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# AIMS

AIMS

Founded 1960

# Association for Improvements in the Maternity Services Quarterly Newsletter

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SUMMER 1981

Contents



## Editorial

A modern obstetrics text would hardly be complete without the obligatory reference to the last century's tragedy of Semmelweis. Medical science has come a long way since he was ridiculed for suggesting that lives would be saved if doctors followed midwives' example --- washing their hands before attending a woman in childbirth. But are obstetricians being complacent in assuming that they have learned that lesson from the past?

Resistance by the obstetric profession to innovative reform faces us still in our efforts to improve the quality of childbirth services. Fetal monitors and fingertip-control contractions may be readily accepted without full scrutiny; these are innovations that enhance the dominating position of obstetricians. But reforms advocated by AIMS - such as avoiding unnecessary interventions in labour, or recognising midwives as colleagues of equal standing - are threatening to the supremacy of obstetricians, and can evoke both anger and ridicule.

And conscientious professionals still don't have it easy. Recently a midwife was disciplined because she overstepped her role to save a woman's life (see page 2). An obstetrician who wants to see midwives and GP's dominating maternity care is having to leave his teaching post because his ideas are threatening to his colleagues, and cannot be implemented there (see page 25).

Childbirth reformer David Stewart (see 'Books' page 22 ) lists the following milestones on the way to acceptance of a good new idea:-

1. Anger "It's a crazy idea and it won't work".
2. Openness "It may work for some, but not for us".
3. Acceptance "It's probably a good idea; we'll try it".

4. Pride "It's a great idea and we're so glad we thought of it".

Faced as we sometimes are with Anger, it seems a long road to Pride.

At the recent RSM conference (see page 16), Murray Enkin from Canada described Family Centred Maternity Care, and Michael Odent reported on the pioneering approach at Pithiviers. A member of the audience then asked the panel, why aren't these things happening in Britain? How can we promote change? The answer seemed to be that a national health system, with its many great advantages over private medicine, is more resistant to innovation because the voice of the consumer is less important - we can't take our money elsewhere if we don't like the service. And sympathetic professionals often lack the independence to implement the changes they would like to see. But while we may lack inspired services, we also don't suffer from the worst excesses.

We can to some degree vote with our feet, by utilizing the best options open to us. A safe and satisfying home birth serves more than the family involved; its very existence helps to set a standard for our services in hospitals. To protect and extend our options we can state our concerns as often, loudly, and articulately as we can, and be assured when we provoke an outraged response that at least our comments have been on target. And we can support, both publicly and personally, those professionals who have the courage to stand against the tide, providing services of the quality we endorse.

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Congratulations to Christine Burley and family on the birth of their new baby girl, Georgina Mary Jane, a house-warming gift born the day after a move to a new house ("literally with me holding onto my husband and a packing case!" says Chris). Having passed on the job of Editor just in time, it appears that Chris is still working to deadlines!

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## A PROFESSIONAL DECISION

On the 25th December 1980 at 7 p.m. community midwife Janet Jennings received an urgent telephone call to attend a young pregnant woman who was bleeding. The woman was not booked for delivery with Mrs. Jennings and had no G.P. booked. Mrs. Jennings rushed to the woman's mother's flat where she found, upon examination, that there was no fetal heartbeat. She then checked to see that the cord had not prolapsed vaginally. The woman was in good shape and had stopped bleeding.

Mrs. Jennings was then faced with a problem; does she call an ambulance (a colleague had waited 1½ hours for an ambulance the day before) or gamble upon obtaining the flying squad? The problem with the flying squad was that it too could be unreliable. Mrs. Jennings herself had called out the flying squad twice in 6 years; on the first occasion they had arrived - from Scotland Yard! Scotland Yard then sent for the flying squad themselves but only an ambulance came. The second time, 3 years ago, concerned a woman booked for a G.P. delivery, with an ante-partum haemmorhage at home - the flying squad arrived after 70 minutes, the woman was by then in a very shocked condition. With this track record in mind, Mrs. Jennings decided that she herself would take the mother to hospital - a journey of 7 minutes.

She instructed the family to telephone the hospital that an obstetric emergency was on its way. The family could not get through - the hospital switchboard was not manned. It was evening meal time on Xmas Day!

Within 55 minutes of receiving the original call the mother was receiving medical care. The consultants at the hospital asked Mrs. Jennings to stay and she delivered the dead baby and she stayed to comfort the mother. Mrs. Jennings arrived home soon after midnight.

It would not be unreasonable to suppose that Mrs. Jennings would then have been congratulated for having possibly saved the mother's life; even though she broke a Central Midwives Board ruling that medical assistance must be called. That did

not happen; what did happen was the Registrar at the hospital felt obliged to write on a scrap of paper that her action was "criminally incompetent" and that it needed "very positive action". This was left in the supervisor's office, in full view of anyone who entered, for at least 3 days, as the supervisor was off duty over Christmas. He was not duty on Christmas Day and had not seen or spoken to Mrs. Jennings about the case at any time. After Mrs. Jennings had written up her notes, that night, she found the next day that questions were being asked about her actions and as she was going off duty for 5 days, she asked a solicitor friend what to do and was told to type and sign a complete history of the events, which she did.

A letter was received from the Divisional Nursing Officer asking her to attend a "fact finding" meeting on the 5th January. Mrs. Jennings requested an official of the Royal College of Midwives to accompany her but she was told to take her local steward, who knew nothing about disciplinary procedures. Mrs. Jennings had been instructed by the RCM to answer "Yes" or "No" to the questions asked, and it was from this meeting that she was reported to the Central Midwives Board. Hardly surprising, as they were unlikely to get much information out of a single syllable answer. Mrs. Jennings was never asked to make a statement by the AHA and indeed they did not ask her for the mother's case notes until the 19th January 1981.

The action of Islington AHA appears precipitate but the circumstances prevailing in the area must be borne in mind. Relations over a period of time between the area's community midwives and hospital administrators have been appalling; and Mrs. Jennings has been one of the few midwives who has spoken out on many occasions about the inadequacies in the service. Mrs. Jennings, therefore, represented a considerable thorn in the side and her breaking the CMB's hallowed rule that 'in an emergency a midwife must call medical assistance' presented them with a golden opportunity to discipline this midwife. The CMB rule that in an emergency a midwife can make her own decision was conveniently ignored. This is the first case we have come across where a midwife has breached the rules but acted in the best interests of the patient. We would be very interested to hear from anyone who knows of a similar case occurring.

During the period of time leading up to the CMB hearing, Mrs. Jennings had 2 appeals heard against her employer's decision; one at district level and one at AHA level. The disciplinary action was upheld. She was 'grilled' about her conduct for no less than 31 hours in total. She was initially suspended from duty for 3 days and then required to work in the hospital for 11 weeks. Her clients in the community were taken on by the hospital midwives and some of her colleagues. She was also issued with a first written warning.

After a 4-hour hearing on the 7th May 1981, the CMB found Mrs. Jennings, guilty of misconduct, and gave her a caution to conform to established procedure in future. This misconduct remains on Mrs. Jenning's file until she retires - her solicitor says there seems to be no right to appeal unless a midwife is STRUCK OFF, or suspended.

Mrs. Jennings herself has ruefully pointed out that had she abided by the rules, sat tight, and patiently waited for the flying squad service to act, the mother may well have bled to death, but then there would have been no CMB hearing and no doubt her midwifery managers would have been congratulating themselves that here was a good midwife who obeyed the rules.

Mrs. Jennings was also, rightly, extremely angry that the AHA's solicitor had visited the mother concerned in order to obtain a statement of the event. She had no knowledge of Mrs. Jenning's indictment and was required to relive the misery of the events leading up to the loss of her baby. A copy of the mother's statement, given to Mrs. Jennings 3 days prior to the CMB hearing, was neither dated, signed or witnessed. A letter written by Professor Peter Huntingford endorsing Mrs. Jenning's views of the emergency obstetric unit was not produced in evidence by the defence.

Clearly Mrs. Jennings' 18-week ordeal put her under considerable strain, but she did not endure this entirely alone. The GP's in her area rushed to her defence; indeed the CMB received about 70 unsolicited letters of support from doctors, some midwives, and parents. While receiving no counselling or support

from hospital midwifery or medical management, Mrs. Jennings received many personal letters of support from professionals who had seen her case's publicity.

This case had highlighted the enormous dilemma facing midwifery. Midwives consider themselves to be members of a profession, but one of the criteria of a profession is that its members be free to make professional decisions. In this case a midwife, in full knowledge of the circumstances prevailing in her area, made a professional decision. She has been called to account, told that she was wrong, and must abide by the rules in future. The moment the rules become immutable, especially in an exceptional case, then from that moment midwifery ceases to be a profession and becomes a job. The effect of this decision by the CMB will be a considerable undermining of the confidence of the midwifery profession.

This case has also drawn attention to the state of the flying squad service in this area. During the CMB hearing a community midwife testified that the flying squad was unreliable (appearing only once in her 6 calls for it) and a senior midwife testified that the service worked wonderfully well! This matter should have been investigated much more explicitly.

One hopes that the questions raised in our minds about flying squad provision are also worrying the CMB, and that they have been motivated by this case to carry out their own investigation. This case has also drawn attention to the appalling standards of management in this health authority; is it too much to hope that a careful investigation of their activities is also taking place?

Finally, because of the implications for midwifery as a whole caused by this decision, Mrs. Jennings may take her case to the European Court of Human Rights; her European MP and local MP both contacted her after reading of the case in the newspapers. We wish her well, and hope they will show greater understanding of the problems facing a community midwife than any professional body has yet done.

Note: The Registrar, whose note (stating that Mrs. Jenning's action was "criminally incompetent") initiated this whole indictment has stated "I unreservedly retract and apologise for my note. It was a personal one to her supervisor and was not intended for publication".

Beverley Ann Beech

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## FLYING SQUAD

Another instance of inadequate flying squad cover has prompted a Wiltshire G.P. to write to the Minister of Health to request secret random testing of the flying squad service in all areas, to discover where provision is inadequate. He suggests also a diversion of resources to ensure that vehicles are always available to the emergency team, and that the flying squad bleep should directly notify the on-call registrar, who should not be in theatre with gynaecological cases.

