereas it is self-evident, that nowhere can pathology of pregnancy and labour be handled better than in a large, well-equipped hospital by a highly specialized staff, there is no proof that normal women who are willing to bring their child into the world under their own power have any advantage of such a surrounding. It is even probable that for them such a surrounding will be unfavourable, since it enhances the chance of unnecessary surgical and pharmocological interventions.

The most important objection against this, in itself very logical and convincing idea (the sick in the sickhouse or hospital under the care of doctors, and nurses, the healthy ones at home, under the care of midwives or G.P.'s) is the problem, that pregnancy and labour are only normal in retrospect and that there always is a possibility that something will happen "out of the blue".

In the industrialized world on both sides of the iron curtain, only the Netherlands still sticks to the idea that pregnant women have to be considered healthy and normal until the opposite is proven. As long as everything stays normal, they can be cared for and assisted by midwives and have a free choice to stay at home or go to hospital for delivery under the care of the same midwife who was caregiver during the pregnancy.

From 1958 until 1975, the number of home confinements decreased from 70% to 35%, but since 1978, this percentage did not go

down further, and in 1982, it was the same as in 1978. The number of confinements under the care of a registered midwife only (at home or in hospital) is 40%, and this percentage is the same as 20 years ago.

The data of 1982 are given in tables 1-3 and show that a well-selected group of apparently normal women can deliver in a simple surrounding without electronic monitoring and without sophisticated means, with very good results. A perinatal mortality of 2 per thousand (including, of course, all transfers to hospital during labour), 7 times lower than the perinatal mortality in hospital and 5 times lower than the average for the whole country, is in striking contrast to the results reached in countries where home confinements went down to less than 1 or 2%. But showing that home confinements are much more acceptable than many obstetricians think is not enough. The same holds true for sharing obstetric care with midwives. Where are the advantages?

The advantages are: a far greater amount of completely spontaneous births without any form of anaesthesia or instrumental or pharmacological interference. Whereas caesarean section rates in almost all countries with total

TABLE 1

1982 BIRTHS IN THE NETHERLANDS

Site of delivery	Number of births	Percentage
At home	61,205	35.4%
Hospitals	106,911	61.8%
Maternity Hosp.	2,188	1.3%
Midwifery schools	2,156	1.2%
Abroad	621	0.4%
Total	173,081	100.0%

TABLE 2

1982 BIRTHS AT HOME

With Maternity Home Help	Births	Percentage
with maternity home help	56,785	92.8%
with other kind of help	4,420	7.2%
total	61,205	100.0%

TABLE 3

1982 MATERNITY HOME HELP

Total births at home	56,785	
Stillbirths	47	
First week mortality at home	33	
After referral to hospital	34	
perinatal mortality M.H.H.	114	0.2%

In 1982 perinatal mortality in The Netherlands 1.0% (in 173,081 births)

hospitalization are above 10% and in some countries even 16 to 18%, this percentage was 4.7 in 1980 in the Netherlands and forceps and vacuum extractions were 5.9% in 1982. And these data of the Netherlands are already influenced by international pressure. In the Netherlands, too, there are hospitals with a caesarean section rate of 15%, influencing our national figures.

Therefore we decided in 1970 to make a very precise regional study to investigate the value of our system of selections and midwifery care. The leader of this study was my colleague, Van Alten. This investigation took place in Wormerveer, a rural district north of Amsterdam.

In all, we studied from 1979 till 1977 a group of 4804 women who wanted to deliver at home or in a small home-like maternity unit and who were under supervision of a midwife or a general practitioner at or before an amenorrhoea of 28 weeks. The overall perinatal mortality was 44 in 4835 = 0.9%. The highest mortality was found in the group that was selected during pregnancy by prenatal care and got advice to deliver in hospital. Perinatal mortality: 32 in 778 = 4.4%. The lowest mortality was found in the group born at home or in the maternity under the guidance of midwife or general practitioner: 6 in 3741 children = 0.16%.

In 316 cases, labour was planned and started at home, whereas during labour referral took place to the hospital. In this group perinatal mortality has been 6 = 1.9%. If we take together all women who were allowed to stay at home and started to deliver at home (or in the maternity), including the 316 cases who were referred to hospital during labour, then the perinatal mortality is 12 in 4057 + 0.3%. Three of these 12 cases were caused by congenital malformation, not compatible with life. There were 2 cases of abruptio placenta. In one case it concerned the second child of a twin, a stillbirth of 1100 grams. In 6 cases the possible avoidability could be discussed; 4 in the sphere of the maternity unit; 2 in the hospital. An improvement of the selection procedure is still possible and in the mean time realized. During the years 1978-1981 perinatal mortality in the group that delivered at home decreased to 0.18%.

The results in the country as a whole and in the Wormerveer study show that the results of deliveries under responsibility of a midwife are very good. In fact, the countries that showed the lowest perinatal mortality of the world during the last ten years, the Scandinavian countries and Holland, have one thing in common, which is not the home confinement, but the fact that in these countries an important part of prenatal care and the physiology of labour is left to midwives.

