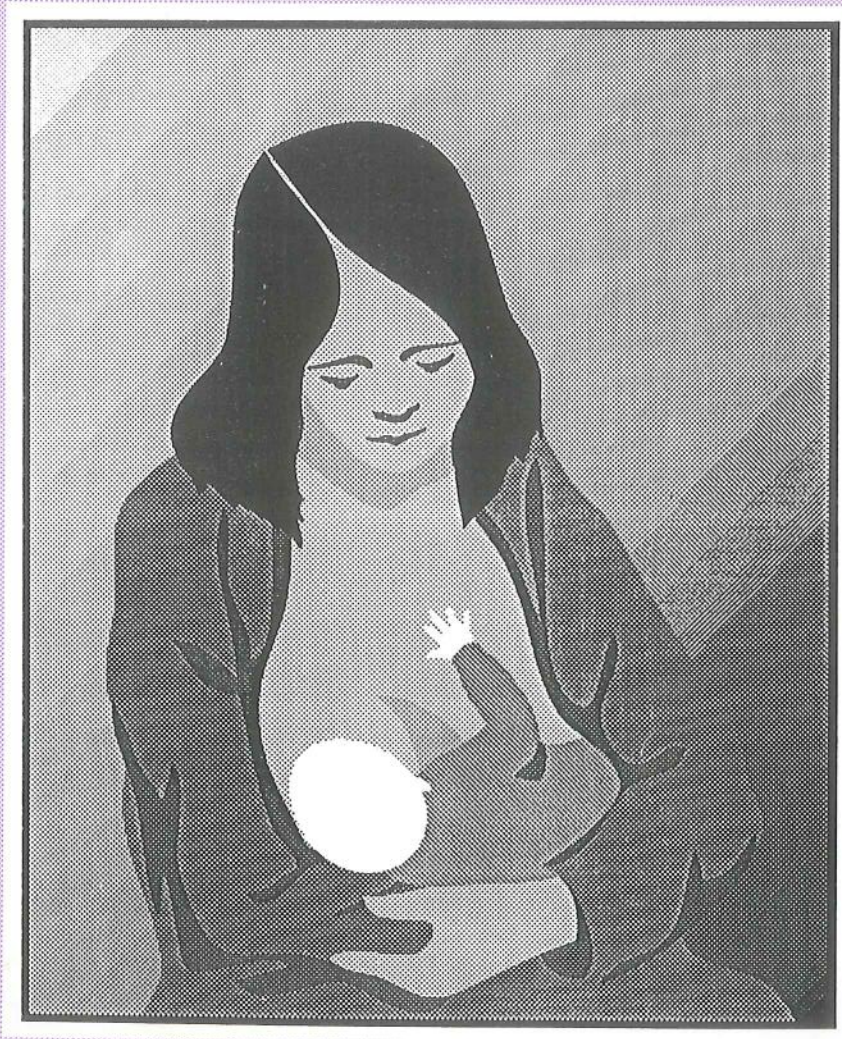




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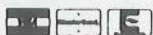
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C O N T E N T S



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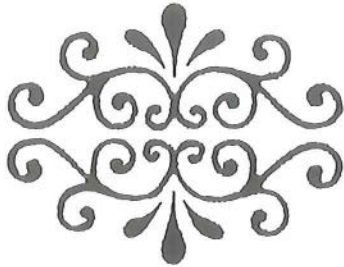
Contributions such as the letters, reviews, forthcoming events and other items of interest and research are needed, and are welcome from anyone who feels they have something to offer. Art work and photos will also be gratefully accepted. We can return originals.

Articles printed in this edition do not necessarily express the opinions of the editors/editorial committee. They are the views and opinions of the authors.

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EDITORIAL



LETTERS TO EDITOR

Australian College of Midwives Journal

Congratulations on the birth of your National Journal!

As one of the Midwives responsible for the birth of the Australian College of Midwives Journal, which is about to publish its fourth edition, I can sympathise with the blood, sweat and tears that are mandatory before a new publication is ready for launching.

I wish to encourage all of our New Zealand colleagues to get behind their Journal, and to flood the Editor with material, and don't leave all the work to a dedicated few.

I hope that the birth of your Journal brings as much joy to our New Zealand colleagues as it has to your Australian counterparts.

Martin Goreing
Editor, 1989

Independently Practising Midwives Communique

Congratulations on a superb journal and on the birth of your College of Midwives.

You are a shining example to midwives all over the world in your achievements. To encourage consumer input to the level of actually guaranteeing it in your constitution; to win the right to practice independently and that your wonderful Joan Donley

Welcome to the second issue of New Zealand College of Midwives Journal.

Firstly, we would like to introduce and thank the editorial committee for their support, encouragement and guidance in selecting, writing and proof reading articles for this issue. They are:

Andrea Gilkison (Palmerston North),
Chris Hannah and Marion Lovell (Wellington),
Liz Smythe (Auckland),
Bronwen Pelvin (Nelson), and
Karen Guilliland (Christchurch).

Secondly, how could we fail to mention the domination of our minds by the effects of the 'Bill'. Since the last issue, the

has been honoured with an OBE for her services to midwifery; certainly helps us all to walk a little taller, thank you New Zealand!

As the Judy Small song says of another of your outstanding achievements

"Oh, Oh, New Zealand,
Who would have thought it could
be you!
If Kiwis can stand up to Eagles
Why not the Kangaroo?"

Mind you it was referring to another kind of eagle, but you're still challenging big birds and we love and admire you for it.

Maggie Lecky-Thompson
Editor

Congratulations

Congratulations on successful production of the journal. It is a terrific effort and commitment and I think you have done an amazing job. Thank you so much. All credit where credit is due.

Christine Barbier
Christchurch

Congratulations

Congratulations on the first issue of the journal. It made me feel very proud to be part of the College and to see how far we have come in just a year.

The journal articles are excellent and this will be a wonderful forum for us to share our knowledge and views. The cover design is beautiful. Well done and I look forward to the next issue.

Sally Pairman
Dunedin

Nurses Amendment Bill has been introduced to Parliament (Helen Clark's speech has been included in this issue) and now it is at the Select Committee stage. As we all know, changes to this Bill will restore the present status of the midwife. Bronwen's very timely and relevant article is presented as a challenge to practising midwives.

Our congratulations go to Joan Donley, the only NZ COM Honorary Life Member who received an OBE for service's to midwifery at the New Year. Well done Joan!

Judy Hedwig, Helen Manoharan
Co-Editors NZ COM Journal

Lay-Midwifery

We were pleased to read an article by Joan Donley on Professionalism in your first issue of this journal, and would like to address the issues of autonomy for midwives and power.

Some midwives may be feeling apprehensive about taking on the responsibility of the women they care for (the role the doctor once assumed). It should be pointed out that taking responsibility for someone else is having power over them. A woman in choosing to give birth at home is taking responsibility for herself. What she needs from her midwife is support and trust in her ability to birth in the way she chooses. The midwife who can be with the woman and share power with her, will have a lot to offer her.

Some women are choosing to give birth with lay-midwives after previous home-births with domicillary midwives because lay-midwives share their power with the woman. Lay midwives have never worked under the supervision of doctors, and are accountable to themselves and the women in their care.

As Joan Donley correctly points out, if midwives choose to take on positions that doctors have left vacant they will eventually be replaced by lay-midwives.

Kali Judd
Annie Gordan
Mandy Waata
Hokianga

ICEA NZ Coordinator

Your first issue of the *Journal* made exciting reading. The growth, in a few short years, from 'near extinction' of midwives, through to the establishment of the NZ College of Midwives, separate midwifery education,



strong progress towards autonomy, (and now a proposal for a Direct Entry course), is nothing short of phenomenal. It was interesting to read of the influence and support in all this of the Homebirth movement and other consumer-based groups e.g. Maternity Action and Save The Midwives. Perhaps most impressive of all was the emphasis throughout on the involvement of the consumer in planning and decision making. The combined force of midwifery and con-

sumer groups working together has to be a powerful one, and these developments augur well for maternity services in New Zealand.