The G.P., Dr. B.J. Williams of Chippenham, was called to a woman whose blood pressure had risen dangerously four hours after a normal birth. Dr. Williams administered initial treatment, and rang for the assistance of the flying squad. The first response was that no registrar or consultant was available. After 40 minutes and several telephone calls, Dr. Williams was notified that a flying squad was coming by taxi, as no other transport was available. Caught in the traffic, the flying squad finally arrived 65 minutes after it had been called.

In this case, the mother's condition was soon stabilized, and she was transferred to the consultant unit. But it points out yet again the urgency of reviewing flying squad arrangements throughout the country.
('World Medicine' 27.6.81)

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## 1981 A.G.M. REPORT

The AGM is our only opportunity to gather together, and we were very pleased that, as usual, members (and babies) were able to travel, in some instances, quite long distances.

The TREASURER (Leslie Batchelor) thanked members for donations, and reported that, because of the increase in subscription rates last year, the financial situation is improving, although we have had no luck so far in attracting grants from trusts.

On the day of the AGM, AIMS was £100 in credit, but the Treasurer asks all members and groups to settle expenses at least 2-3 weeks before the AGM in future, so that a true account can be presented.

The year's income was £1,900, of which £1,440 came from subs, £230 in donations, and £40 in repaid loans. Membership is increasing (50 last year), but some members only join for a year.

The Christmas card scheme will continue - please let the Treasurer know if you wish to order for Christmas 1981.

Subscriptions will have to be increased again this year ( see end of newsletter for new rates), but the Treasurer said that if the financial situation improves, the subscription could be reduced.

Subscription rates raised comment - it is always difficult to decide how much to expect people to give. However, the Treasurer stressed that the important thing is members' support, and she will always accept a lower sum, orinstallments, rather than turn away anyone who can't meet the full subscription.

Leslie was thanked for all her work, both last year and in the past. Jeanette Sibbald (York) was voted Treasurer-elect, to work in harness with Leslie and take over next year.

The CHAIRMAN (Beverley Beech) reported a very busy year. Beverley attends quite a few conferences and public meetings, and receives invitations to address some. Last year, Beverley spoke at the Northumberland Vocational Training Scheme Conference, and at a RCGP conference, and will address the Glasgow Multidisciplinary Group in September. AIMS views are generally well received at these meetings, and Beverley makes many useful contacts.

Publicity in the press is increasing (eg: 'Mother and Baby', June '81), which again attracts many enquiries.

AIMS has had very courteous correspondence with John Blackburn MP., (please report any expression of opinion by your MP on AIMS-related matters to Chairman or Secretary) The Chairman also discussed the possibility of following up contacts with the House of Commons special interest group. The Chairman has spent a considerable amount of time and effort on the debate surrounding the Short Report (see previous newsletters).

One of the most important matters for AIMS is hospital procedures, particularly where these involve individual couples, and the problem of informed consent. The use of electronic fetal monitoring has featured prominently last year. The Chairman discussed in detail 3 cases which she has followed up, and there was some discussion about how we can react individually and as a group to these developments.

Beverley was thanked for her work last year, and her tenure of the Chair for the forthcoming year was voted.

The SECRETARY (Elizabeth Cockerell) agreed that the work of AIMS has much increased during the past year. This reflects the work of previous officers ( notably Christine Beels and Anne Taylor); greater media discussion of maternity matters, and growing assertiveness of couples having babies.

It has proved very difficult to share out the work between committee members, and the experiment of appointing a special Groups and Contacts Secretary was considered inefficient; this work will now revert to the Secretary. The need to stimulate communication and discussion within the membership and groups was stressed, and will be a priority for next year.

There are an increasing number of meetings at which AIMS is represented by the Secretary. If you wish to be informed, please send the Secretary a few SAE's, although we often don't find out until quite late.

Most of the Secretary's work consists of answering letters (all committee members receive daily letters to be attended to). There is a considerable number of enquiries from pupil midwives and research personnel, and while we are happy that AIMS' views are sought, writers often ask for help in very vague terms about large areas of discussion and research, which is time-consuming and expensive. In future, a more rigorous policy of asking for payment will be followed.

In addition, the Secretary receives enquiries and many distressing phone

calls and letters from couples regarding their experiences. It was agreed that this is a very important part of our work, and these must take priority.

The preparatory documents promised at the previous AGM (on episiotomy and bonding) are now completed and duplicated. These are preliminary drafts and will form the basis of discussion for more development. If you would like copies, please send SAE to the Secretary. In addition, revision of existing literature is now urgent.

The SECRETARY will continue in office for the forthcoming year.

The EDITOR (Christine Burley) has now edited the newsletter for 3 years, in which time it has grown from 12 pages to 26. When she took over her job, Chris eagerly welcomed every scrap of copy, but now the problem is one of selectivity.

The house style of the newsletter is changing, and a new heading (designed by Chris) will be used after old stock is used up.

Content last year has been variable, but with an emphasis on the Peri-natal Mortality Rate. The Technical Matters Column has been introduced, Home Birth has been a constant theme; Other Organisations and Our Hospitals are established features (The Ed always sends copies to institutions referred to); the Research Column is now much enlarged, as is the Groups Report (thanks to Nancy Stewart), and Member's Viewpoint is another innovation (please keep the letters arriving). The other important feature is the book and film review, and the Professional articles.

The valiant typist (Sylvia Morrison-Moore) was thanked for yet another year's work.

An ARM member present wished to express thanks for the high quality and usefulness of the newsletter, which is, she said, superior to many professional journals.

Christine was thanked for her editorship and Nancy Stewart was voted as Editor-elect, to take over this year. Christine was elected to the new post of Vice-Chairman for the coming year.

Our PRESIDENT (Sally Willington) spoke to us about events and developments over the last 21 years. Sally said that she never expected AIMS to be still here all these years later, and that it was an occasion of sadness and happiness to meet us all once again.

21 years ago, childbirth was not to be discussed in public - now at least that has changed. But early hopes that pioneers will effect changes - will be the yeast in the lump - have been disappointed. So, a bitter-sweet reunion.

We were delighted to welcome long-standing and steadfast friend of AIMS, Dr. Pamela Fox-Russell, who, like Sally, had revealing memories of past years to share with us.

Dr. Fox-Russell and Sally had both brought birthday cakes, so we celebrated with cake and sherry.

The Groups sent in very impressive reports of their work last year. (PLEASE send these reports to the Secretary so that she can duplicate them and send them to all group members). Of course, the Groups Reports gave rise to important discussion about the role of AIMS and our direction for the future.

In particular, Auriel Hill, (London South) raised the problem of AIMS' image. Auriel said that we are often thought of as solely a home birth pressure group and an anti-obstetric technology group. This problem has been discussed among the committee during the year, and we very much regret the media emphasis on these isolated aspects of AIMS' work. In fact, most of AIMS' attention is devoted to improving the conditions most women face in hospitals, and our view encompasses the wide range of issues in maternity care. In reacting to current debates, the Chairman said the risk (of being labelled thus) is one we have to accept, and the Editor pointed out that freedom of choice has always been important to AIMS.

A few other points. AIMS was represented at the Women's Action Day (by the Treasurer). Following this, AIMS has been invited to sit on the Women's Action Group, and it was agreed that we should accept this offer. Christine Rogers agreed to undertake this job.

The saga of the Community Midwife who had been involved in dealings with the Central Midwives' Board was discussed. AIMS gave the midwife wholehearted support, and Catherine Pallett said that the matter of community midwives' professional independence must be protected. It was suggested that AIMS follow activities of the CMB more assiduously in future.

Membership of The Maternity Alliance (a new group in the field) was also discussed. A vote was taken, and it was decided not to join (with 5 abstentions), because AIMS couldn't be bound to agree in advance with another group's policies. However, individual members and groups may of course join the Maternity Alliance.

One member raised the very distressing matter of mothers admitted to hospital (especially psychiatric units for severe post-natal depression) being told to wean their babies and leave them at home. Obviously, there is no need to comment on this to AIMS members; indeed some of us were shocked to learn that this could happen routinely. Nevertheless, it is an important matter, and if anyone has further information regarding this policy. please let the committee know.

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## NEWS FROM THE GROUPS

Huddersfield - Relationship of AIMS with Local Groups

Following the AGM, no vote of thanks was given to the committee members for their work. May the Huddersfield Group now do so, appreciating that their work is entirely voluntary and that much of the success of AIMS, to date, is through the unselfish donation of the various members time and energy.

However, since its beginnings in 1979 the Huddersfield Group has felt uneasy about certain aspects of communication between groups and individual members and the national committee. Personal contact via the telephone has usually been helpful and satisfying but wider issues, highlighted by the 2 AGM's attended, have led to some disquiet about the overall procedures.

Rather than criticise and quibble as a Group we discussed possible ways of preventing members from feeling that the committee acts autonomously, however erroneous this impression may be, and does act representively. The resulting discussion produced a number of suggestions which the group would be interested in hearing others' views upon:-

1. An agenda of the AGM together with copies of the reports of the Committee members and any other business to be discussed, should be circulated to all members prior to the AGM to allow for individual comment and group discussion. This would allow a group's delegate to be representative at this potentially valuable exercise. Time would also be saved at what is a very short meeting as reports would not have to be given verbally, just points arising discussed.

2. Members should be allowed to vote by postal vote on major decisions, for example the raising of AIMS fees, with sufficient time to allow groups to contact all members.

3. The Committee to submit to each issue of the newsletter, which we feel to be excellent, a report of their activities for and on behalf of AIMS. Whilst appreciating the work done by the committee and aware of the load they already carry, we feel that the members would feel greater contact with them as individuals through their reports and be able to participate more freely in elections by an awareness of the personalities involved and the roles they occupy.

4. Greater direction/guidance/publicity could be given, again via the newsletter, of the work done by different groups of AIMS to enable emulation and/or discussions, eg: the Waltham Forest/Redbridge Groups guide to choice of maternity care is perhaps something each group could adapt and/or copy to increase a national awareness of AIMS as well as a feeling of belonging to a nationwide organisation.