Another very important feature of the Dutch system is the amazing low number of artificial deliveries, amazing at least, if we compare them with other western countries.

In figure 9, the rates of the artificial deliveries in the total group are given; the caesarean section rate was 1%, for vacuum extraction and forceps-delivery: 3.9%.

In the group selected for home delivery (including of course the referrals to hospital during labour), the caesarean section rate was 0.4%; the rate of vacuum-extraction and forceps-delivery together was 2.8%.

The most remarkable group is formed by the 1575 women, who were pregnant for the second time. In this group the caesarean section rate was zero; there were 5 instrumental deliveries (0.3%). The perinatal mortality in this group was 1 case (less than 1%), certainly non-preventable.

All this, in my opinion, is evidence that a system based on selection during pregnancy by good prenatal care, based on the idea, that the majority of all pregnant women (70-80%) belong to a low risk group, based on the idea that a well-educated midwife can bear the responsibility for both procedures (the selection and the care for the healthy ones), based on the idea that midwives and obstetricians have to be complementary), can combine very good obstetric results with a very high amount of spontaneous deliveries, that is: with active participation of the mother and the father during labour, with an absolute minimum of anaesthetic drugs, with optimal possibilities for early interaction and effective bonding between parents and new-born child.

All over the world there exists in every society a small group of women who feel themselves strongly attracted to give care to other women during pregnancy and childbirth. These women like to accept responsibility. Their goal is not an easy life and a large income. Failure to make use of this rather small group of highly motivated people (mostly women) is regrettable.

The modern midwife has to be somebody who has had a training of at least three years in obstetrics. During her training she has worked and studied in a large obstetric hospital and has had a much more intense and thorough education and experience in obstetrics than a medical student. She has seen hundreds of deliveries and has delivered personally at least 50 women during her training.

Whereas she is familiar with all kinds of pathology, her aim is not to handle pathology

but to recognize it as early as possible and to hand it over to obstetricians. Her pride is to advise and coach a woman during pregnancy in such a way that a normal spontaneous labour follows and a healthy child is taken in the arms by a mother who did the job herself.

Such a midwife makes it possible for the obstetrician to devote him (or her)self to his real task, that is: the study of human parturition and handling of pathology.

There is a rather great difference in the field of activity and the personality of a highly motivated nurse and a born midwife; the nurse works among the sick, preferably in a hospital, works together with doctors and follows their instructions; the midwife likes to bear responsibility, must be convinced by good arguments before she is willing to follow instructions and feels herself complementary to the obstetrician. She recognizes the superiority of the obstetrician in handling clearcut pathology, but is willing to argue with him about the limits of physiology and pathology. Very often she feels that under her guidance pathology could have been prevented or some kind of interference could have been avoided. This is the reason why many doctors prefer to work with nurses.

In my opinion, there has to be a difference between the education of a hospital nurse and a midwife. It is unnecessary, and indeed, a waste of time and talent to train exclusively nurse-midwives. At the end, they will have to choose: to become a maternity nurse, working in a hospital together with obstetricians and working under their responsiblity, looking after pathology and using all the equipment of modern technological science, or: to become a midwife, a person who is happier if she has been able to avoid an artificial delivery than to assist at it and who sees herself more as an assistant of Nature than an assistant of the doctor. Of course, if she is a good midwife, then she will be happy that doctors exist and she will do everything to send her patient in time to him, but her most important question is not always: How? but Why? The kind of nurse most akin to midwives are the district nurses.

There is another argument that midwives must not be involved too much in nursing. They must get and keep a great experience in prenatal, natal and postnatal care and therefore, we think it necessary that they take care of one hundred pregnant women or more per year. This would not be possible if they were involved in maternity nursing as well.

In my country, a nurse who wants to become a midwife has to follow the midwifery training for three years, that is, as long as a girl who finished her secondary school and began midwifery training. The same holds true for a midwife who wants to become a nurse. Therefore, a nurse-midwife in my country has a training period of 6 ½ years, almost as long as a medical student to become a doctor. They form a minority; the majority of our midwives did not take nurses' training.

A doctor who wants to settle down as a midwife has to follow a course of one year at least in a training school for midwives before she or he can do so.

At last I should like to give this answer to the question: Why midwifery?

Midwifery is indispensable and an essential part of good obstetrical organization, since midwifery means: protection of health and normality, whereas obstetrics, as part of medicine, belongs to the "department of knowledge and practice, dealing with disease and its treatment".

To start a pregnancy, you need a woman and a man; their functions are different, but everybody will hope that they will love one another, respect and admire one another. To care for pregnancy and childbirth, you need a midwife and a doctor. I hope that they will love one another, respect and admire one another and will know that they are both needed and complementary.

Update . . .