To the New Zealand College of Midwives, I would like to say that it is good to see amongst the draft position statements being considered by the College one recognising the qualifications of childbirth educators who have completed training e.g. through the International Childbirth Edu-

cation Association (ICEA), Associates in Childbirth Education (ACE), and National Childbirth Trust (NCT). This is the first recognition that I am aware of from a professional group, and it is significant that it is coming from midwives. Childbirth education training is another area of change and growth that is starting to happen in New Zealand.

Congratulations on a great start and best wishes for future success!

Jenny Drew

Letter to New Zealand College of Midwives

In the first issue of your College Journal, September 1989, there is a comment which is wrongly attributed to me. It is alleged by Joan Donley that I told the Wellington O & G Society that the three greatest threats to modern obstetrics are:

1. consumerism
2. feminism
3. midwives

In fact I said no such thing and such a view is contrary to my beliefs.

I was addressing a private meeting on the future of obstetrics, particularly on moves the Government might make. I said "Apart from the Government there are several influences that we need to consider, including changes to society with consumerism and feminism; medico-legal aspects; the news media; the nursing profession; private insurance and ourselves." No mention of threats nor of "modern obstetrics" which is a term I cannot recall using, ever.

With regard to feminism I said "much of the criticism is valid and needs to be acknowledged in my view, so that we can move forward and make real improvements to the service that we provide." Consumerism clearly has produced major changes and I said we, doctors, must listen to the wishes of women and encourage their self determination, accepting alternatives to our ways and working with them.

I noted, without comment, the WHO definition of a midwife, the moves towards autonomy of midwives, changes in midwifery training, the formation of the College and the Domicillary Midwives Standards Review Committee.

No-one has asked for my personal views on independent midwives, your College or even on home births but, as it happens, I support all three.

There has been a lot of misinformation about medical involvement in childbirth and it is very destructive. If the current vogue of denigration of specialist obstetricians continues, with the apparent lack of respect for anyone who is not a midwife, the prospect of co-operation between the people who care for women becomes a forlorn hope. The lives of countless women and babies have been saved by medical intervention because even though childbirth is a natural process, it can go badly wrong, like all natural processes.

M.A.H. Baird

M.B., Ch.B., F.R.C.O.G., F.R.N.Z.C.O.G.

Auckland

We apologise for any misrepresentation that may have occurred, and accept Dr Baird's views as expressed in this letter.

We have no hesitation in offering Dr Baird our unreserved apologies.

Editors

POEM

*He was merely a sailor
A spectator of the rhythm
Watching a midwife
And a mother
In the amazing birthing
It was a beautiful speechless moment
Real, breathtaking, everlasting
Looking back, all in all
He felt as a travelling salesman*

Anon Male

The Nurses Amendment Bill: The Implications for Midwifery

Bronwen Pelvin
Domiciliary Midwife

"...or registered midwife..."

Three words are poised to change the face of midwifery practice in New Zealand as most midwives have known it. Inserted after "general practitioner" in Sections 54.1 and 54.2 of the Nurses Act, these words return to midwives our status, our professionalism and our independence. Helen Clark, Minister of Health, introducing the Nurses Amendment Bill to the House of Representatives said "Having a baby is not an illness. It is a normal physiological process that for generations was viewed as such. With the advent of medical technology, there has been a trend towards treating pregnancy and labour as an illness. This has resulted in an increasing amount of medical intervention in the management of normal pregnancy which has led to the erosion of the midwives role. This has proved both costly and in many cases, inappropriate.

The care that a midwife is qualified to give includes detection of abnormal conditions in mother and child. ...The midwife has an important role in the prevention of complications and achieves this through education of the woman and her family within the wider community. ...In conclusion, Mr Speaker, this Bill will allow qualified midwives to take responsibility for the care of their clients."

We are ready for it; more than ready for it! In the last ten years, we have forged an alliance with women dissatisfied with the care they have received or simply desirous of retaining control over their own life processes including giving birth. Some of us have refused to accept the conventional medical interpretation of the Nurses Act that "responsibility for the care of the patient", has meant that the doctor involved gets all the decision making power and his permission is needed for midwifery care. One or two of us have taken the responsibility charged to us under the Social Security (Maternity Benefits) Regulations 1939:

13.(1) Application for the services of an obstetric nurse in relation to maternity benefits may be made... by the woman concerned ... to any obstetric nurse whose name is for the time being on the list of obstetric nurses for the health district in which the services are required.

(2) If for any sufficient reason the obstetric nurse ... is unable to undertake to provide the services applied for she shall ... inform the applicant to that effect, and, pending the making of other



arrangements by the applicant, it shall be the duty of the nurse, at the request of the applicant, to provide any nursing services in relation to the maternity benefits that may be urgently or immediately required. (my emphasis)

-seriously and have attended women without the sanction of medical cover. Responsibility in childbirth is shared between the practitioner, the woman and her family. That shared responsibility is best carried in the relationship between the participants in the event, where midwifery care can then become responsive to expressed needs rather than concerned with legal 'cover' of our actions.

The major step in this new world of midwifery has to be the provision of continuity of care. It is the cornerstone by which midwifery stands or falls. It demands relating on a one-to-one basis, as equals, with the pregnant woman. Midwifery is best carried out in a relationship between the midwife and the pregnant woman, building up trust throughout the pregnancy so that when she goes into labour, the woman feels safe with a midwife who knows her and is in tune with her needs and desires at this crucial time in her life. Midwifery is about connecting people - mothers, babies, fathers, brothers, sisters, grandparents, friends - and we can best do this by example - connecting ourselves to the women we take on as our clients.

There is tremendous scope for midwives to offer continuity of care once the Bill becomes law. This can be achieved by: the individual midwife, domiciliary midwives, midwives in partnership-sharing clients, midwives in collectives, or midwives in teams, where the woman gets to know each midwife throughout her pregnancy; and always with the goal of the woman in mind that she is being attended by a midwife who she knows when she goes through labour and gives birth to her baby. These styles of midwifery practice can operate from home, community clinics, birthing centres, base and teaching hospitals. Imagine community based midwifery, behaving as if birth is a normal, everyday, miraculous event. Imagine all the small, closed maternity units in rural New Zealand re-opened and offering midwifery care to the women in those districts. Imagine every closed Post Office re-opened as a community midwifery clinic

providing antenatal care within walking distance of the women they serve. Just imagine midwives working amongst women in the communities where they live and learn what it means to be 'with women'. The change in the Nurses Act will allow midwives to determine the services they can offer to women.

But first, we have to elevate our perception of ourselves. We need to see ourselves as practitioners of the ancient art and science of midwifery and recognise our own knowledge and expertise that makes us specialists in the field of delivering babies. To take on the responsibility inherent in this change in the legislation, we need to re-educate ourselves and relearn our basic 'watching and waiting' skills.

How prepared are you to practise as an independent midwife practitioner? I'll ask you to look at the things you do when a woman is in labour. How many vaginal examinations? How often do you listen to

the baby's heartbeat? Go out of the room? Draw up oxytocic drugs? Local anaesthetic? Cut episiotomies? Suction babies? Give Vitamin K? All (fairly) routine obstetric behaviours except palpation and all valuable tools when used appropriately which, I'll maintain, in normal midwifery is hardly at all! These behaviours stem from a basic belief that women can not give birth without intervention of some sort. And it is our unlearning of this that teaches us to be midwives - with women.