5. Possibly a greater number of national and/or REGIONAL meetings could be organised to include all members, to allow for greater contact between members and to increase publicity and recognition.

We would like to stress that we have found informal contacts with committee members to be both easy and useful; however, the growth of AIMS may require more formal procedures to contribute to the strength and vigour of the Association.

We would be interested to see if other groups share our views.

Contact: Mary Blacka (Sec),
122 Halifax Old Road,
Birkby,
Hudds.

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West Country

On 2nd March we held a meeting to assess whether we might set up a local crying baby service. However, the HV's who came had been instructed not to take on any voluntary work, and the

discussions ended with their assurance that the needs of mothers in the area were adequately catered for. We felt we could not continue our plans without some assistance and so the idea was temporarily shelved.

On 8th May, 2 members of the group went to the Swindon Maternity hospital to meet with 2 Divisional Nursing Officers. The views of AIMS seemed not to be taken kindly, especially regarding home birth.

On 12th May our secretary went to the RUH at Bath to give an informal talk on the aims of AIMS. The audience consisted of 16 health professionals. The talk described what AIMS would like to see improved, with an outline of suggested alternatives. All the literature was eagerly taken and several contacts within the hospital were made. A member of the staff indicated she may begin her own survey of the excessive waiting times in the ante-natal clinic.

We are currently sending out letters to all G.P's in the Bath Health District requesting permission to put our 'Choices' leaflet in their surgeries. Our secretary has been invited to attend a meeting of the Mother and Child Welfare Working Party (in Bath) about Parent Craft classes on 10th July. It will be interesting to see if other 'consumers' have been invited!

Contact: Miriam Elloway, Shepherd's Cottage, Fairwood Road, Dilton Marsh, Nr. Westbury, Wilts.

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## ULTRASOUND: WATCHING BABIES GROW

Routine ultrasonic scanning in pregnancy is rapidly becoming the norm, including repeated scans to closely follow a baby's growth. Debate about the merits of this trend is beginning to surface, both because of possible hazards and for its social implications - the necessary centralization of ante-natal services in high-technology centres, and the effect on people's attitudes to the normality of pregnancy and birth.

A series of letters in 'The Guardian' in May raised the issue of safety of ultrasound for the fetus. In response to a statement by Jean Robinson of the Patients Association that ultrasound might damage a baby's central nervous system, paediatrician Peter Scanlon, claimed that there is no evidence of such damage. Nancy Stewart for AIMS replied that while there is no conclusive evidence of damage, there have in fact been no long-term studies of effects, and there are numerous indications of damage by low-level exposure in both animals and human tissue. She quoted American FDA warnings about ultrasound safety, and suggested that pregnant women should not be told that ultrasound is unequivocally safe, and that its use should be reserved for cases where essential diagnostic information cannot be gained by other means. Jean Robinson then noted various reports of harmful effects of ultrasound exposure, and directed readers to a report by an FDA researcher into ultrasound effects. ('Birth and the Family Journal' Summer 1980)

An editorial in 'The Lancet' (25.4.81) calling for universal ultrasound screening was answered by an American radiographer ('Lancet' 20.6.81) objecting on 3 grounds: cost; irrelevance ("What difference is it going to make if 20% of 'patients' (your term, not mine) do not know when they conceived? The fetus will signal when it is mature."); and possible hazards.

Ultrasound scanning has been touted as "this almost incredible benefit" by doctors. A. Gunn, M.D. ('Mother & Baby' 11.80) has advised mothers of a "subtle but tremendously advantageous benefit of scanning: because the mother, watching the screen each time she is scanned, sees her baby long before it is born, she identifies even more closely with it than she might otherwise do. 'Maternal-child bonding' is the technical name for this". The same author claims there would be fewer abortions if every pregnant woman had a series of scans. and "few would face the agonies of stillbirth or the disaster or their premature baby's death". But how can simply seeing pictures of a fetus put pounds on a tiny infant, or prevent congenital malformation?

In fact, a routine scan has a much greater effect on late babies, not early ones. The most commonuse of routine scans is estimating fetal age, so the birth can be induced if the pregnancy goes 'post-dates'. The argument is that stillbirth rates rise after 42 weeks of pregnancy compared to 'term', so most doctors feel

obligated to ensure that no baby is more than 10 days to 2 weeks 'overdue'. As Ann Cartwright points out ('Dignity of Labour'), the stillbirth rate at 40 weeks is extremely small, and the slight rise in following weeks is insignificant compared to the overall stillbirth rate. (50% greater than zero is still zero.) She concludes that inducing all births after 42 weeks would have negligible effect on the stillbirth rate.

But most inductions are performed because of 'postmaturity', usually based on the evidence of a scan. A recent report ('BMJ' 20.6.81) on the accuracy of mid-trimester scan dating described what the authors felt were "reliable estimates": 80-85% of the women scanned delivered within ± 2 weeks of the estimate, compared with 72% within ± 2 weeks of the date based on last menstrual period. In other words, for 80 out of 100 women, the scan predicted the birth to within the span of 4 weeks. And what of the other 20? Because of the development of their babies did not follow the average rate, were they subjected to an induced birth? Scan dates become much less accurate in the last trimester. How often are women sent in for repeat scans, given new, conflicting dates, and then induced or not, based on inaccurate data?

The cultural implications of ultrasound scanning were considered in a paper presented in March to a conference of the British Society of the History of Science, excerpted here by kind permission of the author, Dr. Edward Yoxen, Department of Liberal Studies in Science, Manchester University:

"(An obstetrician explained) that he would first scan the abdomen to form 'an acceptable, non-threatening image' and then explain its significance. This immediately raises a number of questions, such as what are the specific characteristics of 'acceptability' and what kinds of threat the obstetrician would be seeking to remove. It also suggests that control of the image, its meaning and the production of a meaning lies with the doctor, although under certain conditions the image and its information will be shared, presumably modifying in some way the feelings, fears, hopes and desires of the expectant mother and those with whom she is associated.

Ultrasound equipment is expensive. It tends, therefore, to be located in the obstetrics department of major hospitals where it forms part of the complex of diagnostic facilities on which physicians can draw.

Now diagnostic ultrasound not only seems to enhance the status of radiology as a discipline, by offering to obstetricians a technique of real clinical vlue; it also represents a further shift of medical resources and expertise into the hospital. Indeed it facilitates the centralization of ante-natal services in hospital out-patient departments, and it contributes to the redefinition of expert knowledge about pregnancy and childbirth in highly specialised, technologically based, professional terms and to the corresponding devaluation of ideas, skills,and procedures grounded in everyday experience and bodily sensations. In this sense it tends to make women more dependent on a predominantly male medical profession.

One is led to questions about the social management of pregnancy and childbirth. The hospitalization of childbirth and the medicalization of pregnancy may well have been associated with a fall in maternal and neo-natal mortality in industrialized countries, although this has brought with it increasing distress and resentment and opposition to the ways in which ante-natal services and obstetric services are constituted; and women and their babies 'processed' in hospital. It is against this background that the claim that ultrasound technology facilitates 'bonding' of mother and child during pregnancy should be viewed. For although this may be true, its full meaning has to be seen in relation to all the other experiences of being pregnant, and having that pregnancy 'managed' by hospital personnel. The technology, in its image-generating capacity, offers a 'fix' to some of the psychological problems of confusion and anxiety, that high-technology, hospital medicine has created."

If we are concerned with possible hazards of ultrasound, it seems reasonable to suggest that its use be reserved for gaining essential diagnostic information that cannot be obtained by other means. A midwife's skillful hands can feel a baby's position, and can monitor a baby's growth, week by week. An attuned ear with a simple metal trumpet can hear a baby's heartrate. A mother can bond to her unborn baby by tuning in to its movements and rhythms; by recognising the validity of her

own sensations. These are skills and potentials that are not to be taken lightly, and that need not be sacrificed to the lure of still more sophisticated technology.

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## ULTRASOUND: INSTRUMENT OF TORTURE

This account concerns what happened to me during my last pregnancy in February of this year, where 'information' ostensibly from the ultrasound machinery was used to pressurize and frighten me. The man I live with, himself having been a victim of torture, described it as 'psychological torture'. This was my fourth baby, and because the second had been born by caesarian section, by G.P. wouldn't hear of me having this one at home. However, I found out about the S.S.H.C., and arranged to have maternity care from a community midwife and no G.P. (I later found out that I was the first woman in Coventry ever to do this!)

All went well until January. Because there was some confusion over E.D.D. (I had conceived whilst breastfeeding) and my midwife wanted to go on holiday, I agreed to have a scan. I had this on 2nd January and was given an E.D.D. of 1st April, but was told that, to be absolutely certain of the date I'd need another scan. That was done on 19th January and again I was told that the E.D.D. was 1st April. When I said I didn't think that could be right, the Sister said, very aggressively, "This machine is accurate to a $\frac{1}{2}$ millimetre and I have 10 years of experience".

My real problems started less than 2 weeks after on 31st January when I started bleeding. This continued off and on until 4th February, and I decided to go into hospital. In the hospital I had a dispute with the midwife in the Admissions Room as I wanted my man with me, and I didn't want an internal examination. On this point I later relented when I saw that it was a woman doctor - though she made no attempt to be reassuring and also wouldn't tell me when I asked what the blood samples were for.

I had another scan that evening. The consultant came to see me the next day, and told me I'd have to stay in hospital for "quite a long time". When I asked how long, he said 2 or 3 weeks, so I said no. By now it had become obvious to me that a) I wasn't going to bleed to death as no-one rushed around to do anything and they couldn't do anything to stop the bleeding as such and b) if I asked any questions about my future treatment they were only going to be met with evasions and arguments against my having the baby at home. I was already pretty inured to these as, at the beginning my G.P. had painted scenes of my death and my family being unable to manage without me as I'm the breadwinner! So, I discharged myself. The junior doctor who brought me a discharge form to sign had my file with her and I asked to see the print-offs of the scan. She briefly showed me them, but didn't indicate to me where the placenta praevia was.