Carolyn Vogler has challenged the Arkansas Health Department to publish the birth statistics from Arkansas hospitals. She says, "The Health Department needs to be kept in line and stopped from saying that homebirth is not safe." Carolyn has sent a letter to the Arkansas Medical Center and eight or nine other hospitals in her area, asking for their statistics. She maintains that if certain officials feel that birth in the hospital is so much safer than out of hospital, they won't mind making these statistics public.

AUCKLAND'S STUDENT MIDWIVES

Midwifery students at Auckland Technical Institute are dismayed at the poor quality of the tuition they have recieved this year. The course has been the cause of three complaints by the students, the final one to ATI's Director, Dr John Hinchcliff.

Areas of concern include a tutor with no teacher training, insufficient midwifery theory, no timetables, no domiciliary input, and ineffective liasion with teaching hospitals. The midwifery students have been supported in their criticisms by ATI's non-midwifery ADN students, and by the Principal Nurses of two major teaching hospitals, but stil no action has been taken.
Save The Midwives, along with the students, has taken the matter up with Dr Hinchcliff. In this article we outline the problems the students have faced this year.

* 1) In Term 1 the students were not provided with a timetable, so were unable to prepare in advanc. for any of the work. They were in the wards the equivalent of one day per week, and their midwifery theory, a total of 3 hours per week, consisted merely of a revision of nursing obstetrics;the Pelvis, Embryology, and the Menstrual Cycle. Their Midwifery Tutor resigned at the end of this term.

* 2) The students requested a meeting with their Course Supervisor and their Principal to voice their concerns over the quality of the first term programme. Their tutors were also present, and it was hoped that the situation would improve as a result of the meeting.

....and so on

* 3) In Term 2 the remaining midwifery tutor became the main tutor. She had had no teacher training, her previous year having been her probationary one at ATI, which she entered immediately after completing her ADN.Tutoring is a responsible task, and not an easy one, and it is surprising that these qualifications were considered adequate for the position.

* 4) Unbeknown to the students until Term 2, two hours per week were incorporated into the prescribed 70 hours midwifery theory time. These two hours were Monday 8.30 - 9.30 a.m. and 1.00 - 2.00 p.m. during which no tuition was ever given. The students consequently received only 40 hours of theory that term.

* 5)A lot of time was spent sorting out administrative hassles, e.g. the timetable, with the Course Supervisor that term.This sort of thing should have been organised before the students even entered ATI!

* 6) Another meeting was requested with the Course Supervisor for the 24th of July, the reason again being the quality of tuition.The midwifery tutor was not present at the meeting, being away on a four-week teacher training course, and the students again agreed to wait and see if things would improve.

* 7) In term 3,midwifery theory was held mostly on Friday afternoons only. Not the best time of the week to teach one of the most important parts of the curriculum. The non-midwifery ADN students requested a meeting with the Course Supervisor to voice <u>their</u> concern over the midwifery programme, and the Principal Nurses of two of Auckland's major teaching hospitals wrote to ATI concerning the quality of the tuition being given to the students assigned to their hospitals.

As a result of these letters, the students had yet another meeting, this time called by the Nursing Division's Principal. It was suggested at this meeting that the Principal Nurses meet with the student midwives. The students agreed, but the meeting has never taken place.

* 8) Again in Term 3, the midwifery tutors agreed to provide the students with extra Clinical Tutorials in order to make up for the lack of theoretical time to date. These have never eventuated.

* 9) The only input regarding domiciliary midwifery has been one lecture, specifically requested by the students. This took the form of a discussion with two domiciliary midwives, and was held the week of the final exam. There is of course no other training programme for home birth midwifery, and so the students who complete this course and then eventually undertake domiciliary midwifery are essentially untrained in that area.

. . . . . the end of midwifery . . .

With a course like this the end of midwifery is in sight in Auckland. One could hardly provide a more badly structured course if one tried - midwifery training seems to have a very low priority for ATI's Nursing Division.

This year's midwifery students are disillusioned, dispirited, and tired-tired of all the hassles to get a decent training programme when all they wanted was to become midwives. And how many people, when they finish with such a poorly organised course, will find that it has coloured their perception of the profession, and change their minds about practising midwifery?

What we need in Auckland is an <u>excellent</u> senior midwifery tutor, capable of giving the students the benefit of wide experience, very good qualifications, and well developed interpersonal skills.
The position needs to be advertised overseas so that a tutor can be selected from a wide range of well-qualified and experienced candidates. New Zealand mothers deserve the best possible midwives, and our midwives deserve the best possible training.

*** Judy Larkin

YOUR PREGNANCY/TO HAPUTANGA ME TO WHAKAWHANAUTANGA
Published by the Department of Health

Broadsheet, November 1985

BROADSHEET

This is a 46 page booklet which is to be given free to all pregnant women by their G.P.'s or through hospital clinics.