I do know is that the passing of the Nurses Amendment bill will give us our job back. And we can reclaim our profession, for so long in the shadow of medical obstetrics. We can begin to re-educate ourselves. By standing tall for midwifery, we can begin the long, slow process of re-educating women to believe in themselves and their bodies' ability to give birth and nurture their babies. ■

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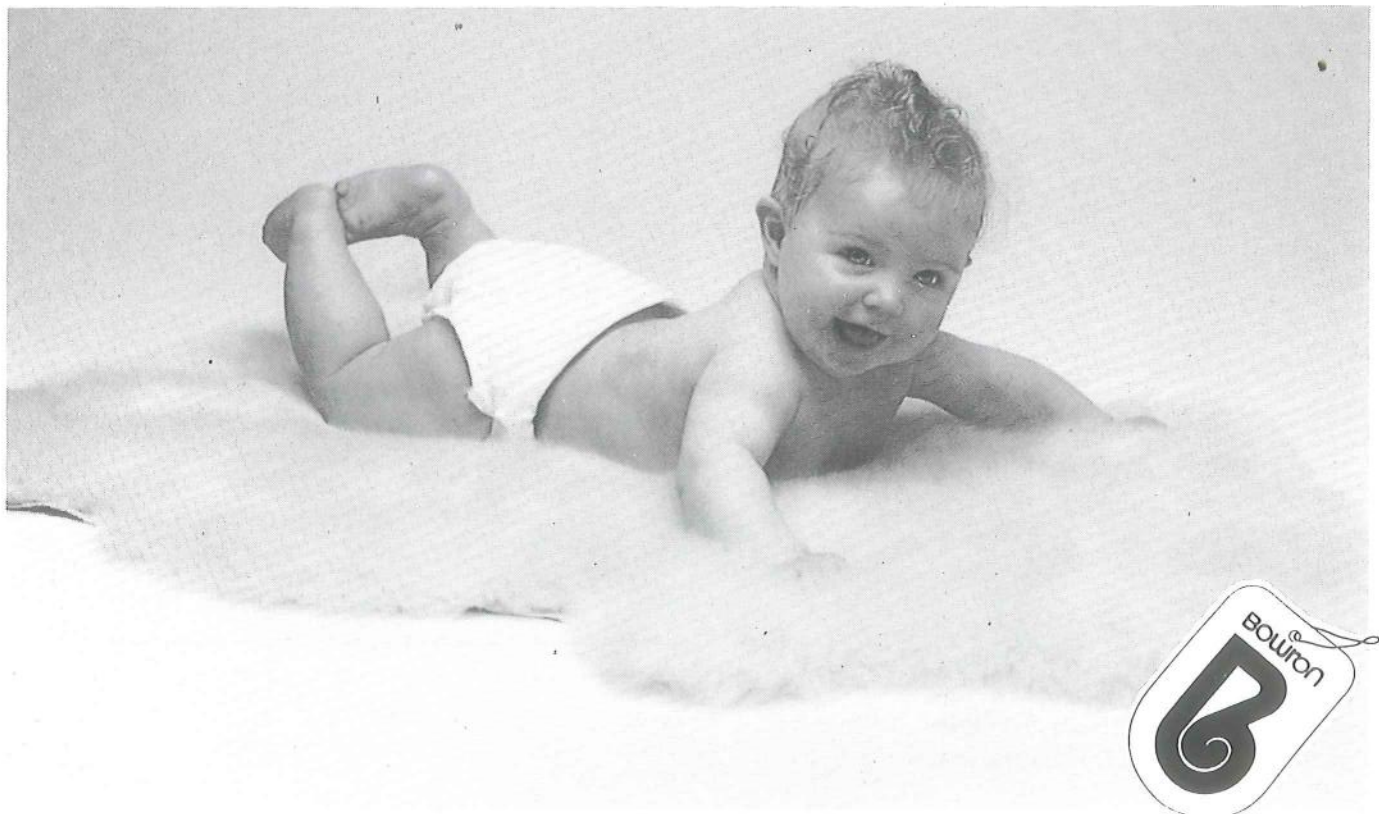
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Introduction of the Nurses Amendment Bill in Parliament

Hon. Helen Clark
Minister of Health

MR SPEAKER, I MOVE THAT THE NURSES Amendment Bill be introduced.

Although the Bill has only two clauses, it will have a significant impact on the delivery of childbirth services, and the practice of midwifery.

This Bill will enable a midwife to take responsibility for the care of a woman throughout her pregnancy, childbirth, and post natal period. At present Section 54 of the Nurses Act 1977 makes it an offence for a midwife to provide a service unless a medical practitioner has undertaken responsibility for the care of the client.

At present, subsections (1) and (2) of section 54 of the principal Act have the effect of prohibiting a person from carrying out obstetric nursing if responsibility for the care of the patient is undertaken solely by a registered midwife. Such responsibility may be undertaken only by a medical practitioner.

The effect of the clause is to allow a registered midwife to undertake sole responsibility for the care of the patient in such cases. This places a registered midwife in the same position as a medical practitioner for the purposes of section 54.

In recent years there has been a consistent message from various groups and organisations that childbirth is a natural process, and that a woman should be able to choose to have a midwife deliver her baby, without the need for a woman to also be under the care of a medical practitioner.

The New Zealand Planning Council noted that pressure has grown for childbirth to be seen as a natural process, whilst the Women's Health Committee to the Board of Health saw the role of the midwife as central in providing choices and alternatives in the birth process. In 1987 Treasury questioned in comments on the maternity benefit schedule whether it was the public or doctors who benefit from the restriction in Section 54(1) of the Nurses Act 1977.

Area health boards are exploring alternatives in the provision of maternity services. Some boards are developing innovative new ways of delivering childbirth services that fully utilise the expertise and skill of midwives. This amendment will facilitate changes already planned by boards who wish to make services more flexible and consumer oriented.

Mr Speaker, in removing the restrictions on the practice of midwifery, it is essential that the safety of the woman and baby remain paramount. I am confident that such safety will be maintained because registered midwives are competent to undertake the more independent role proposed.

A midwife must successfully complete a recognised midwifery course, before gaining registration as a midwife. Midwives are held accountable for safe professional practice through the Nursing Council of New Zealand.

Having a baby is not an illness. It is a normal physiological process that for generations was viewed as such. With the advent of medical technology, there has been a trend towards treating pregnancy and labour as an illness. This has resulted in an increasing amount of medical intervention in the management of normal pregnancy which has led to the erosion of the midwives' role. This has proved to be both costly and in many cases inappropriate.

Medical practitioners are trained to diagnose and treat people with illnesses and abnormalities. In the area of pregnancy and childbirth, their expertise is necessary with the high risk, complicated, and abnormal pregnancy and childbirth. The focus of the midwife's expertise, however, is the low risk, uncomplicated, normal pregnancy and childbirth.

The majority of births (85 percent) in New Zealand are normal, and do not re-

quire medical intervention as a matter of course. It is appropriate that midwives provide a low technology childbirth service to meet the needs of the low risk women in New Zealand. This amendment will give New Zealand women the choice to access the services of either a medical practitioner or a midwife.

Midwives as a profession are committed to providing care of the highest quality. Midwives have national standards for midwifery practice, service, and education.

The development of peer review systems that involve consumers is more evident of the professionalism of midwives.

A midwife is educated to give the necessary supervision, care, and advice to women prior to, and during pregnancy, labour, and the post natal period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant.

The care that a midwife is qualified to give includes detection of abnormal conditions in mother and child. A midwife is ultimately concerned with the healthy, well woman, and is skilled in assessment and referral of women with complications to medical practitioners.

The midwife has an important role in the prevention of complications, and achieves this through education of the woman, and her family within the wider community. She is qualified to work in any setting, be that in a home, hospital, or community.

A working group was set up by my department to investigate safe options for low risk pregnancy. The membership of this group includes a general practitioner, an obstetrician, midwives, and various consumer groups. The group has endorsed the removal of the restriction on midwifery practice. The group's comment on the proposed change was that they believed it would generally be very well received by their colleagues. Midwives will be working together with other health care providers in the provision of childbirth care.

In conclusion, Mr Speaker, this Bill will allow qualified midwives to take responsibility for the care of their clients. It will encourage better utilisation of skilled health professionals. It acknowledges womens childbirth choices, makes the service more accessible, and maintains safety standards for mother and child. ■

THE NEW YEAR'S HONOURS LIST SAW THE recognition of Joan Donley and midwifery; it endorsed their value and paid tribute to the service midwives provide to the community. It also recognised giving birth at home as an accepted choice, domiciliary midwifery as a respected midwifery practice, and gave a final polish to the bridge which has built between hospital and community based midwives.