I went home from the hospital on 6th February and stayed in bed. Then I went for another scan on 20th February. This was done by the same sister who had earlier told me that she had 10 years of experience and the machine was accurate to .5 mm. She refused to discuss it with me and called in a registrar. He didn't mention placenta praevia at all, and wouldn't talk about it when I asked what grade of placenta praevia I had, but just said I'd have to come into hospital because the baby "wasn't growing properly". He wouldn't elaborate on this, just said that the scan showed it. I said I didn't think so and no, I wouldn't come into hospital for these (unspecified) tests. He then told the Sister to write on my file 'patient refuses to be admitted to hospital' and they both signed this!!

Then the Sister refused to phone the results of the scan to my midwife's superior, and refused to get me an ambulance to go home in. (I had come in an ambulance that my own midwife had booked). She argued and argued and only relented when I asked "Do I have to walk 6 miles home in my nightdress and dressing-gown in the snow, then?"

When I arrived home, I phoned my midwife's superior and later she phoned me back to say that my midwife was coming to see me. This was rather odd as she was on holiday and arrived at about 8 p.m. When she came she told me that the scan had showed that there was a hole in the baby's neck and that it looked like a neural tube defect.

I was terribly distressed because although I didn't really believe that anything was wrong with my baby, I suspected that I was being deliberately lied to and I was shocked at the cruelty of people who were doing this.

Finally, Delia was born, at home, 8 days later, i.e. on 28th February. She was obviously full-term, weighed 7lb 12oz and was very strong and healthy. There was no excessive bleeding, and the placenta (which my man had a good look at) was intact.

So, in the end, the ultrasound and/or those who interpreted it had been wrong on 4 points:-

1. The E.D.D. was 1 month out.
2. There had been no "failure to grow"
3. There was no placenta praevia.
4. There was no neural tube defect.

After an interchange of letters, Mr. Schofield of Coventry CHC and myself went to an interview at Walsgrave Maternity Hospital with the Head of Nursing, the Consultant Obstetrician, and the Sector Administrator. My version of what happened regarding the ambulance was accepted, and then we came on to the subject of the scans. The obstetrician firstly said that the ultrasound was very accurate for E.D.D. When I pointed out that it was one month out in my case he then said "Oh well, if you think medical science is an exact science..." and of course babies are all shapes and sizes! He then said that there was no ultrasound equipment which could show what degree of neural tube defect was present. I then pointed out that, in fact, there was no neural tube defect at all, and he then said that this equipment was operated by highly skilled technicians who knew how to interpret what they saw! Mr. Schofield then intervened to ask how it was that this meesage had been given to me in the way it had, and Mr. M. admitted that this type of information - congenital abnormalities as shown by scan - should be communicated to the patient by the highest medical authority in the hospital.

I am happy nowthat I did complain, but still very angry that, at first, my first letter of complaint was treated dismissively. Much of the credit in my receiving an apology and what amounts to an assurance that this would not happen again, goes to the Secretary of Coventry CHC who accompanied me to the interview. He had thoroughly studied my complaint, and during the interview, which was intimidating, he kept me to the point and directed questions of his own to the consultant.

My main reason for never giving up, either about giving birth at home or complaining about the hospital afterwards, was the thought of how, if I didn't do it, then I'd always feel a victim and always blame myself. I think I was helped through this ordeal (and so does M.W. of SSHC) because I've worked with ex-prisoners who have been tortured and also done translations with accounts of torture for human rights groups. So, having known the various mental and emotional strategies that other people have used, I was better equipped to resist. But should completely innocent pregnant women have to resist in this way?

Sharon Hayden,
Coventry.

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Ed; Though the parents remain convinced of the midwife's good faith in passing on the information about the supposed abnormality, and the hospital's letter of apology concedes that she "assumed that she had been asked to convey the instruction as you were intending to have your baby at home", the letter claims that instead she had been sent only to arrange for urine collection of oestriol tests. "What we have been unable to resolve is how the original instruction could have been misinterpreted along the communication chain but without doubt we owe you a most sincere apology for the effect that this unintentional error caused", the letter continues.

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## CONSUMER COMPLAINTS

The number of complaints received by the Ombudsman was up 15% from the previous year, according to the Annual Report. Two cases were described of 'serious failures' by maternity ward staff that led to tragedy. 'Annual Report of the Health Service Commission, 1980-81', Stationery Office, £2.90.

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From September 1st, patients who have a complaint about doctors' decisions and treatment will be able to have their complaints dealt with in a formal procedure. There has been some debate about extending the Ombudsman's role to include areas of clinical judgement (see last Newsletter), but the DHSS has instead accepted the BMA's design for having complaints against doctors investigated by doctors, against the advice of the Patients Association.

The scheme, to operate on a trial basis, will consist of 3 stages. First, the consultant will meet the patient to discuss the grievance. Any other doctors involved must be consulted at all stages. If the patient is not satisfied, the Regional Medical Officer must be informed. The RMO will talk to the consultant, and possibly to the patient. The RMO has the power to move matters to the 3rd stage: 2 consultants in a similar medical speciality, with at least one from another health region, will read the medical records, meet the consultant, interview the patient, and then make a confidential report to the RMO. If the assessors decide to support the doctor, they must "endeavour to resolve the complainant's anxieties". If they think the complaint justified, they may talk to the medical staff concerned, in the hope of preventing the same problems arising again. The final step will be a formal letter to the patient from the district administrator.

The plan seems to have several shortcomings from the patient's point of view. First, while members of a profession are unwilling to have their actions and decisions judged by non-professionals, the patient may suspect a tendency for professionals to protect their fellows in the face of criticism. Second, the patient will not be allowed to be accompanied by a CHC representative (or other advocate?) at any point in the proceedings. Also, if the consultant refuses to cooperate with the second opinions, it is unclear whether the investigations will have to stop.

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## IN BRIEF

A climbing rose called 'Breath of Life' has been specially grown by Harkness for the Royal College of Midwives centenary this year. An article by the same name appeared in 'Nursing Times' (8-14 July), assessing the current state of midwifery and concluding with optimistic indications that the fortunes of midwifery will parallel the upward climb of its rose. Includes references to AIMS and our long-standing support for a strengthened, central role for midwives.

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The new 'BMA Handbook of Medical Ethics' warns doctors against screening patients unless immediate treatment is available if results prove positive. For instance, it is seen as 'irresponsible' to screen a pregnant Catholic woman for spina bifida or neural tube defects, since she would be under 'intolerable strain' with no alternative but to continue the pregnancy and bear a handicapped baby.

It is up to individual doctors to decide whether to save the life of the child of a Jehovah's Witness by giving a transfusion against the parents' wishes, the handbook says. In such instances, the doctor could have the child made a ward of court.

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A drug to increase milk production in breastfeeding mothers is being tested in Finland. The drug, metoclopramide, works by stimulating secretion of prolactin, 'the mohering hormone' normally stimulated by infant suckling. (Prolactin promotes milk production, causes the milk to flow, and also causes the mother to feel calm, tranquil, and loving toward her baby.)

In the Finnish tests, mothers with low milk production were given the drug between 8 and 62 days after delivery, and babies were test weighed before and after feeds. Both milk production and prolactin levels increased, compared to a group given a placebo, and 33% of women treated were able to stop supplementary feeds.

A possible hazard noted is the unknown effects of metoclopramide on the baby, and the authors call for further study on this point. (Ed: The study apparently did not compare effectiveness of the drug with other natural methods of increasing milk supply, such as

longer and more frequent nursing, switch nursing, and avoidance of supplementary feeds). ('Lancet' 30.5.81)

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While in the U.S., a drug company has been agressively marketing a new drug to suppress milk production. Parlodel, the brand name for bromocriptine mesylate produced by the Sandoz Pharmaceutical Company, works by suppressing prolactin, and is designed to treat all mothers, "unless they elect immediately to breast-feed". The drug is prescribed for 2 weeks after birth, and has side effects such as lowered blood pressure, fatigue dizziness, headache and nausea. After treatment is stopped, 18-40% of women experience a rebound engorgement. There is also a rapid increase in fertility which may cause women to become pregnant again sooner than they think.

A medical panel discussing the drug reported that while it had significant advantages over cancer-causing oestrogens, the "best treatment may be no treatment at all", since discomfort for a day or 2 can be managed with aspirin and ice packs. NAPSAC International questioned the impact on mother/child relationships of using a drug that interferes with prolactin production, saying it could become known as "the anti-bonding drug". The real alternative, they suggest, is to encourage universal breastfeeding. ('NAPSAC NEWS' Vo.5, No.4)

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It seems that DES (diethylstilboestrol), a synthetic oestrogen prescribed widely in the 50's for its unproven benefits in preventing miscarriage, is still with us - and still affecting our children. The DES babies of the 50's developed vaginal cancer and sterility; today DES is used to promote growth in livestock, and boy babies in Italy are reported to have developed breasts as a result of eating veal-based baby foods from DES-fattened calves. The European Commission has proposed that hormone use be banned from livestock rearing, but the Biritsh Agriculture minister will oppose the ban. ('Le Monde', Vol. 6.81)

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Spermicidal jellies and creams, used with birth control methods such as sheaths and caps, have been linked with increased chances that any baby conceived will have a congenital defect. An American study of the records of 4,772 women found the frequency of substantial congenital defects to be twice as high among women who had used spermicides, with much higher incidence of Down's syndrome and limb malformations. While the results support earlier reports of a possible association between spermicides and defects, it is noted that the results are not conclusive, and that chances of conceiving are low while using barrier contraceptives and a spermicide. ('JAMA' 3.4.81)

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A ban on the use of Depo Provera as a contraceptive, until proven safe, has been called for in a Labour Party Wales discussion document. DP has been licensed as a short-term contraceptive by the Committee on the Safety of Medicines, but there are claims that in some cases the drug is being prescribed for long-term contraception. 'Depo Provera - Cause of Concern', 30p from Labour Party Wales, Transport House, 1 Cathedral Road, Cardiff CF1 9HA.