The book is colourful and attractively presented with headings and sub-headings in both English and Maori. Essentially I suppose this is tokenistic but maybe it is also a step in the right direction. The book is well illustrated apart from the really horrible picture of a bespectacled, balding, smirking male carrying out an internal examination. This picture probably lets the cat out of the bag.

The book talks throughout of pregnancy and birth as natural functions. It sets out to stimulate women to help themselves and to retain responsibility for their health, to give up smoking and drinking, to attend ante natal classes; and to breast feed etc. But it ignores the reality, which is that most women are going to end up in the hands of male doctors and increasingly high-technology hospitals.

Reading the book one would expect that things have changed significantly for the better and that women will be respected and treated as intelligent human beings. But the changes in our larger hospitals have been window dressing. There may be wallpaper on the wall of the birthing room but you can't take your partner with you if you need an ultrasound scan.

Your Pregnancy/To Haputanga Me To Whakawhanautanga discusses hospital versus home birth which in itself is a radical change, even referring women to the Home Birth Association. But the department's prejudices come through clearly and we learn that, 'Most doctors and midwives believe that babies should be born in hospital because no *delivery* can be regarded as *normal* until it is over.' As the mother of three babies born at home I'd like to echo the words of one Auckland doctor who, having been in obstetrics for twenty years attended his first home birth and realised that this was the first *natural* birth he had seen. Large hospitals mess women up and what may be normal in hospital won't equate with natural birth at home.

The now famous Rosenblatt Report appears in a three page precis in the August edition of *Lancet*. The authors say,

> "Moreover, the quality of care may be better in some respects in small hospitals. The significantly lower perinatal mortality rates of normal-weight infants in level 1 (cottage) hospitals by comparison with level 2 and 3 (base) facilities may indicate that low-risk mothers fare better in low technology environments. It is possible that small hospitals in New Zealand achieve a better outcome partly because the level of medical intervention and the setting in which birth occurs are more appropriate to the medical and non-medical requirements of the mothers who go there."

And this brings me to the major criticism of the book. It accepts uncritically and to varying extents encourages the use of four dubious medical practices.

Firstly, we are told that ultrasound scans are "used quite frequently to find out the position of the baby ... check the baby's age ... make sure the baby is growing normally ... It's often done at 16-17 weeks ... Most mothers find that they enjoy seeing the baby and having the test done." Secondly, the book states that "An episiotomy prevents serious damage to the tissues supporting the Vagina." Thirdly, women are reassured that pain relieving medicines "will not affect the baby. No woman should feel she must try and do without."

The use of these practices on a routine basis should be deplored but I rarely meet women who have recently given birth in a large hospital who haven't had all three.

Lastly, in the discussion on contraception women are advised, "There's a special one-hormone pill for those who are breast feeding. It is not quite so reliable, but should not interfere with the milk supply."

Auckland domiciliary midwife Joan Donley has compiled extensive supporting data for her criticisms of these practices. The Department, in the introduction, has requested ideas on how the book can be improved. Well, the book can easily be improved but how do we change our hospitals?

Barbara Macfarlane

mediawatch

TORONTO STAR 7/85

Midwives fight for recognition

The Association of Ontario Midwives, an amalgamation of the Ontario Association of Midwives and the Ontario Nurse-Midwives Association that represents about 100 practising midwives, argues that midwifery should be a separate health profession, licensed and governed by its own college.

This would put midwives in an independent position, free to respond to the needs of clients. For some, this would mean attending home births. Mention home birth, however, and immediately the safety factor is raised by opponents of independent midwives. Only in hospitals can the medical profession maintain control of how midwives operate.

"Any formally trained midwife recognizes that problems can occur and do occur that can't be dealt with adequately in a home," says Milligan. "In developed countries, midwives work in hospitals, in teams."

Douglas Geekie, director of communications and government relations for the Canadian Medical Association, points out the ultimate decision on midwifery belongs to the provincial governments. But he is firmly opposed to midwives working independently.

And he predicts that any government that licenses midwives for independent practice "will find themselves with serious problems. Physicians will be put in the position of taking over situations that have gone bad on midwives. The doctors will be in malpractice situations and any physician who does so is asking for trouble."

Midwives and their supporters argue that midwives practise independently elsewhere.

"Canada is the only developed industrial country in the world that doesn't recognize and widely use midwifery," says Dr. Marsden Wagner, a spokesman for the World Health Organization in Denmark. "Every country in the world that has perinatal mortality rates (deaths that occur about the time of birth) equal to or lower than Canada's, without exception uses midwives as the birth attendants in about 75 per cent of all births."

(While the United States has recognized midwifery, it allows only nurse-midwives to practise, either in birth centres or hospitals. Yet the demand for lay midwives has not abated; they continue to practise underground.)

Why the difference between those countries and North America?

"Because for some time European countries have had a growing appreciation that health care is too important to leave in the hands of doctors," Wagner replies. "Midwifery provides a very important balance to the obstetrical perspective. In Denmark, in fact, if complications arise in a labor, the midwife calls in an obstetrician. They discuss the case and she gives him directions. In the Netherlands, 75 per cent of the midwives work independently."