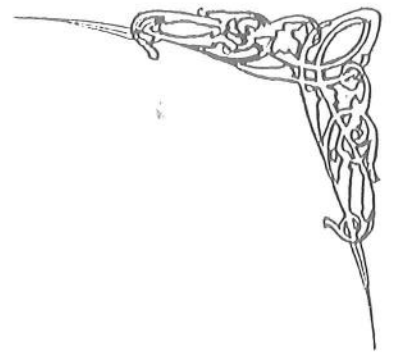
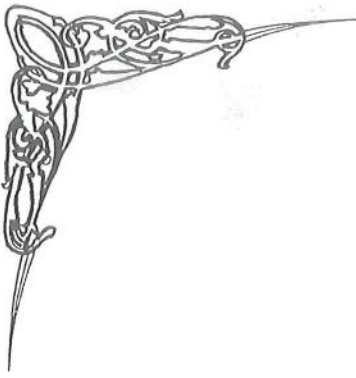
Joan herself would, no doubt, be very relieved if I stopped there. She sees her O.B.E., which sits somewhat uncomfortably on her genuinely modest shoulders, as - while a little embarrassing for her personally - a matter for great pride for all midwives as a recognition of their worth nationwide.

In this she shows her usual accuracy. Midwifery has become the brave new world of childbirth and struggled back out of the closet to re-claim the pride and skill it rightfully owns. The door has been opened, not only by professionals, but by the women of our communities, who want midwives to befriend, and care for them through their childbearing, to bequeath the gift of an effective midwifery service to future generations. We acknowledge these unsung hero-

The Honouring of Joan Donley, O.B.E.

Carolyn Young

Domiciliary Midwife



Photograph by Jane Scotts

ines, the hard working consumer who has toiled to reclaim what was rightfully hers in the first place; uncluttered midwifery based childbirth as her first option. However for Joan to be chosen as the symbolic midwife is totally appropriate and truly heart-warming to all who know her; it is no mere accident that she was selected as the individual recipient of a universal recognition.

For those who don't yet know Joan, she is a very dynamic 73 year old, who indulges heavily in wholesome foods. The sort of combustion this creates when coupled with her incredible drive produces a high octane energy level which is daunting to behold. At the age of 54 Joan made the decision to train as a midwife. She began practicing as a domiciliary midwife in 1974, a then maligned fledgling form of midwifery that has since gone from strength to strength; a transformation in which Joan herself has played a major role. She still continues to provide a much sort after midwifery service to home birth mothers, having seen some hundreds of babes born safely into the world, amongst them her own grandchildren.

Not seeing herself as croquet material, she looked around for a few things to while away the time, inbetween delivering babes at all hours of the night and day and her own family life. She took her formidable talents off, to become a member of five different committees concerned with human rights and health issues. Still not satiated,

and finding a lack of any more associations with strong appeal, she diligently got involved in creating three more; the NZ Home Birth Association (1978), Domiciliary Midwives Society Inc. (1981), NZ College of Midwives (1988). Duly this led to Joan being on the negotiating committees connected with each. One would understandably assume, with such a heavy level of commitment, that Joan is passive, the back bencher, the "yes woman" - I'm afraid not, fortunately for us all. Joan's input is immense, her research notoriously thorough - she not only pulls her weight, she pulls most of everyone else's too. To round off her day without having to resort to "housie", Joan has involvement with three government working parties, is a Consultant for the International Childbirth Educators Association and is in on-going demand as a lecturer from many quarters. However even with a self indulgence for her organic self-sufficient gardening, Joan still discovers some spare time. So what better to do with it, having decided to spurn playing bowls, than rattle off a few papers, (7 in all), sprinkling some articles and reports amongst them (42 in the Homebirth Newsletter; 14 in Save the Midwife). Then of course there are always issues which warrant the effort of writing reports and submissions - 10 so far. Joan then figured out that if she wound the alarm clock forwards on the nights she wasn't out delivering babies, she could write

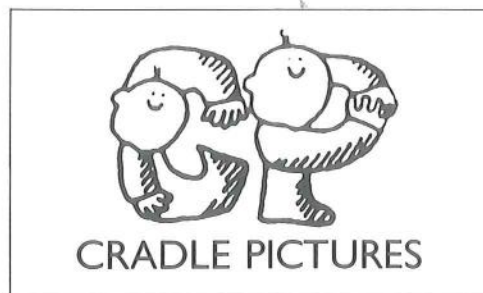
the much needed book - the highly researched publication of "Save the Midwife" was born in 1986.

This background forms the picture of an incredibly hardworking and genuine woman who was too busy living life to realise many of her peers were settled into the retirement village focusing on the daily "happy hour". A real battler for the rights of others, and in particular for women and babies and for midwives everywhere, she continues on as a trail blazer. However there is another side to Joan that she practices so discreetly only the immediate recipients are aware of it and this seems an appropriate time to let her dark secret out. Joan is a bearer of pots of soup in times of need. Sometimes her "pot of soup" is actually a pot of soup, sometimes a salad, a box of groceries, household help, financial help, a shoulder to cry on, a listening ear, or sometimes its a cup of coffee (her one vice) to laugh over. Joan is always there - not just to an exclusive few, but many people who have simply crossed her path in genuine need. Not only is she a professional giantess, she is a very generous and caring woman.

That Joan has therefore been accorded an O.B.E. is no mere chance, a toss of the dice for the symbolic midwife. It is a true and just recognition of a woman who has quitted herself well, of a woman well loved. ■



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CRADLE PICTURES

A Minor Discomfort

Julie Ashton

1989 Student Midwife at ATI
presently working fulltime
as a midwife at National

PROBLEMS ASSOCIATED WITH PREGNANCY have long been classified in two distinct categories - those considered to endanger the health of the woman and/or baby and those considered to be "bothersome" to the mother but seemingly not of significant interest to raise great concern in the carers. The former category has been arbitrarily labelled major disorders of pregnancy, the latter has been described by various euphemisms to portray non life threatening problems that women during their pregnancy may be forced to endure. Some examples of these are "Minor Disorders" (Beischer Mackay, 1978:62; Sweet, 1988:170; Hickman, 1978:22) "Minor Discomforts" (Gaskin, 1977:231; Brickner, 1988:67) "Minor Complaints" (Green, 1975:141).

Pregnancy affects all systems of the body, some more markedly than others and great variance may be found in individual women. The changes may produce problems that include morning sickness, fatigue, constipation, backache, dizziness, ptialism, urinary frequency, breast tenderness, oedema, vulval and peripheral varicosities, leg cramps, haemorrhoids, epistaxis, bleeding gums, dyspnoea, heart burn, pruritis of skin and vulva leukorrhoea, palpitations, nasal stuffiness, round ligament pain, spider angiomas and skin changes. This discussion will examine the significance of these so called minor discomforts with reference to two discomforts so commonly encountered by women during the early weeks of their pregnancies - morning sickness and fatigue. In doing so, it challenges the very concept of 'minor'. Does this use of language accurately reflect experiences of women during pregnancy? What are the connotations of 'minor' and what influence does this have in the management of women with such problems? To examine this word more fully, a journey into Collins English Dictionary (1986:82) unveils the meaning of the work 'minor' - "lesser or secondary in amount, extent, importance or degree". Collins Minigem Thesaurus (1988:150) enlightens us further - "inferior junior, less, petty, secondary, smaller, subordinate, unimportant, younger". Thus, 'minor' is hardly considered synonymous with 'important' in fact can be regarded as its antithesis and it is this very issue that needs to be addressed.

Jayne is 29 years old and she and her husband Dan are planning to start a family. They have been together for four years and both have been anticipating the time for having a baby with eagerness. Jayne thoroughly enjoys her work as a ballet teacher and her pupils spontaneously respond to her contagious enthusiasm and quick sense of humour. Socially she is very active and well

liked for her sensitive, vital and vivacious personality.

One afternoon having felt a bit seedy and tired for a week or so, and no sign of her overdue period, Jayne returns from the Family Planning Clinic having had her pregnancy confirmed. Feeling stunned and yet not surprised, her mind fills with a myriad of conflicting thoughts until she is quite unsure of how she feels. Her intellect seems to have been undermined by the triumph of her fertility, and an overwhelming feeling of not being able to turn back sweeps over her. At home she is reassured by Dan's unconcealed delight and demonstrative affection at her news.