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And a once-a-year contraceptive is now possible, using hormones in a patented 'hydrogel'. The hydrogel would be injected under the skin, where it would be gradually released. The same compound has been used in a once-a-month pessary containing prostaglandin, which is inserted into the vagina and causes the uterus to contract, shedding its contents (it does not prevent conception, but is an abortion-causing agent). The hydrogel, developed at Strathclyde, has been used with prostaglandins to induce labour, with a reduction in length of labour and reduced Casesarian rate. ('Sunday Times')

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While the Government has ruled out any major changes in the maternity benefits system, Conservative women at their annual conference voted to weaken employment protection legislation concerning maternity leave. They felt employers were reluctant to hire women because of the economic consequences of pregnancies. "If a woman chooses to have a baby, I really do not see why an employer should be penalised", a G.P. speaker said. ('Guardian' 14.5.81)

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A course has been developed to help Asian women cope with hospital procedures surrounding pregnancy and birth. The Help Maternity Course consists of 120 illustrated worksheets with line drawings, covering medical procedures and basic information on pregnancy and

birth, and teacher's notes. Copies cost £3.50 from Leeds Department of Education, Roseville Arts Centre, Roseville School, Gledhow Road, Leeds.

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Also in Leeds, a pamphlet on maternity rights has been published by the Trade Union and Community Resource and Information Centre. Including a step-by-step guide to legal entitlements to maternity pay, job security and leave, a useful pull-out calender showing when to claim each of these rights (though we regret the illustration on the birthday shows the mother flat on her back), and a guide to how trade unions can negotiate improvements on maternity rights, the pamphlet can be ordered from TUCRIC, 6 Blenheim Terrace, Leeds 2. (10p each, A4 s.a.e.).

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## OTHER ORGANISATIONS

The Caesarian Support Group of Cambridge is holding meetings on the first Wednesday of each month to discuss the needs of Caesarian families; and to provide information, encouragement and support. Contact, Claudine Webster, 42 Shelford Road, (840561) for more details or individual counselling by phone or post. The group is concerned about the rising rate of C-sections and is interested in vaginal deliveries after a Caesarian. Let us know if you have any information or literature to recommend.

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The Birth Centre, London has its 15th newsletter available, focussing on Mothers and Midwives. Price 40p or £3 p.a. Membership from 16 Simpson Street, London SW11. Please enclose an s.a.e.

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The Association of Radical Midwives new contact address is Harcourt House, 82 Harcourt Road, Stratford, London E15. General enquiries to Erica Marks. 01-504-2010 and subscriptions (£3 pa.) to Billy Hunter, 45-47 Brunel Road, London SE 16. A.R.M. T - shirts in small, medium or large (light blue or gold) with their owl and stethoscope emblem (small illustration over left breast or large one in centre)are available for £3 plus 20p p&p from the Nottingham Group, 71 Forest Road East, Nottingham. June issue, No. 10 newsletter has articles on birth on all-fours (Caldeyro-Barcia) and 'The Physiology of Natural Labour and Pain Relief( by Michael Odent.

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Cambridge Birth Centre Newsletter No.4 has a feature article of the translation of Michael Odent's book 'Genese de l'Homme Ecologique'. Also sections on Caesarian birth and children at birth. Membership £3 pa. Contact, Cambridge Birth Centre, Community Room, Mill Road Library, Cambridge.

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The Couple to Couple League is a non-sectarian group promoting and teaching Natural Family Planning, highly effective as a method of birth control acceptable to most of the world's faiths.

The Couple to Couple League teaches the sympto-thermal method of fertility awareness combined with creative continence at the fertile time if pregnancy is not desired. The Sympto-thermal method combines mucous, temperature, and calendar methods and other ways of observing female fertility, on a chart. Properly taught and practised, it provides, surprisingly, a method of birth control which is as reliable as the Pill and more reliable than the I.U.D.. Irregular cycles, breastfeeding, drug treatment, menopause, and emotional or physical upset can all cause unexpected changes, but these can be charted and taken into account. Breastfeeding and natural mothering are an integral part of the teaching of the Couple to Couple League, teaching couples how to manage the many months of postnatal infertility. It can also be used to help couples, even those thought to be infertile, to achieve pregnancy. Contact: Mr. & Mrs. F. Howard, 38 Hampden Road, Hitchin. Tel: Hitchin 56294

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Campaign for the West London Maternity Unit: Ealing Hammersmith & Hounslow AHA withdrew in April their proposal to merge the West London Hospital Maternity Unit with the Queen Charlotte's Maternity Hospital. The Campaign is pressing for the RHA and the future District HA to not only respect that decision but further to recognise the need for the continuing existence of the West London Hospital Maternity Unit, ideally at Charing Cross Hospital, as originally planned.

The campaign has 3 specific objectives:-

4. To oppose any future threat to the unit.
2. To preserve, improve if necessary, and promote the aims and methods of this unit - within the confines of the Health Service.

3. To provide a forum for exchange of ideas between patients and staff, (medical, nursing and ancillary).

Contact: Jan Auvache (Secretary)
95a, Southfield Road, London W.4.
Tel: 01-995-6829

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The Down's Children's Association is launching an appeal for £100,000 to assist with the cost of a new research and development centre in Birmingham. The DCA is a support group, and teaches the Brinkworth programme, for therapy starting as soon after birth as possible to improve the Down's syndrome child's physical and mental condition by dietary supplements and physical and mental stimulation.
Contact: DCA, Quinbourne Community Centre, Ridgeacre Road, Birmingham B32 2TW.

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Tips on preventing recurrence of depression, or anxiety, medical treatment, and ways the family can help, are included in the newly revised leaflet of the Association for Post-Natal Illness.
Contact: Clare Delpeck, Sec.,
7 Gowan Avenue, Fulham, London SW6.

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## OUR HOSPITALS

### Fetal Monitoring - Consumer Choice?

In February last year AIMS was approached by our members in the Manchester area who were concerned about the high levels of fetal monitoring at the Wythenshawe Hospital. We wrote to the Wythenshawe questioning their policy of fetal monitoring for 100% of their mothers and asked them to review their policy in view of the research data which indicates that fetal monitoring is of little benefit to low risk women. We also asked them for their statistical data.

The Chairman of Manchester AHA replied, stating "The hospital certainly does not have a policy of monitoring the fetal heart rate during all labours". They questioned our view that "the majority of women who are booked into the Wythenshawe are those who have little understanding of the procedures", stating that the consultants' experience suggests that "their patients are well capable of comprehending their service offered to them, and of voicing their opinions ..... these localities have a preponderence of residents in the Register General's Social Classes I, II & III".

Following that reply, AIMS members carried out an investigation of a group of 37 women whose babies were born in the Wythenshawe during April. Every single one had her labour monitored. All of them were in Social Classes I & II. We wrote again to Manchester AHA telling them of this investigation and also pointed out the risks of assuming that pregnant women are well capable of voicing their opinions, as Ann Oakley's study into women's reactions to ante-natal care revealed: "you do not tell the garage mechanic that you do not like the way he is speaking to you when you are waiting for him to start your car!" AIMS also asked, once again, for the statistical data.

The Chairman replied that it was the consultants' view that "in the vast majority of cases, fetal monitoring is to the advantage of the patients and of great help in the care of patients" and went on to quote the Short Report recommendation of routine fetal monitoring of every labour. He then stated that the Wythenshawe "use fetal monitoring to a very considerable extent because the general view of the obstetricians is that it is the best method". The letter enclosed a leaflet which told these well-informed women all about fetal monitoring. It is as follows:-

"NOTICE TO ALL PATIENTS

(General Intro about the length of stay)

Most patients have an ultrasonic scan when they attend the ante-natal clinic and it is hospital policy for us to attempt to monitor babies during labour. Should you have any worries about this, or would like to discuss it further, please raise this with the Doctor you see at the ante-natal clinic and he or she will discuss it with you."

And still no mention of that statistical data.

So we sent a further letter asking the Chairman to substantiate the obstetric view with evidence. A final letter was received stating that "it does not seem to me that we are ever likely to reach a consensus on the subject. You must surely appreciate that it is right that I must be guided by the technical advice given to me."

It is interesting that a hospital can adopt a policy of 100% fetal monitoring in spite of this procedure being subject to considerable medical debate, ranging from those who consider it beneficial to those who consider it to be dangerous for low risk women.

One wonders about the ethics of this policy when the women concerned are so badly informed, are unable to judge for themselves the value of this technique, and tell us that they have to ensure a stand-up fight if they dare refuse.

If the consultants believe fetal monitoring is so beneficial, why was there a need to lie in response to our initial query? And why won't they answer our request for statistical data? Until these questions are answered we would not recommend any woman who does not want routine fetal monitoring to have her baby in this hospital.

Beverley Ann Beech

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## CONFERENCE REPORTS

PREGNANCY CARE FOR THE 80's - A CHALLENGE FOR THE PROFESSION Royal Society of Medicine, April 1981. £30 for 3 days.

This conference, sponsored jointly by the GP and Obstetrics sections of RSM, was held to assess present maternity services and consider innovations. Areas discussed by an impressive list of speakers included ante-natal care; parent and child interaction; innovations in obsteric care; intra-natal care - domiciliary obstetrics, within the hospital; preparation for parenthood; and tomorrow's developments. Some highlights:

- In Canada, Murray Enkin provides family-centred obstetric care to all women (the opposite of the birth centre' philosophy that selects a small number of low risk labours for 'homely' surroundings.
- Dr. Michael Klein compared low risk births in a GP unit with similar low risk births after shared care, delivered in a consultant unit. Consultant births had more forceps deliveries; epidurals; intubation of newborns; asphyxia; large pethidine dosages.
- Kate Newson urged midwives to keep their own audit of their own practices, and urged hospitals to publicly publish their own statistics.
- Professor Sir John Dewhurst suggested that future obstetric care would mean universal fetal monitoring, and more tests and investigations to reveal risk. He had not attended any of the previous sessions, andwas perhaps unprepared for the groans from the audience of his calls for more intervention.

The conference was attended by a larger number of obstetricians than are usually seen at such events. The gap between the views of obstetricians and consumers could be lessened by careful consideration of the proceeding of the RSM conference, it will provide a great deal of interesting material for consideration when published.