While doctors have yet to say under whose authority midwives should fall, the College of Nurses of Ontario maintains midwifery should be under its jurisdiction.

"The College believes midwifery should be recognized as a health-care specialty based on nursing preparation and practised only by a nurse-midwife — a registered nurse with additional formal training in maternity and infant care," wrote Susan Smith, president of the college, in a letter to The Star last fall.

"There are two serious problems with that," argues Wagner. "Historically, nurses have always been the handmaidens of doctors and if midwives are to practise their profession, they must not attach themselves to a professional body that is underneath doctors."

Some argue that nurse-midwives (flippantly referred to as "physician extenders" because they were invented by doctors) would be prime targets for co-option. "It's hard to be an advocate of childbearing couples if you work for and are paid by the medical establishment," argues one midwifery advocate. "The essential elements of co-option — job, prestige, professional recognition — are all right there."

Consumer pressure mounting for access to midwives

By Lois Sweet Toronto Star

July '85

Forget any easy answers: The current midwifery debate is complicated. Competing professional interests, differing cultural perceptions and the discrepancy between patriarchal and feminist assumptions add up to inevitable conflict.

The clash between the involved parties has created a major thorn in the flesh for provincial governments across the country. The actors in the drama are:

- Midwives, who want to practise their profession legally and independently;
- Doctors, who aren't keen to give up control of childbirth;
- Nurses, who want midwives to practise legally, but under their jurisdiction;
- Consumers, who want the right to choose the form their health care takes.

The arbitrators in this exchange are the provincial governments, responsible for deciding who can provide midwifery services. Midwifery is legal in every province, but because it is declared a medical act, only licensed physicians in good standing are allowed to practise it.

"That isn't what we mean by midwifery," says Holly Nimmons, a spokesman for The Midwifery Task Force, a consumer support group. "The medical definition of midwifery is at complete odds with how midwives define their profession."

Midwives and medical personnel deal with the same phenomena — pregnancy, labor and childbirth. The differences arise in the way they view them. For the sake of clarification, let's call the current legislated form the medical model, the other, the midwifery model.

300 year-old debate

The midwifery model has a history as old as that of the human race. The medical model developed only 300 years ago or so, when men and technology entered the picture.

When barber surgeons — always male — began to use mysterious instruments called forceps in normal deliveries, midwives called their methods "meddlesome midwifery." While forceps were life-saving in difficult births, some midwives charged they were being used unnecessarily.

To this day, some view the medical model as simply an extension of "meddlesome midwifery." With its emphasis on "managing" childbirth through technology, the medical model puts the doctor, usually a male, firmly in control.

In Canada, the two approaches to childbirth have been at odds for the past 200 years. Now pressure is mounting to resolve the conflict. Expectant parents increasingly say they want the right to choose between the medical and midwifery models.

At the current inquest into the death of a baby born at home and attended by two Toronto midwives, the medical perspective was most clearly expressed by Dr. James Knox Ritchie, a Mount Sinai Hospital obstetrician. Speaking on the active management of labor, Ritchie was reported to have said that if a laboring woman's cervix didn't dilate at a rate of one centimetre an hour, he would rupture the membrane holding the amniotic fluid or use drugs to hurry the labor.

If pregnancy, labor and childbirth are medical problems, the woman becomes a patient. It follows that a sick person's childbirth has to be managed only by those with skills formally defined by the medical profession.

The midwifery model, on the other hand, assumes that while childbirth involves pain, it is much more. It is work, mother's work. When viewed as work, control goes to the laborer — the mother.

Midwives presume that a woman's pain, in a normal low-risk pregnancy, can be dealt with through support, reassurance and human contact. Hence the origin of the word midwife, literally, with woman.

American sociologist Barbara Katz Rothman described the orientation of midwives: "They took women as their norm, and focused and centred on women; and they saw our reproductive processes in a holistic, naturalistic way. They believed that women's bodies are meant to bear children — not necessarily that we should, or have to, but that when we do it, we are no more stressing the system than we are when we are digesting a nutritious meal."

That philosophy led midwives to treat childbirth within the larger context of women's lives, teaching women how to give birth, refraining from unnecessary intervention and involving the entire family in childbirth.

Increased pressure

Sometimes they seize that right by having midwives help them deliver in the privacy of their homes. Sometimes they take a midwife along to a hospital birth for support.

Others lobby for free-standing birth centres, where midwives can practise their profession in a safe, home-like setting.

Whatever the choice, there is increasing public pressure for access to the services of recognized midwives. The Midwifery Task Force, an Ontario consumer support group, says it has several thousand members, more than 90 per cent of them with post-secondary education.

The Ontario government is not oblivious to these signs of discontent. Nor is it unaware of what it costs the state to provide facilities for physician-attended hospital births. One study revealed Canadians would save a minimum of $8.2 million a year if people other than doctors were used in births.