Like Jayne, early indications other than amenorrhoea are often apparent such as breast tenderness, nausea and fatigue before pregnancy is confirmed.

Some women are convinced they are pregnant from the moment of conception and others are not. Even if the pregnancy is planned, there is an element of surprise that conception has occurred. Rubin states in Olds (1980:203) "This feeling is often coupled with a feeling that the timing is wrong, that pregnancy is desirable 'some day' but 'not now'". Associated with the striking physical changes of pregnancy, this may account for much of the ambivalence commonly experienced by women in the early weeks.

At nine weeks, Jayne is feeling wretched. She has never felt so tired and this "morning sickness" she has heard and read about seems to be lasting most of the day. The kitchen has become an unbearable environment and fleeting sensations of appetite often dissolve at the sight of food. In the evenings on returning home she feels so utterly drained, all she wants is to lie down. She has felt frustrated and pressured too, no longer able to trust her body to cooperate with her life and all its activities. Feeling unable to tell others she is pregnant except her family and friends until the 'danger' time is over, only adds to the mounting pressure, anxiety and diminishing self confidence at the prospect of motherhood. Attempts by Dan to comfort and cuddle her are often unwelcome. This feeling frightens her and he feels confused. Her whole body seems totally consumed by producing and protecting this miniature baby, validated only by overwhelming fatigue, nausea and a urine test that says "positive". At the library, Jayne locates a book about pregnancy and discovers that morning sickness and fatigue are common amongst women in early pregnancy and usually diminishes at about 14 weeks. She feels greatly reassured to know that an end is in sight. She notices that the chapter is titled "Minor Dis-

comforts of Pregnancy" and decides to talk to her mother to shed further light on the matter. What a relief to find that her mother too felt like she does! Her mother goes on to advise her to stop lying around feeling sorry for herself, to keep busy, that it will pass. She reminds Jayne how lucky she is to be having a baby. Jayne feels guilty for having complained - yes she should be thankful she conceived so easily, and recalls a friend who has been trying for a year. She goes home feeling worse than before and resolves not to complain. The task ahead seemingly insurmountable, makes her tearful.



Various theories have been proposed about nausea and vomiting in pregnancy although a single aetiological factor remains unproven. As Youngs and Ehrhardt (1980:72) states "Even on a relatively straightforward question such as the causes of nausea and vomiting in pregnancy, investigators have not been able to reach agreement". Bruckner (1988:67) proposes several common themes that include high levels of circulating oestrogen and Human Chorionic Gonadotrophic hormone stimulating the chemoreceptor cells in the prostroma of the medulla associated with vomiting and high levels of circulating progesterone slowing gastrointestinal peristalsis. Olds (1980:252) suggests in addition, that a change in carbohydrate metabolism may lead to a decrease in blood glucose in early pregnancy. Other obstetric texts often do not explore aetiology and in fact morning sickness may only be allocated a few short lines. Green (1975:36) dedicates eleven words to address the problem!

The majority of women in the first trimester experience nausea to some degree and by 16 weeks it has usually dissipated (Beischer and Mackay 1978:62; Olds, 1980:252). Relief may or may not be experienced by simple measures and since the severity and reaction to morning sickness varies greatly from woman to woman, time and attention must be given to addressing the discomfort. It can be a miserable situation and the woman needs support and information. Recognition of her own experience is the single most effective avenue to successful reduction of symptoms. Like

Jayne, other factors like fatigue and anxiety may augment the existing nausea creating a swings and roundabout situation. Thus, the focus should encompass the woman in her entirety.

Many women experience extreme tiredness in the early weeks of pregnancy though it is rarely acknowledged. Fatigue is commonly omitted in many Obstetric and Midwifery texts (e.g. Sweet, 1988; Beischer and Mackay, 1978; Hickman, 1978 and Green, 1975) despite some women finding it crippling in the first trimester. With the enormous changes taking place in pregnancy it is not surprising that many women, like Jayne, feel excessively tired. Because so little is written regarding fatigue, its aetiology is largely unknown though increasing levels of circulating oestrogen, progesterone and HCG and the psychological reaction to pregnancy are thought to play a part (Jones, Cox, Levy and Thompson, 1984:234). Anaemia as a possible cause, should not be discounted.

Women, who are lethargic and weary in the first weeks of pregnancy, often find they are revitalised in the the second trimester. To reassure the woman that fatigue is a normal physiological process in early pregnancy can be revitalising in itself. As Kitzinger states "it seems logical to consider that if you are exhausted at the beginning, it is going to get worse and worse throughout the later months." Immense support can be derived from knowing that this is not the case and there are many practical measures to minimise fatigue that can be tailored to meet the needs of a woman in early pregnancy. The final weeks of pregnancy often sees a return of tiredness, as the load literally increases, but even that is not like the sensation of being completely drained of energy as a woman's body makes its first huge adjustment to pregnancy. (Kitzinger, 1987:17).

The nausea and exhaustion continue until Jayne is 15 weeks pregnant, at times this has overwhelmed her to the point where she has felt like giving up. Concerned about the welfare of her baby, she visits her doctor who reassures her that all is well. The dietary modifications he suggests as treatment, she has already tried but doesn't like to say. His calm, staid manner seems so discordant with the anguish she has attempted to portray; it makes her feel foolish. She wonders how other women cope, other women with small children and unrelenting responsibilities.

Do women receive the support and confidence needed during the vital transition to the potentially hazardous territory of pregnancy? Helping a woman to be con-

fidant and comfortable in herself, and in her pregnancy means she needs to be listened to, respected and she needs information - early. Some women feel well, cope with the stresses and enjoy their pregnancy but there are others, like Jayne, who do not. Jayne experienced nausea and fatigue to an extent to which they became major disruptions with complex repercussions in her life. It can be seen that the label "minor" disorders of pregnancy is a gross misnomer. It is essential that these, thus far considered in-offensive problems, have their importance acknowledged, that they may be accorded the attention required to ensure the women who endure them have optimum support and minimal discomfort in both a physical and psychological sense. ■

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(Ed's Comment)

We would like to invite other midwifery students to send in their assignments or projects for consideration for publication.

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New Zealand College of Midwives

National Conference - Women in Partnership

August 17 to 20, 1990, Knox College, Dunedin

Keynote Speaker

Dr Marsden Wagner

Regional Officer for Maternal and Child Health, WHO

Programme

Friday 17		Annual General Meeting (evening)
Saturday 18	<i>Consumerism</i>	Opening Ceremony, Cocktail Party (evening)
Sunday 19	<i>Midwifery</i>	Conference Dinner (evening)
Monday 20	<i>Feminism</i>	Closing Ceremony

Conference proceedings will be published after the Conference and be available for purchase from the College in November 1990.

Enquiries should be directed to:

Conference Committee,
New Zealand College of Midwives,
Otago Region,
P.O. Box 6243,
DUNEDIN NORTH

Midwifery Data/ Consumer Survey

Dunedin Domiciliary Midwives Collective Report 1/9/1988 to 31/8/1989

Chris Hannah/Rhondda Davies



From left to right: Chris, Rhondda, Suzanne, Sally, Jenny

THE COLLECTIVE DMC WAS FORMED IN August of 1988 following the departure from Dunedin of the only domiciliary midwife, Adrienne Mulqueen in the preceding July. Several local women wished to have a homebirth; the Collective formed in response.

The Collective format developed as those midwives interested in participating all had other commitments, so sharing client care was the only feasible way of providing a homebirth service for the Dunedin community. The Collective also provided a continuity service for women who choose to have hospital births. This was possible because at the outset three of the five midwives involved in the Collective worked in the Delivery Area of the local maternity hospital, Queen Mary. This service operated like a domino with the woman usually returning to her home within a short time after the birth.

When the Collective began Dunedin homebirths were very rare events, averaging only one per month. The income generated from this or rather the lack of it was another reason to opt for the collective style of service.