THE ASSOCIATION OF RADICAL MIDWIVES National Conference - Sheffield June'81. £3 - 1 day

This was the most pleasant meeting about childbirth that I have ever attended. The only disadvantage was that there were several sessions in parallel, so we all had to miss something. 5 years after its birth the ARM has won its colours, and was rewarded by a large conference audience of 250. AIMS members will be pleased to know that the need to put women first was repeatedly stressed, as was the beneficial effect of the growth of parents' voice in childbirth matters.

Speakers included: Dora Henschel (Sen.Mid.Tutor UCH), Zita Barnett (retired DNO), Kate Newsome (Mid.Tutor, St. Mary's), Chloe Fisher, discussing Breastfeeding and Mona Romney (research midwife and ward sister, Northwick Park Hospital) discussed her research (published in the 'J. of Obs & Gyn' Aug.'80, 'Predelivery Shaving : An Unjustified Assault?'). Though supposedly introduced to help prevent infection, predelivery shaving has been shown in repeated research over the years to actually increase infection rates. The real reason why it was introduced was embarrassment of personnel at the sight of women's genital hair. The reason it is retained is midwives' ignorance and reluctance to abandon training. Predelivery shaving has now been abandoned at Northwick Park, and Mona Romney has received letters from at least 300 other hospitals which have followed suit. Mona Romney has also researched the peculiar preoccupation with bowels, (that predelivery enemas are unjustified as a routine measure) these findings are meeting much more resistance. (See 'BMJ' April'81) Many midwives said that they found the ARM a great source of comfort and support. As one said, this was their first opportunity to have informal talks together, instead of being talked at.

Elizabeth Cockerell.

The entire proceedings of both conferences will be published - watch for details.

IMPORTANT DATES

N.C.T. Jubilee Conference 10th October

9.45 a.m. - 4.30 p.m., Friends Meeting House, Euston Road, London NW1 'Choices in Childbirth', including Luke Zender, Peter Huntingford, Martin Richards, Sheila Kitzinger and John Tomlinson. Non-members £7, members £5. Enquiries to Christine Stephens, 9 Queensborough Terrace, London W2 3TB

Couple to Couple League 17th September

8 p.m. The Lucas Room, Hitchin Town Hall. Speakers, John and Judy Arnold. (See other organisations page 14).

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MEMBER'S VIEWPOINT

Nutrition in Pregnancy

"Kathleen Gell's article on the latest books on nutrition was the last straw. My friends and I have become increasingly confused about what we ought to be eating, and what we ought to be giving our children, over the past year or 2, so that now I am putting in a plea for sanity on the whole issue.

For one thing, every individual has requirements, as well as different preferences and attitudes concerning her food. Any detailed diet charts must be doomed to failure for this reason alone.

For another thing, the 2 quoted recipes for daily intake of 2 pints of milk and 2 eggs conflict totally with many alternative diet therapists, who are at present questioning the value of milk and eggs in children and adults. Many people (up to 50% of the population, it seems) are actually allergic to cows' milk. Might it not be that this too is harming our unborn children? There is, after all, very little logic in consuming the milk of another species, which is intended for its own young.

If we could all be given a full list of every natural food containing the vital nutrients, such as Vitamins B6 and E, and folic acid, out of which to construct our own preferred diet - with an eye to cost too - there would surely be a better chance of women following it. Who but an avowed eccentric is going to eat eggshells, or even buy real vanilla?

There is, by the way, yet another book, with a chapter on nutrition which substantially agrees with those reviewed. It is 'The Child Before Birth' by Linda Ferrill Annis (Cornell).

All I'm really saying is that there is a problem of both attitude and finance in ensuring that all women are adequately nourished before and during pregnancy, and the likeliest way of solving these problems is to provide complete, sensible and balanced information as to the most normal sources of essential foods."

Rebecca Smith,
NCT Teacher,
Pulborough, Sussex.

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A further view on the nutrition article came from Patricia Crowley, MRCOG of the National Perinatal Epidemiology Unit, Oxford.

"In the Spring 1981 Quarterly Newsletter AIMS rightly points out that a large prospective study of the effects of ante-natal diagnostic ultrasound should have been conducted "before ultrasound in pregnancy was adopted on such a vast scale" (Page 9). In the same issue we find a totally uncritical review of 2 books on nutrition in pregnancy (Page 19). Low-birthweight, difficult labour, high blood pressure, congential malformations, peri-natal death and handicap are all attributed to defective nutrition in pregnancy. There is no evidence from properly conducted trials to support any of these statements.

Two studies of peri-conceptional vitamin therapy in women who had previously delivered infants with neural tube defects have suggested that multivitamins or folic acid may reduce the risk of recurrence. Unfortunately neither of the trials was properly conducted.

A controlled trial in a poor black community in New York showed that women whose diet was supplemented with 40 gms of protein and 470 calories per day had an excess rate of very early premature birth and associated neo-natal death compared with control women who received no supplement. This emphasises that even the most apparently harmless interventions must be subjected to controlled trials before being foisted on pregnant women. The protein supplement which was associated with such adverse outcome is not dissimilar to the mixture recommended on page 20 of the Spring Newsletter and doubtless being consumed by enthusiastic AIMS newsletter readers at this very moment.

The unfounded claims made for the benefits of nutritional supplementation

quoted by Ms.Gell are curiously reminiscent of the claims made by exponents of universal intrapartum monitoring and potentially as dangerous. To state that "every woman by her choice of foods before or during pregnancy largely determines the type of baby she will produce" is guaranteed to increase the guilt and anguish of parents who have suffered the birth of a dead or handicapped baby. AIMS beware! You wouldn't advertise a fetal monitor would you?"

1. Smithells et.al - 'Lancet' 1980 i,339-340.
2. Laurence et.al - 'Br.Med J' 1981 i,1509-1511
3. Rush et.al - 'Paediatrics' 1980; 65,683-642

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Tom Brewer, M.D., co-author of one of the books reviewed and author of numerous works on nutrition in pregnancy, was asked to reply to Dr. Crowley's letter:

"Dr. Crowley's letter regarding the subject of nutrition and malnutrition in pregnancy is itself a classic example of the profound ignorance which dominates this critical area of human pre-natal care in the Western World in the 1980's. Did she even read our work? Did she review its 65 references from the scientific literature? The Royal College of Obstetricians & Gynaecologists in the U.K. doesn't know a thing about the role of malnutrition during pregnancy in causing human reproductive casualty for both mothers and their unborn and newborn babies. They know even less about the protective effects of enough decent foods to eat, salt to taste and water to thirst in maintaining maternal-fetal health.

J.F. Kerr Grieve in Motherwell, Scotland insisted that every pregnant woman eat every day a full pound of lean meat during pregnancy. He didn't like milk either, and discouraged its use, but he got remarkable results in eradication of metabolic toxemia of late pregnancy and abruptio placenta. (J.Rep.Med. 13:170-174, 1974). We are not concerned that everybody follow our diet to the letter; we are trying to establish some scientific principles in this field on the clinical level and one of these is that amino acid deficiencies and calorie deficiency (Protein-Calorie Malnutrition of PEM, Protein-Energy Malnutrition) lie at the root of a vast amount of pregnancy disease and death. Another principle is that lack of dietary salt alone or in combination with PEM causes maternal hypovolemia (low blood volumne), intrauterine growth retardation, and eventually metabolic toxemia of late pregnancy. This was recognised by the pioneering Margaret Robinson at St. Thomas Hospital, London U.K. ('Lancet' 1:178, 1958). Her work was simply buried by RCOG, the British Medical Research Council and the National Perinatal Epidemiology Unit.

Dr. Crowley cites the work of Rush, Stein and Susser among the pregnant poor of Harlem in a futile attempt to discredit our own point of view and dietary plan. We have long studied and been critics of this inhumane, unethical blind 'experiment' on women in poverty recognised to be malnourished in pregnancy. The premature births and neonatal deaths in the supplemented Harlem women were not caused by the supplement of 40 gms of protein and 470 calories per day but by the fact that early, physiological weight gain of these women in the first half of gestation was interpreted by the OB-GYN doctors as pathological, so they were put on low calorie, low salt diets for blind weight control in the last half and FAILED TO GAIN WEIGHT PROPERLY DURING THE LAST MONTHS OF THEIR GESTATIONS, i.e. they suffered iatrogenic PEM and salt deficiency! (It was a 'blind' study so the OB-GYN doctors did not know which women were getting the supplement). This experiment does in fact support our basic position!

Our dietary approach has been used in over 26,000 pregnancies without one case of eclampsia, the disease we term metabolic toxemia of late pregnancy, convulsive phase. Anybody who tries our methodology can verify this thesis. Our position is supported by another book written for physicians and other medical care professionals by Douglas Shanklin, M.D. and Jay Hodin: 'MATERNAL NUTRITION & CHILD HEALTH', Springfield, Illinois, C.C. Thomas Publi., 1979. This work has analysed 239 scientific works in the field, and it contains a scientific criticism of the works of Rush, Stein and Susser and their ridiculous conclusion that feeding pregnant human beings a decent, well-balanced, adequate diet all through gestation is harmful.

Any pregnant woman who uses our basic principles in her daily life can learn in a few weeks from her own experiences the value of careful attention to daily meals and snacks, the value of salt to taste and water to thirst, practices

which make most drugs unneeded."

Tom Brewer, M.D.
Croton-on-Hudson, New York.

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- "In the Winter newsletter on page 6 and on a Horizon programme it was stated that America has the greatest technology and a high infant death rate - but what are the latest figures? Also, what are the latest figures for Holland and Sweden? Also, what was the percentage of home births in this country when the peri-natal mortality rate dropped down to 17 or so per 1,000 (c.1965, I believe)?