The Health Disciplines Act, which defines the health professions given legal status by the government, is under review and there's been strong representation to include midwives.

The medical profession is also aware of pressure for change. In a discussion paper, On Directions in Health Care Issues Relating To Childbirth, members of the reproductive care committee of the Ontario Medical Association (OMA) outlined the role of midwives as one issue.

According to committee chairman Dr. John Milligan, an effort is being made to put allied health professionals in perspective. While the opinions he expresses are not OMA policy, they reflect the direction in which the OMA seems to be moving.

"We may indeed need individuals other than physicians practising midwifery," Milligan says. "But for the sake of safety, they need to be trained and adhere to very high standards. At the moment, a lot of people call themselves midwives and they have virtually no training."

THE OBSERVER, SUNDAY 7 JULY 1985

Trust the midwives

Midwives are fed-up. DR WENDY SAVAGE puts the case for childbirth reform

CHILDBIRTH has never been safer or more likely to result in the birth of a live healthy child, yet women have become increasingly vociferous about the deficiencies they encounter in the maternity services and obstetricians often become defensive as women ask for more say in how they have their babies.

The debate is often seen as a conflict between 'technology' and 'nature,' but in reality I think it is more complex than that. All women want the best possible chance for their babies, and will endure crowded, hot antenatal clinics, physically uncomfortable monitoring in labour and operative delivery if the doctor advises them that this is best for the baby.

What I think women, most midwives and some doctors are increasingly questioning is the scientific evidence on which today's obstetricians base this advice, and secondly, the application of a mechanistic type of care to all women as a routine.

Midwives deliver about 80 per cent of women nationally. There are 27,000 of them for the 630,000 annual births, and all the prenatal and postnatal work (which theoretically works out at one midwife for every 23 births). Another 90,000 are not practising, and whilst perhaps half of these never intended to do so, we must ask why the rest have left the profession and why Department of Health figures show between 11 and 16 per cent of midwife vacancies are remaining unfilled. Women like the care that a good midwife provides, the opportunity to discuss problems with another woman who does not have other more 'important' commitments. Often the class differential is less. And midwives are trained to and enjoy assisting a woman to give birth naturally without episiotomies or tears to the perineum.

Many midwives express dissatisfaction with their role of handmaidens to doctors (who are often much less experienced than they are); they are underpaid (staff midwives can earn no more than £7,000 a year; sister midwives no more than £9,254). Also, current staffing policies mean women see a different set of midwives in the antinatal clinic from those in the labour ward, the post-natal ward and when they go home. Only midwives in the labour ward, or those working in a home delivery or 'domino' scheme in the community ever get a chance to use the delivery part of their training.

One solution to the present situation would be to allow midwives to work independently, as in Holland, with a case load of 50 women a year. If they followed women right through a pregnancy women and midwives would get a better deal. When a woman became pregnant, her GP could refer her to one of a group of midwives, who could in turn refer women back for an opinion from the obstetrician or general practitioner of their choice, if complications were present or developed.

What we must seek to avoid is defensive obstetrics, practised when relationships between women and their doctors break down. This situation has clearly arrived in the US, where doctors often resort to Caesarian section just in case something goes wrong for which they can be sued later. The Caesarian section rate in the US has quadrupled in 20 years to 20 per cent by 1983, and appears to be still rising.

Induction of labour, routine episiotomy, routine electronic foetal monitoring, routine iron supplements, elective forceps deliveries, Caesarian section for breech presentation and for low birth-weight babies, are all procedures which have been introduced in Britain without proper scientific evaluation. More obstetricians and general practitioners are needed who have been trained to cope with their own anxiety, have enough time to read the literature and to learn about normal labour in the home or GP units from midwives and GP obstetricians rather than gynaecologically-orientated consultants who spend little if any time in the labour ward. The speciality needs more people, so that a doctor who has been up all night doesn't have to face a huge antenatal clinic and an operating list the next day. The training of doctors needs to be altered to take account of the fact that this is not just an emotional business but one where emotions are relevant and valid. Paradoxically, it would be an advance if young doctors were able to admit to their own ignorance about many aspects of pregnancy and childbirth, and to share decision-making with women.

Paying midwives more and increasing the number of obstetricians in training and at consultant level would cost money — but there is somewhere it could come from. In the US it has been estimated that each 1 per cent rise in Caesarian section rate raises health costs by $63 million a year. In Britain such an operation costs about £1,000 per person, and I contend that if the professionals had more time to spend with women, and they applied technology on an individual rather than a routine basis and provided more care in the community, the resultant savings would outstrip the initial investments and costs. Women would be happier, midwives would have more job satisfaction, and obstetricians might both have time to spend with their families and not feel so threatened by women.

SUE ADLER

Wendy Savage at home in North London : ' Avoid defensive obstetrics.'

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what are we after?