All the women who wished a homebirth were visited by all Collective members. Decisions whether to accept or decline the care were made by consensus. Thereafter each of the three midwives involved in the homebirth aspect of the Collective's work would visit the woman and her family in an attempt to establish the necessary level of rapport and understanding that is essential for homebirth.

Bookings for both services were by word of mouth and through the Homebirth Association. No formal advertising was undertaken. The equipment used by the homebirth midwives was provided by the local Homebirth Association, as well as the telepager that became necessary as the number of bookings began to grow. Disposable equipment was replaced through the cooperation of the Otago Area Health Board and the sterilisation of instruments was done at Queen Mary Hospital.

Over the Collective's first year of practice the midwives involved have found that their individual levels of confidence in their own skills and practical midwifery ability grew significantly. Each midwife became more grounded in normal community midwifery. Each of the homebirth midwives found that it became increasingly difficult to limit their practice to the usual hospital obstetric parameters when working with women who are actively and very determinedly equal partners in any decision making that has to be made. Every woman,

birth and situation had to be assessed individually.

By the end of the Collective's first year homebirth bookings were averaging five per month. The Otago Area Health Board had also recognised the growth of interest in this service and approved contracts for visiting staff status with the domiciliary midwives, should it be necessary to transfer any of their clientele to hospital.

The work of the Collective also considerably augmented the clinical practice experience of the Southern Region Midwifery Course, which commenced in May of 1989. Each of the Collective midwives enjoyed the experience of teaching and sharing with the student midwives.

Throughout the Collective's existence statistics have been kept relating to the midwifery service and client satisfaction. The information collected allows the midwives to reflect upon their practice and implement changes to better meet consumer needs. Below are some of the raw statistics and consumer comments.

Homebirth Statistics

Planned to deliver at home	26
Delivered at home	19
Client changed her mind	01
Collective declined care	01
Transferred in labour	02
Became high risk in pregnancy	03

Continuity Statistics

Contract enquiries	17
Received complete continuity of care	06

Results of the Questionnaires

When asked why they had opted for a homebirth, the women mentioned such factors as natural environment, ease of family involvement, less disruption to family, family 'centeredness', more control, more autonomy, eliminates move to hospital, lack of faith in maternity hospitals and doctors, previous traumatic birth experiences, continuity of care-givers, peacefulness, securing of quality family time immediately postpartum.

Some of those who chose a hospital birth and early discharge mentioned that their ideal was a homebirth, but for various reasons - e.g. new in town, geographically isolated, too many other small children, less than adequate home support network - opted for this as 'next best'. Many wanted the perceived security of a hospital birth but also the comforts, relaxing atmosphere, as close as possible to continuous family contact by immediately returning to their familiar home environment.

When asked to describe their experience in obtaining medical assistance, the homebirth women reported a range of reactions and experiences from extreme difficulty (six women changed their GP), reluctance but eventual acquiescence, to 'very supportive'. The bulk of the follow-through women reported no problems and overall supportive attitudes. When asked about experiences in obtaining midwifery assistance, many simply explained how they had become aware of the service, e.g. personal acquaintance, Homebirth Association, midwife at booking-in, or GP referral. Many expressed some anxiety initially, but once contact was made, found attitude very positive and supportive.

The vast majority found the timing of the first antenatal visit from the midwives appropriate; the four who did not, would have preferred earlier contact. Fourteen women indicated that they felt they had received 'enough' antenatal contact, six though 'not enough', one ticked 'more than enough' because she received far more than she had anticipated! The majority again indicated they felt they had received 'enough' postnatal care. Those (three) who ticked 'more than enough' added that they intended this in a positive sense.

The woman's partner was present at every birth; children and/or adult relatives were present at twelve of the births for which there are data. Friends were present at seven.

On a satisfaction scale of 1:5, with '5' indicating 'most satisfied', 19 women circled '5', four '4', two '3', one each of '2' and '1'.

There was a wide range of comments from those who wanted to assess medical care, from '...couldn't be better...' to '...lack of trust in my abilities...'. The pre-dominant comment, (six women made mention of this), appeared to be that a role could be seen for the GP as back-up, or in the background, but that midwives could have provided the antenatal care, and were all the assistance necessary at the birth and afterwards. Perhaps inevitably in a survey run by the caregivers, similarly requested comments on the midwifery care were one hundred per cent positive, e.g. '...excellent, continuity important...'; '...friendly, easy to relate to...'; '...sensitive, competent, non-intrusive...'.
The following are representative:

Finally, the women were asked to make constructive suggestions to enhance the service. The following are representative:

1. Make it widely available (at present it is not).
2. Advertise that this service is available.

3. The DMC service should be discussed more fully antenatally.

4. The Area Health Board should encourage this programme by making it possible (financially and other) for Queen Mary Hospital to implement a complete domiciliary midwifery/continuity of care programmes.

5. Encourage midwives to have more service in the environment.

6. Training of midwives - ?? Perhaps TOO hospital based at present.

7. More discussions with the clients and staff interested in this programme, e.g. Drs, nurses, etc.

8. Midwives working as domiciliary midwives only, would be ideal, though not always available. It seems a little unfair for several midwives to have to invest time into a client not knowing that they will attend the birth. Continuity of care - spread antenatally, during the birth and postnatally is just wonderful.

9. Start antenatal visits sooner and more often. One visit by each midwife is not enough, especially when visiting in a group as it doesn't offer enough time for real understanding and trust to develop.

10. I personally don't think a Dr's care is necessary antenatally, at normal birth or postnatally but it seems there is a lack of continuity when nearly all antenatal care is done by GPs and all postnatal care by midwives.

11. Two hours per day free home help for two weeks for everyone! plus a pack of hospital sanitary pads for home? oil to oil baby?

12. Linen service for the first week is a godsend.

Our first Standards Review session took place in December, and was seen as a positive learning experience for all concerned.

The establishment of the Collective has been important for the women of Dunedin, in that it has maintained and extended choices in maternity care. It has also been very rewarding for the midwives. The satisfaction of being able to provide continuity of care cannot be overstated. Each of the midwives have gained invaluable work experience and benefited purely from working as a collective. There has been much needed strength gained from the mutual support of the group. At times difficult decisions have had to be made. We have had to look again and again at the questions: What is normal? What is at risk? What is informed choice?

The Collective thank the Dunedin Homebirth Association for its support over their first year of practice. ■



From Small Beginnings

Kath Ryan

Professional Liaison Consultant
LA LECHE LEAGUE NEW ZEALAND

WHO WOULD EVER HAVE THOUGHT THAT A PICNIC ATTENDED BY seven friends and their babies in Franklin Park, Illinois, in 1956 would have led to the establishment of a multinational organisation with branches all over the world and affiliates in Canada, New Zealand, Great Britain, Germany and Switzerland?

The one thing that these women had in common was a desire to breastfeed their babies and to help their friends who wanted also to feel the deep fulfilment of the breastfeeding bond. And now, more than thirty years later that is still the common link between women involved in La Leche League (pronounced la lay-chay league) which simply translated means "the milk".

The organisation has grown to be the recognised world authority on breastfeeding. In New Zealand, La Leche League began at a meeting in Cambridge in 1974 and has since grown to cover the whole country. In 1988, La Leche New Zealand became an independent affiliate of La Leche International. It is a voluntary non-profit making organisation funded by member's subscriptions, donations and supporting grants.

Trained La Leche League leaders are mothers who have breastfed who offer information and encouragement to mothers in a caring manner on a one-to-one basis, such that they may gain the confidence needed to successfully breastfeed their babies. Besides offering telephone counselling, these leaders are responsible for running 112 support groups throughout the country. Group meetings are run in a relaxed atmosphere in a member's home and any mother and baby or mother-to-be, is welcome to attend. Discussion at the monthly meetings revolves around one of the following topics: The advantages of breastfeeding to mother and baby; the baby arrives; the art of breastfeeding; overcoming difficulties; nutrition and weaning. The group leader shares her knowledge and encourages mothers to ask questions and share their experiences.