With reference to all of those who have suffered like the Plymouth member (Members Viewpoint : Winter newsletter) I am sure they would find the difference between hospital and home the difference between a nightmare and a happy event. If any woman cannot get a home confinement (apart from moving house!) perhaps she could ask if she could sign to the effect that she insists on a home confinement against medical advice and then the doctor could provide a back-up for her pregnancy and confinement. This might work if the doctor was afraid of repercussions should anything unforeseen go wrong as the ultimate responsibility would lie elsewhere. After all, one signs to discharge oneself from hospital - so why should one not be able to sign not to go in in the first place?"

Diana Beamish,
Eynsford, Kent.

Ed. Comment

Latest figures available (1978 Infant Mortality rates per 1,000 live births):

Sweden, 7.7 (rank 1)
Netherlands, 9.5 (rank 6)
England and Wales, 13.1 (rank 15)
U.S.A., 13.6 (rank 16)

An analysis for Great Britain showed that after hospitalisation rates exceeded 75%, peri-natal outcomes got steadily worse (Fryer & Ashford, 'British Journal of Prevential & Scoial Medicine', 26:1-9, 1972). Marjorie Tew has calculated that, had the percentage of births at home remained the same in 1970 as in 1958, the peri-natal mortality rate would have been not 21.4 as it was, but 17.4 ('Health & Social Service Journal' 30.5.80).

While Diana's suggestions for home birth sound plausible, may we remind members that in many areas, parents-to-be are required to sign such a disclaimer, but that it has no legal basis whatsoever (see Page 8 Spring Newsletter).

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## HOME BIRTH

The debate about home birth has raced on in high gear over the past weeks, with articles everywhere from glossy parent monthlies, to regional newspapers, to medical journals.

An enlightening pair of articles, pro and anti home birth, appeared in 'Maternal and Child Health' (6.81). Gwenyth Rankin contributed a very positive, thoughtful, and many-sided view of the case for birth at home. In contrast, the article entitled 'Never at Home' by R.T. Booth, consultant obstetrician, is an amalgamation of practically every spurious argument ever made against home birth.

For instance, in discussing mortality statistics, he informs us that "the hospital figures include the vast majority of patients delivering in England and Wales and these are heavily biased towards high risk cases." Are the majority really biased toward high risk? See M. Tew, Spring Newsletter. One of Mr. Booth's primary arguments against critics of some elements of hospital care (and he refers specifically to AIMS) is that "they conveniently ignore the fact that most women are sensible enough to see the advantages of hospital confinement" - the article mentions 3 times the fact that most births take place in hospital as confirmation for his view of hospital superiority. What he conveniently ignores is that many women may choose hospital because they are told it is better and safer, and they have increasingly less experience of birth at home for standard of comparison. We might remember the study in Glasgow some years ago, where 69% of women whose only experience had been with hospital birth wanted a hospital birth again, but among mothers whose only birth experience was at home, only 22% wanted a hospital. In another study, 80% of women surveyed wanted to have their first baby in hospital because they believed it was safer. But among mothers who had experiences both in the hospital and at home, 86% preferred the home, 10% preferred the hospital, and 4% were undecided.

It certainly cannot be claimed that all women who give birth in hospital have made a free choice. Even the new daughter of Princess Anne, reported to have been eager to have her baby at home, was born in hospital at the insistence of her doctors. ('Guardian' 15.5.)

A curious editorial in the 'BMJ' (23.5.81) claimed that many obstetricians see the home birth issue as "unimportant", "an irrelevance". For the few women who do want to have their babies at home, the 'BMJ' suggested that either community obstetric services must be improved, or "lay midwives will have to be licensed". Should women be free to reject orthodox medical care? they ask. We would hope our maternity care will not be offered on a take-it-or-leave-it basis, but that there will remain scope for a variety of approches to birth, including the care at home by community midwives as is now our right.

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A West Cumbria newspaper has quoted a midwife as saying that Barrow has facilities for home births, which are used by a few parents. But in more geographically isolated parts of Cumbria, the midwife said, home births were "not possible". ('North Western West Cumbria Evening Mail' 19.1.81). The AIMS member who sent us the clipping commented, "I live in a 'geographically isolated' part of Cumbria and so according to this do not qualify for a home birth. What a surprise they'll get when I have another baby!"

Parents choosing a home birth are, of course, entitled to midwifery services regardless of where they live. Health authorities are expected to provide a home birth service that is "as safe as circumstances permit", in the words of the government's reply to the Short Report.

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## RESEARCH

Evidence from mother-and-child pairs interviewed separately in hypnosis indicates that people really can remember their own births. Babies reported accurately on such things as their mother's hair style, obstetrical instruments used and delivery room conversation. Most complained bitterly about being separated from their mothers, a psychologist reported to a scientific meeting of the American Society of Clinical Hypnosis.

The report indicated that both mind and personality are real at birth and that babies actually experience, mentally record, interpret and misinterpret the remarks and actions of adults around them at birth. Without language skills, infants appeared to assess the character and behaviour of attendants, and to perceive the emotional and physical status of their mothers, noting who is nervous, careless, tired, crying, smiling, or angry. ('NAPSAC NEWS' Vol.6, No.1)

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Impressive results published by the researcher who discovered both the extra chromosome of Down's syndrome and the fragile X chromosome (see AIMS Winter newsletter 80/81, page 20) indicate that some forms of genetic mental handicap may be curable. Prof. Jerome Lejeune found that if cells containing the faulty X chromosome were deprived of folic acid, a gap would appear at the fragile zone; increasing the folate supply would cause the gap to disappear. Folic acid is an important reservoir for the basic chemical monocarbons used to build membranes, necessary for vital nerve functions.

By exposing cell cultures to monocarbons, Prof. Lejeune found the proportion of affected chromosomes was reduced from 22 to 0.4 per cent. A clinical trial with a severely disturbed 10-year-old boy suffering from fragile X syndrome showed that with daily folate injections for 8 days, his abnormal chromosomes were reduced to one 30th, and his immediate psychiatric improvement was "spectacular". When the folate injections were stopped, the boy's condition relapsed almost immediately, so treatment was restarted with the same remarkable effect.

Prof. Lejeune believes that many forms of genetic handicap may be treatable. His work ties in well with evidence that folate deficiency is implicated in spina bifida. ('GP' 15.5.81)

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Folic acid deficiency as a possible cause of neural tube defects has been implicated by a further study by Laurence, et.al, of the Welsh National School of Medicine in Cardiff. (See last Newsletter page 12, re: dietary deficiency and neural tube defects.) In a research trial involving 111 women who had previously borne a child with neural tube defects and who planned to conceive again, one group was given tablets of the vitamin folic acid,

while the other group was given a placebo, both with instructions to begin taking the tablets when contraceptive precautions ceased. Through interviews before conception, diets were judged to be adequate or inadequate. Blood tests were performed to determine whether the women were taking the tablets, and 27% of the women who were to be receiving folate treatment were found not to be taking the tablets consistently.

There were six neural tube defects in the 111 pregnancies: 4 in the women with placebos, and the other 2 in women who had not complied with taking the tablets. There were no neural tube defects among the women taking an adequate diet, while all 6 were among those with inadequate diets. The authors conclude that women receiving a poor diet who are at risk of recurrance of fetal neural tube defects can reduce their risk either by improving their diet or by taking folate supplements.

Both the small number of women who agreed to participate in the study (12% of those interviewed) and the high rate of non-compliance make the trial unsuccessful as a method of preventing neural tube defects. The authors suggest further multi-centre trials to assess the effectiveness of folate treatment. ('BMJ' 9.5.81).

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At least 43% of pregnancies end in miscarriage before the 20th week, according to a study reported from Southampton and London - but the authors point out that this is likely to be an underestimate. Using urine tests to recognise implantation in the uterus, researchers were able to verify pregnancies before there were any clinical signs. Out of 152 women who became pregnant, only 87 were still pregnant after the 20th week. Of the 65 lost conceptions, only 14 occurred sufficiently late for there to have been clinical signs of pregnancy. There may have been many more losses, before implantation in the uterus, so that conception was not detected. ('Lancet' 13.9.80).

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Supporting other studies that have found that maternal anxiety in pregnancy could adversely affect the health of newborns, a recent report concludes that unresolved fears and conflicts in pregnancy may predict newborn health status. Both conflict in the acceptance of pregnancy and fear of losing self-esteem in labour, assessed from ante-natal interviews, were significantly correlated with mothers' anxiety levels measured in labour, with abnormal fetal heart rate patterns, and with lowered Apgar scores at 5 minutes. Maternal blood levels of epinephrine (which is highly responsive to stress and has the effect of constricting the blood supply to the uterus and baby, and results in a decrease in uterine activity) were measured in early active phase labour, and were found to be significantly correlated both with pre-natal conflicts and anxiety, and with anxiety in labour. ('Am.J. Obstet. Gynecol.' 15.4.81)

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Findings from a comparison of outcome of 1,000 low-risk births, half in a traditional maternity unit and half in an attached home-like birthing unit in Sacramento, California, indicate that high technology care may work to the detriment of low-risk mothers and babies. In the traditional unit, there was a 12-fold higher incidence of failure to progress in labour, 15-fold increase in oxytocin use, 10-fold increase in signs of fetal distress, 3-fold increase in caesarian section, 5-fold increase in forceps deliveries, and twice as many vaginal lacerations. Infants delivered in the traditional unit were reported to have suffered 5 times higher incidence of central nervous system abnormalities, jaundice, scalp infections, and polycythemia.

Robert Goodlin, M.D., reported on his findings at a Nebraska neo-natal conference. He once held the opinion that every labour should have electronic fetal monitoring, but now feels he was wrong in that opinion. "Putting a fetal monitor on a woman sometimes induces uterine dysfunction. That has been observed time and agin," he explained. ('Ob.Gyn.News' Vol.15No.1)

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The benefits of upright position and movement in normal labour have been documented before, showing an increase in uterine activity, shorter labours, and greater comfort for the mother. A new report on 'abnormal' labours indicates that ambulation is at least as effective as oxytocin for enhancement of labour. 14 women who had demonstrated failure to progress in active labour for 1 or more hours and whose contractions were deemed to be inadequate and to require augmentation were randomly assigned to the oxytocin group or the ambulation group. All women had

had ruptured membranes, and their fetuses were monitored internally, connected either directly or via telemetry to a fetal monitor.