What are we after as an organisation? We have been asked by one member to print a more detailed outline of Save The Midwives policy. When the Women's Health Committee of the Board of Health called for submissions earlier this year, we sent in a submission compiled by some of the Auckland members that details the thirteen major aims of the organisation as we see it after reading the responses to the questionnaires that we included in 4 newsletters, and after discussing the points amongst ourselves. We are, as always, appreciative of any comment - please write to the Editor, c/- 24 Ashton Rd,Mt Eden, AK 3. The body of the submission is as follows:

The Save The Midwives Association is concerned with the quality of maternity care provided in New Zealand both from the perspectives of the midwife and the mother. Save The Midwives is an association of health professionals and parents who work together towards the same end: the highest quality of maternity care compatible with freedom of choice in childbirth.

Improvements that we would like to see in the maternity service fall under two headings;

A) Midwifery training

B) Midwifery employment

1) We wish to see more midwives trained in New Zealand. In 1970, we trained 92 midwives. In 1980, we trained 12. This year, 13 students are training in Auckland, with a comparable number training at the other technical institutes that offer the course. This falls far short of the 180 or so midwives that the Nursing Council registers each year, and if for some reason the overseas-trained (mostly British) midwives stop coming to N.Z. to work, we will find ourselves with an extreme shortage of midwives.

2) We wish to see midwifery training removed from the Advanced Diploma of Nursing, and returned to a seperate course that can be undertaken in either a technical institute or maternity hospital.This was the situation previous to 1980.

3) We wish to see a greater practical component to the midwifery training. In 1982, 24 New Zealanders trained as midwives here, while 39 New Zealanders trained as midwives overseas. This is a common pattern, and the reason given by midwives is that the N.Z. course lacks a sufficient practical component.

4) The EEC countries recently increased the trainingperiod for non-nurse midwives to 3 years, and for nurse midwives to 18 months. The latter course in N.Z. is only 8 months. We would like to see this extended to 18 months so that a N.Z. midwife's qualifications are acceptable to the EEC countries. It is notable that England recently changed the midwifery training period for nurses from 12 months to 18 months for this reason.

5) We would like to see direct-entry midwifery training available in New Zealand. England and Holland both provide 3-year midwifery courses for students who are not also nurses. In fact, 80% of Holland's midwives are trained in this way, and Holland consistently has one of the lowest perinatal mortality rates in the world. Women work either as midwives, or as nurses; to train them as both is unnecessarily expensive in these times of economic stringency. Short bridging programmes can be provided for those who wish to change profession at far less cost.

6) We would like to see community-based midwifery clinics, where antenatal care is provided by midwives, and from where a midwife attends either a hospital delivery or a home birth, positively promoted by the Department of Health. We envisage these functioning in much the same way that the Plunket Society clinics do, so that women who wish to choose their midwife for a hospital birth may do so. This is presently an option unavailable to NZ women.

7) More domiciliary midwives are needed in this country. They currently earn approximately half of what they earn in hospital, and this is the major reason for the shortage in this area. Throughout most of New Zealand, a home birth is simply not an option, so the 1% of New Zealanders who choose a home birth could well mushroom to 35%, the Dutch figure for 1984, given a sufficient number of midwives.

8) Early Discharge should become a more frequent phenomenon. Women leaving hospital 2 hours or so after a birth need the attention of a midwife daily, and there is an insufficient number of trained midwives to meet an increased demand for this service. We are opposed to the Plunket Society providing aftercare in the puerperium; this is the task of the trained midwife.

9) We wish to see the Nurses Amemndment Act altered to allow direct-entry midwives to practise domiciliary midwifery, as was the case before 1 April 1984.

We would like to see two research studies set up in N.Z.:

10) With equally-matched groups of low-risk mothers, a comparison of outcomes achieved by midwife-only care, with G.P.care, and with specialist obstetrician care, antepartum, intrapartum and postpartum. Overseas studies have consistently shown the midwives as achieving the best results.

11) Again with equally matched groups of low-risk mothers, a comparison with the outcomes of home births with hospital births. Overseas studies have shown home births to have better outcomes.

12) Finally, we would like to see the recent report on New Zealand's maternity service by Professor Roger Rosenblatt officially published by the Department of Health. The Department has recently published it with a complete disclaimer; an extraordinary situation since the co-researcher, Judith Reinken, worked on the report as a member of the Department's Management Services and Research Unit. The erport shows that New Zealand's small maternity hospitals have an excellent record, and that our system of G.P.-Midwife care for normal births works extremely well. The report is entitled "Regionalisation of Obstetric and Perinatal Care in New Zealand- a Health Services Analysis " and is dated July 1984.

the dalkon shield

OPEN LETTER TO WOMEN WHO HAVE EVER USED AN IUD

The following statement was issued by Margaret Shields, Minister of Consumer Affairs and Ann Hercus, Minister of Women's Affairs.

The Dalkon Shield is an IUD (intra-uterine contraceptive device) which was marketed in New Zealand from 1970 to 1975 but have been inserted up until two or three years ago. It was promoted as suitable both for women who wanted no more children, and for women who had not yet had any children.