Each group has a library of breastfeeding and parenting books which mothers are able to borrow. La Leche League New Zealand is backed by a Board of Consultants consisting of nine members from various medical professions who are supportive of breastfeeding. The parent body in the United States of America also has a Professional Advisory Board from whom information may be sought. An active research Library keeps up-to-date with current breastfeeding information from the scientific journals and offers an information service to health professionals, La Leche League members and the public.

The La Leche League New Zealand Office (P.O. Box 13-383, Wellington 4) stocks a wide range of informational reprints and texts on various breastfeeding, childbirth, parenting and nutrition matters. Further information can be obtained by writing to the Office or contacting the La Leche League listing in your local telephone directory. ■

Political Column

Joan Donley, O.B.E.

1989 HAS BEEN A MOMENTOUS YEAR FOR MIDWIVES.

First, there was the official launching of our New Zealand College of Midwives; after many years of being little sister to the nursing profession, we made our debut.

Then, after ten years of struggle, the 'separate' midwifery education - a whole academic year devoted to midwifery - was commenced at three centres - Auckland, Wellington and Otago/Southland. A further important facet of this course is, that it is based on the ICM definition of a midwife, as an independent practitioner.

In November, the Nurses Amendment Bill, amending S 54 of the Nurses Act 1977 passed its first reading. When the legislative process is completed midwives will again be able to practice independently of medical supervision.

The right of a woman to choose a midwife for her care during a normal pregnancy and birth is supported by the Department of Health Policy Recommendations for Pregnancy and Childbirth (6th draft). This document also endorses the 'holistic approach to all health care during pregnancy and childbirth'. Even more importantly it states that 'pregnancy and childbirth are part of the normal life experience of women. The majority of women have the ability to conceive and undergo pregnancy and give birth without problems'

This is the first time since the 1920s that the Department of Health has officially proclaimed that pregnancy and birth are normal. Then, a Board of Health Special Committee, 1921, deducing that the high incidence of puerperal sepsis was related to instrumental deliveries, recommended that the public should be advised that 'childbirth is a normal physiological process, and the healthy woman in healthy surroundings is attended, with very small risk'.

As there were no radio/TV services in those days, Department of Health officials (Minister of Health, Sir Maui Pomare; Director of Division of Child Welfare, Sir Truby King; and Director of Health Dr T.Valintine) embarked on a speaking tour throughout the Dominion advising women not to have doctors at confinements. The doctors reacted by forming the Obstetrical Society.

After 60 years of progressive medicalisation of childbirth, think what this official support for childbirth as normal, is going to do to the medical definition of childbirth - that birth is only normal in retrospect and every pregnancy and birth has a potential for disaster! This 'just in case' potential justifies medical management and interventions.

If midwives subscribe to the obstetric definition of childbirth, then they become dependent on the doctor; this, in turn, undermines women's faith in their ability to give birth, and disempowers them. How midwives view childbirth will determine whether or not they will be able to utilise the opportunities that are now within our grasp.

To paraphrase Shakespeare:

There is a tide in the affairs of midwives
Which, taken at the flood, leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and in miseries.
On such a full sea are we now afloat,
And we must take the current when it serves,
Or lose our ventures.

(Julius Caesar)

We cannot afford to fail the women who have supported us and who are depending on us. ■

A MIDWIFE'S VIEW

I had a birth recently I'd like to share with you and I would appreciate some feedback from you or other midwives.

Christine was having her 2nd baby and opted for a home birth. Her 1st child was born 10 years ago and she had been infertile since.

Her 1st pregnancy went to 43 weeks when she was induced, followed by epidural, forceps etc. This 2nd pregnancy had been conceived while on fertility drugs and under obstetrical care. You can imagine the obstetrician didn't think she was being very 'sensible' when she refused a scan and told him she wanted to have this baby at home.

Anyway, I'm pleased to say she stood up well to all this pressure, even the old 'I'd hate to see anything happen to this precious baby after you've waited for so long' from a GP, obstetrician and some so-called 'friends'.

The pregnancy proceeded really well and we were all very confident.

As 42 weeks approached, we were all getting a little on edge as the doctor concerned was adamant that, this was all he would allow her to go.

The baby felt quite large but everything seemed OK. 42 weeks came and it fell on a Thursday. She managed to persuade him to wait the weekend. We had tried most things we knew of: nipple stimulation, sex, avoiding fish, eating oysters, castor oil, homeopathics but no luck. We were getting niggles but that was about all.

Christine was sick of trying and resolved that it was in God's hands and what would be, would be. She was to go into hospital 9am Monday.

On the Sunday, I happened to be reading something Joan had written about inserting Evening Primrose Oil vaginally

which works as a natural prostaglandin. I rang Christine who happened to have a jar at home.

How many do we use? How to insert it? Rae Abraham suggested soaking a tampon. Christine found only one in the house! She cut open 4 (capsules) into an egg cup and soaked the end of the tampon. It was about 10pm on Sunday night when she inserted it. By 1am she was in labour and 5am fully dilated, 6.15am she delivered a beautiful healthy 10lb 13oz girl with a head circumference of 38.5cm! The delay in 2nd stage was aided greatly with a positional change from kneeling to standing and the last stages, squatting.

Neither the placenta nor the baby looked overdue and Christine was really pleased with the outcome. We all felt, that had she been in hospital, things would have run along similar lines to her first pregnancy.

The Evening Primrose Oil seemed to do the trick and I'd be interested to know of anyone else having used it. ■

Terryl Muir

Domiciliary Midwife
Lumsden

PRESS RELEASE

International Appointment for Dunedin Woman

Dunedin woman, Mrs Jenny Drew has been appointed to the Board of Directors of the International Childbirth Education Association (ICEA).

ICEA has more than 10,000 members in 32 countries who support the philosophy of family centred maternity care and freedom of choice for childbearing families based on knowledge of childbirth alternatives. ICEA has an extensive range of books, pamphlets and audio/visual material for parents, childbirth educators, and health professionals. The organisation publishes a quarterly 'Journal', holds an annual Convention, and offers an internationally recognised Teacher Certification Programme.

This is the first time that New Zealand has been represented on the Board, although Auckland domiciliary midwife Joan Donley is a Board consultant. Jenny is elected to the position of Director of Teacher Services

and as such will oversee the work of three service committees - Breastfeeding, Caesarean Options and Community Outreach. Her main brief will be to assist individuals and groups in any country to develop and improve teacher preparation programmes, and to assist in updating current teaching resources and aids.

Mrs Jenny Drew was active for many years in New Zealand Parents Centre both at the local level in Dunedin and Mosgiel, and as a member of the national executive. In the past she has been involved in 'new mother' groups, postnatal depression support groups, La Leche League, Home Birth Association, and has been a regular visitor in Otago Medical School classes presenting the consumer viewpoint. Jenny was a co-founder of the Childbirth Education Association of Otago, a group which brought the first childbirth educator training course to

ICEA



International Childbirth Education
Association
PO Box 20048,
Minneapolis,
Minnesota 55420-0048,
USA
(612) 854-8660

New Zealand from Australia. She was involved in the production of the birth film "Winter's Child" and producer of the video "Family Matters - From Partners to Parents" (in conjunction with Dunedin Parents Centre and the University of Otago).

Currently Jenny teaches private antenatal classes, assists in a programme for pregnant single women, and holds the position of ICEA NZ Co-ordinator. The two year Board appointment will involve travel to the USA twice a year and Jenny says she sees it as a valuable opportunity to link with other cultures in the area of childbirth and early parenting to learn from and share with them. She says "It is an exciting time to be involved, as there are radical and positive changes occurring, both in the care and teaching of childbearing families, - not least within New Zealand". ■

BOOK REVIEWS

The Politics of Breastfeeding **Gabrielle Palmer**

Published by Pandora, 1988,
\$24.95

Breastfeeding and politics? How are they related you may ask?

Gabrielle Palmer's powerful book convincingly describes how breastfeeding, or at least the demise of breastfeeding and the increase in the use of artificial breast milk (let's not use the euphemism 'infant formula') is indeed a political issue of particular concern to women.

Beginning with a very comprehensive description of the physiology of breastfeeding (good to update ourselves), based on the latest research, Palmer documents the numerous advantages of breastfeeding to mother and baby. She then takes a look at the history of infant feeding demonstrating the way that women have been manipulated by market forces to forgo breastfeeding and feed their infants on potentially harmful substances.

Multinational artificial milk marketing companies in cahoots with medical 'experts' have deviously managed to persuade women that breastfeeding is "inconvenient" in the work place, "offensive" in public and have led women to doubt their own ability to perform this most natural function of nourishing their infants.

Nurses and midwives have been influenced too by subtle (and not so subtle) marketing tactics. An example Palmer cites is that of the US-based company Abbott-Ross providing free advice to hospitals for planning and layout: 'The purpose here is to impose a design that literally builds bottle-feeding into the facility by physically separating mother and infant to make bottle-feeding more convenient than breastfeeding for the hospital staff... A single investment in such architectural service can create new sales opportunities for the entire life-span of the building.' Sales and profits are the prime motivators of artificial milk manufacturers.

While depriving our infants of nutritionally and immunologically perfect food in industrialised countries is relatively 'safe' e.g. we have clean running water, facilities to sterilise, money to buy milk powder and ready access to health facilities, in the Third

World, where these things are not readily available, replacing the breast with bottles, teats and formula is a death sentence. The most common cause of infant mortality in the Third World is diarrhoea, and of course unsterile bottles and infected water are the major cause of this.

We now have the WHO Code of Marketing Breast Milk Substitutes which is adhered to fairly well here in New Zealand, but women in the Third World do not have access to the same information, or the channels of complaint that we do, so unethical marketing strategies promoting the use of breast milk substitutes continues in the Third World.

In New Zealand, I believe that we are still very much under the influence of the marketing that proliferated in the 1960s and 70s. Bottles, teats and breast milk substitutes are rife in most New Zealand maternity hospitals. I continue to hear of women who have been advised by nurses and midwives to supplement or discontinue breastfeeding because they have "insufficient milk" or their baby is not gaining weight according to graphs (based on bottle fed babies). Supplementation of course begins the downward spiral leading to a true case of insufficient breast milk. (Ever see that ad "When breast milk fails...?")

Palmer's book concludes with a very illuminating section focusing on the way that a woman's role as childcarer and homemaker has been reinforced by ensuring that breastfeeding does not occur in the economic sector of society.

As a midwife, and a mother who has breastfed three children well into their second year, I found this book to be excellent reading on all counts, and I would suggest essential reading for all health workers who have contact with mothers and babies. ■

Andrea Gilkison
Palmerston North

Obstetrics by Ten Teachers (14th Edition) **S. Clayton, T. Lewis and G. Pinker** (Editors)

Published by Edward Arnold, London, 1985

This book offers midwives a clear reminder

of the difference between Obstetrics and Midwifery. This book is not about women experiencing the childbirth process. Rather, it is about anatomy, the physiology of pregnancy, labour, the newborn infant, the many things likely to go wrong, with an occasional brief mention of 'the patient'.

In discussing management of the second stage of labour, it is stated that the woman should be on her bed. It is later acknowledged that there is a "recent trend for a minority of women to demand to give birth in various positions". These positions are stated to be no more rapid or comfortable, with the disadvantage that "they make proper observation of the fetal heart rate and some forms of analgesia very difficult, and care of the perineum hardly possible". When I read on the back cover that "the contributors are all active teachers in the London Medical Schools and therefore fully informed about the needs of students" I have my suspicions confirmed. This book offers the knowledge needed by Doctors as defined by other Doctors. There is no mention of the needs of the woman and her family. Statements such as: "Providing that there is free communication between the attendants and the patient there will almost always be full co-operation", make it clear that the attendant is and should be in control. This is not therefore a book about being 'with woman', it is not a book about midwifery.

Once having established a healthy scepticism for the attitudes that filter through the pages, one is left with the cold hard facts. These are presented in an easily accessible and readable manner. There is comprehensive coverage from pre-conception to the puerperium. The depth of knowledge is comfortable for the midwife, offering her a scientific base from which to develop midwifery practice. For instance, did you know that the maternal blood flow through the placenta is 500-700 mls per minute at term, and that the area of chorionic villi exposed to this blood is estimated to be about 11 square metres.

The companion volume to this book *Gynaecology by Ten Teachers* is similarly a useful overview of anatomy, physiology, disease process and current treatment related to the pelvic organs. Again, it is the pelvic organs that are under discussion rather than the woman. Many of the chapters contain information relevant to midwifery practice.

These two books have a place in the library of a midwife. ■

Liz Smythe
Auckland

COMING EVENTS

1990 NZ National Home Birth Conference

May, 1990 Whangarei

Contact:

Agnes Hermans
24 Pah Road
Onerahi
Whangarei

NZ Assoc. of Natural Family Planning Conference

24-26 August, 1990 Lincoln, Canterbury

Topic:

Breastfeeding

Contact:

National Secretary
P.O. Box 380406
Howick
Auckland

International Confederation of Midwives 22nd International Congress

7-12 October, 1990 Kobe, Japan

Theme:

"A Midwives Gift - Love, Knowledge and Skill"

Full Papers:

Deadline 30 June 1990

Registration Fee:

Y50,000
before 15 June 1990
(\$586)
Y55,000
after 15 June 1990
(\$645)

(Exchange Rate of Y35.27 = NZ\$1.00 on 25.1.90)

Enquiries:

ICM International Congress
Nursing Association
International Relations
8-2, 5-Chome, Jingumae
Shibuya-ku
Tokyo, Japan 150



Fourth International Congress on Womens Health Issues

8-10 November 1990

Massey University
Palmerston North

Theme:

Women as Health Providers
Within a Context of Culture, Society
and Health Policy.

Enquiries:

Fourth International Congress on
Women's Health Issues
Department of Nursing Studies
Massey University
Palmerston North

Midwives Workshop 28-29 April

28-29 April, 1990

Hokowhitu Site
Manawatu Polytechnic

Theme:

A National Weekend Workshop
for Hospital and Community Based
Midwives

Topics:

Midwife Autonomy
Legislative Update - Nurses Act
Young Mothers and the
Childbearing Process
Cultural Aspects of Maternal
and Childcare
Caring for High Risk Clients
Current Trends in Breastfeeding
Homebirth - Boundaries of
Practice
Homeopathy

also

26 April 1990

Grey Street Campus
Manawatu Polytechnic

Theme:

Womens Health Issues

Contact:

The Secretary
Continuing Education Section
Nursing and Health
Studies Department
Manawatu Polytechnic
Private Bag
Palmerston North

Telephone:

(063) 65030/65029

ICEA 1990 International Convention 3-5 August 1990

Theme:

Midwifery

Keynote Speaker:

Marsden Wagner

ICEA are offering five convention
scholarships to members of the
ICEA's international region who have
been members for three or more
years. Applications should be made
as soon as possible.

International Board of Lactation Consultant Examiners Certification Programme

Exam Date:

11 July 1990

Christchurch

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Involved in Infant Feeding
Encouraging and Promoting
Breastfeeding
Seeking a Challenge

Contact:

Rachel Walker
41 Halton Street
Christchurch 5

Closing date for fees:

15 May 1990

Australian College of Midwives 7th Biennial Conference

16-18 September 1990

Perth Western Australia

Theme:

Birthdays Birthdays

Contact:

Conference Secretary
ACMI WA Branch
PO Box 553
Subiaco WA 6008
Australia

2nd International Home Birth Conference 1992

Sydney, Australia

Calling for ideas and input.

Enquiries:

Jane Thompson
12 Thornton Street
Fairlight
NSW Australia



New Zealand College of Midwives Membership Form

Regional Information

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Place of Work _____

Type of Membership

Full Member (Registered Midwife Full or Part Time)	\$52.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	\$26.00
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Associate Member (Unwaged interested individual)	\$26.00
Affiliated Member (Other Groups e.g. Parent Centre, La Leche League, etc)	\$26.00

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- Subscription payable to College Treasurer (Please enclose cheque or money order)
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Date of Birth _____

Type of Membership

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Place of Work _____

*Please return completed form (together with money if applicable) to
Local Regional Treasurer
New Zealand College of Midwives*

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