The Dalkon Shield is considered to be dangerous to the health of any woman who has one still in place. While in place it may cause health problems, including pelvic infection, septic miscarriage, infertility and death. If you have an IUD in place, and you know it is a Dalkon Shield, you should have it removed immediately. If you are not absolutely sure what sort of IUD you have, contact your GP or the clinic where you had it inserted, and ask whether you were given a Dalkon Shield.

If you cannot find out for sure, visit a doctor or family planning clinic as soon as possible, so it can be checked. If it is a Dalkon Shield, arrange to have it removed urgently. A. H. Robins Pty Ltd, the manufacturer of the shield will pay all medical costs involved. You will not have to pay the doctor or clinic. Some removals may not be able to be carried out in the doctor's surgery and if this is so any specialist care or hospital treatment will also be paid for by the manufacturer. If your doctor has any doubts about this, Mr Miller of A. H. Robins Pty Limited in Sydney will accept collect calls to telephone Sydney 534-1000 from your doctor to confirm that, before specialist care or hospital treatment is arranged.

Women who have had a Dalkon Shield removed may experience other health problems afterwards. Women's health groups are recommending that you should have a PAP smear and a complete blood count, a culture and a chlamydia test to check for infection, and a course of antibiotics if any infection is found. As Ministers, we are not qualified to make medical judgments but you may wish to raise the possibility of these tests or treatment with your GP or family planning clinic.

Also, the doctor should send any removed Dalkon Shield to a medical laboratory for testing and anlysis report. Ask your doctor to make sure you receive a copy of that report. If your doctor will not agree to that, ask to be given the removed IUD in a sterile sealed container and take it with you when you leave the surgery. Take it immediately, still sealed, to a family planning clinic or women's health group for advice.

Any woman who has ever suffered any damage to her health or physical wellbeing, any emotional distress, loss of fertility, loss of sexual relations, marital problems, or other harm as a result of using a Dalkon Shield may have a legal right to claim against the manufacturer of the product.

Many hundreds of women in the United States, Australia, New Zealand and other countries are bringing claims against the company. There are women's health groups in New Zealand who can help you with information and other assistance, including claims for compensation. These groups include:

Fertility Action
21 Albany Road
Herne Bay
AUCKLAND
Ph: (09)764-893

The Health Alternatives for Women
P. O. Box 884
CHRISTCHURCH
Ph: (03)796-970 (day)

West Auckland Women's Centre & Maori Health Coop.,
111 McLeod Rd
Te Atatu,
AUCKLAND
Ph: (09)836-6381

Other groups are forming in smaller centres and the women in the groups above may be able to put you in touch with other women in your locality who can help. Alternatively, you could contact a law firm in your locality and ask for advice, under the "Law Help" scheme, about your rights and the possibility of lodging a claim for compensation from the company. If this letter applies to you, we urge you to take immediate action to protect your health. Please feel free to make further copies of this letter for display on notice boards or for further distribution.

SAVE THE MIDWIVES

news about our organisation

#Action

MATERNITY ACTION has been given two of the twenty places on the Auckland Hospital Board's new committee on Maternal and Neonatal Services. The committee is advisory only, with decisions in this area made by a 3-woman committee - consisting of Dr Gabrielle Collison, Medical Superintendant of National Women's Hospital, Ms Billie Harbidge, the Board's Service Development Officer, and Miss C Mathewson, the Board's Nursing Officer.
Maternity Action is the 15-member coalition of women's and parenting groups that formed in Auckland a year ago to fight the closure of the city's small maternity hospitals. Save The Midwives is a founding member.

#ACTION

Save the Midwives has joined with Auckland's student midwives to improve the midwifery training here. A formal complaint has been lodged with Auckland Technical Institute's Director, Dr John Hinchcliff, over the quality of the course. See the article in this issue.

SUBSCRIPTIONS

Thanks to Lynda Schroeder for offering to take over this job for a while. It's great to add another worker to the group!

NEWSLETTER

We still need someone to do this - Lil is going back to Canada in early '86. She has done a superb job, but nevertheless someone can follow her lead. You receive more material than you can publish, so it's a matter of choosing what goes in, and collating it-puttingon page numbers, doing the headings, etc. A real attraction is that you get to read all the magazines that come in from overseas so it's easy to stay in touch. Volunteers rush to the phone and call Judy Larkin, the secretary, on 602 301.

SAVE THE MIDWIVES ASSOCIATION SUBSCRIPTION FORM

24 Ashton Rd., Mt Eden, Auckland 3, New Zealand.

NAME_____ _____ PHONE_____

ADDRESS_____

_____

MIDWIFE_____ PARENT_____ OTHER_____

ANNUAL SUBSCRIPTION $4_____ $6_____ $10_____
(your choice)

Australia $NZ10_____ International $NZ15_____ NEW_____ RENEW_____

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