During a 2-hour study period, increase in uterine activity in the ambulatory group was immediate to ranges not reached in the oxytocin group for 2 hours. Labour progress was slightly but not significantly better in the ambulatory group. All patients who received oxytocin complained of increased pain, whereas half of the ambulatory group felt less pain, and all but one of the remainder said that the pain stayed the same.

The authors considered maternal fatigue and motivation to be the limiting factors in ambulation, but noted that their study design did not allow the ambulatory mothers to rest at will; sitting and alternation of vertical and recumbent positions have been shown to shorten labours, and would minimize problems with maternal fatigue. ('Am.J.Obstet. Gynecol' 15.3181)

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The influence of maternal analgesia on newborn behaviour has been studied and reported on in 2 related papers, for pethidine and epidural bupivacaine. In a prospective study in London, by Rosenblatt, et.al., women selected either pethidine, bupivacaine (the local anaesthetic commonly used with epidurals), or no drugs. Neo-natal behaviour was studied at delivery and during the 6 weeks after birth using the Brazelton Neo-natal Behavioural Assessment Scale, which measures various areas of behaviour and is more sensitive than Apgar ratings. Both maternal dose and cord blood concentrations were measured.

Infants with higher concentrations of pethidine were more prone to respiratory difficulties, drowsy and unresponsive immediately after delivery. Throughout the 6 weeks in which the assessments were made, depressed attention and social responsiveness were found in infants with high drug levels; infants with high pethidine exposure tended to change state frequently, to cry and to be less capable of quieting themselves. Pethidine, then, seems to affect infants in much the same way as it affects adults. Interestingly, little dose affect was found in the first hour, and peak effects were not reached until the 7th day. The authors comment that the stimulation of birth itself may counteract the effects of the drug in the short term. They conclude that greater exposure to pethidine results in neo-natal behaviour that might affect the ability of the mother to adjust to her baby in the first weeks of life.

For bupivacaine, the drug effects in infants are different both in nature and in degree from those in adults. Effects of higher levels of the drug were significant on the first day and continued throughout the 6 weeks. Infants with greater exposure were more likely to be cyanotic and unresponsive to their surroundings; visual skills, alertness, motor organisation, response to stress, and ability to control state of consciousness were also adversely affected. Muscle tone alone seemed to improve with increases in drug exposure.

But though greater effects were noted within each drug group, with increasing drug exposure, no overall behavioural differences were found among the 2 drug groups and the no-drug group. According to the authors, this implies that low drug levels must carry some beneficial effect, which counterbalances the impairment of behaviour caused by higher drug levels. ('Brit.J. Ob/Gyn' 4.81)

Questions could be raised, however, about the value of a no-drug control group in the context of high-technology childbirth. To quote from the paper: "At the onset of labour, standard procedures were followed: continuous fetal heart rate monitoring was undertaken in all patients and uterine contractions ... were recorded in the oxytocin-induced and augmented labours". Considering the negative effects on newborn health of maternal anxiety and the possible protective effects of low-technology birth reported elsewhere in this Newsletter, it is possible that a study involving a lesser degree of medical intervention would find less possible benefit of medication.

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## BOOKS/SLIDES

'The Five Standards for Safe Childbearing' David Stewart, Ed., 'NAPSAC International'

"If you are going to read only 1 book before you have your baby, read this one", says Dr. Robert Mendelsohn in the Foreward to 'The Five Standards'. Unrealistic, perhaps, on 2 counts: the book is so forthright in its positions that someone with no experience of childbearing may need a gentler, more gradual introduction to its truths; and having

once read this book, the reader must be drawn inexorably on to some of the hundreds of other sources cited.

But read it, by all means. It is a clear and authoritative statement of the ideal in childbirth, based on the 5 interrelated standards of nutrition, midwifery, home birth, natural birth, and breastfeeding. It shatters the myth that the mother's needs conflict with the demands of safety for herself and her baby. Edited and largely written by David Stewart, it also contains chapters by G.J. Klooster-man, Ina May Gaskin, Rhondda Hartman, Yvonne Brackhill, Marian Tompson, and Lewis Mehl.

The chapters on midwifery and home birth form thoroughly documented (with hundreds of refefences) arguments for home birth rather than hospitals, and for midwives rather than obstetricians, for most births. While hospitals and obstetricians are recognised as essential in a safe birth programme, they are reserved for the minority of births, with their services still measured against the ideals of home and skilful midwifery.

Also included are consumers' guides to common obstetrical practices, critiques of other maternity care standards, and a guide to the use of vital statistics. The nutrition and natural birth chapters are disappointingly slight, but clearly state a position and rationale, and direct the reader to other sources for greater detail.

Though definitely an American book, the coverage is international in scope, and the principles are universal. An excellent resource both for its own information and for its wealth of references, we may welcome it as a positive statement of practical ideals.

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'The Pregnancy After 30 Workbook: A Programme for Safe Childbearing - No Matter What Your Age'

Gail Brewer, Ed. Rodale £5.45

A beautiful companion through any pregnancy, this large format softback book is indeed a workbook, with judiciously placed checklists and questionnaires to help the reader discover and fulfill personal needs in pregnancy, birth, and parenthood. Written with a special slant to parents over 30, it neverthless serves as an excellent guide for younger parents as well. The comfortable tone of the book is complemented by sensitive photographs and drawings, and the personal reflections from womens' experiences scattered through the margins.

A variety of authors (American again) contribute chapters on Childbearing After 30; The 'No-risk' Pregnancy Diet; Movement for a New Life (including a helpful section on preventing episiotomy); Co-operative Childbirth - The Woman-Centred Approach; Breastfeeding; and Pregnancy Means Parenting (a trendy chapter with several techniques aimed at helping adjustments to parenthood, such as the 'Postpartum Crisis Survival Plan').

Co-operative Childbirth embodies a rather unusual approach in this country, rejecting artificial breathing patterns as wasting energy and interfering with the mother's ability to work with her labour. Instead, the emphasis is on progressive relaxation - purposeful, concentrated release of tension throughout the body. Clear guides are provided to the necessary relaxation practice with a labour partner. The Co-operative Childbirth Preference List serves as a blueprint for a straightforward natural birth, the expected outcome of the careful preparation this book suggests. Highly recommended.

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'Will, My Son' Sarah Boston Pluto Press £1.95.

A sensitive description of the short life of a child with Down's syndrome and the subsequent birth of a daughter. It has a long and helpful appendix on good and bad sources of information on Down's syndrome, handicapped children, coping with grief and bereavement, as well as pregnancy, birth, and breastfeeding.

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'Present Day Practices in Infant Feeding 1980'

HMSO £3.60

Updates 1974 edition on feeding and well-being of healthy infants and reaffirms that mothers should be encouraged to breastfeed for the first months of life, recommending that facilities for mothers to do so outside the home should be increased.

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'Depression after Childbirth: How to Recognise and Treat Postnatal Illness'

Katharina Dalton, OUP £1.95.

In line with her work on premenstrual

tension, Dr. Dalton believes post-natal depression is caused by hormones and can be treatedwith progesterone. Including explanations of hormonal changes in childbearing, with descriptions and women's own accounts of post-natal depression, the book takes a very positive approach toward treatment. It does, however, fail to consider other possible causes of depression, such as hospital experiences, isolation at home, and baby's crying, feeding, or sleeping habits, and other possible therapies, such as vitamin B6. There is no indication of the success rate of hormonal therapy, and little information on possible side-effects, but the book may bring help to many women, and highlights the need for better attention for all women after childbirth.

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'Change in Ante-natal Care' report of a working party for the NCT, 75p
NCT, 9 Queensborough Terrace W2 3TB

This slim booklet admirably summarizes the dissatisfactions many women feel with current ante-natal practices, the failure of the system in providing care for women most in need, and positive directions toward improvement. Factors in ante-natal care are of course intertwined with attitudes and practices in all of maternity care, so the discussion is of broader scope than the title implies. Recommendations include decentralized, community care; emphasis on midwifery and continuity of care; GP's involved on their own ground, and with adequate financial reward; provision for a real choice of care models; concentration of resources for mothers most at risk (but not necessarily consultant care); attention to communication between women and their caregivers; more direct entry training and flexible hours for midwives, to attract women with personal experience of birth and babies. An excellent blueprint for the reorganisation of ante-natal services.

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Harrogate CHC Maternity Services.
Report of survey conducted during Jan-April 1979. gratis.

Meechan, D.F. Perinatal mortality in Humberside. Hull Univ., Dept. of Operational Research, 1980. 70p

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'Pregnancy: A Challenging Experience'

Camera Talks, Slides in 2 parts, £8.95 each; cassette tape £5.95 each; notes 80p each.

This latest maternity slide/tape set by Camera Talks, produced at the Victoria Maternity Hospital, Barnet, is divided into 2 parts: 'The Development of the Baby and the Medical Care of the Mother' and 'Self Help for the Mother and Father'. While the emphasis on self help is commendable, unfortunately the view of parents' involvement in a healthy pregnancy is larg. y limited to trivial details of comfort (backache, foot cramp, varicose veins, etc., merit 37 slides, while only 6 slides are devoted to a cursory mention of the emotional adjustment to parenthood and effect on marital relationships). No mention is made of the crucial role of parents in eating well, avoiding toxins, and cultivating an emotional state of confident readiness for parenthood. The only nutrition information is included under Medical Care, and these "doctor's orders" are dismally inadequate both in content and in emphasis.

The picture of ante-natal care is one of standard hospital-based services, with a variety of caregivers. It prepares a woman to uncritically accept whatever procedures may be recommended to her, (eg: "Some of you will be visiting the Ultrasound Department", followed by 4 slides showing the equipment used). Overall, a disappointing programme that falls far short of its aims.

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## HELP PLEASE

### Flying Squads

Oliver Gillie, medical correspondent of 'The Sunday Times', is working on an article about Flying Squads and he wishes to undertake a national survey of this service. He would like an assistant in each health authority area who would be willing to carry out a survey of that area. He hopes,in the near future, to bring together all those who are willing to help, to co-ordinate and discuss the format and scope of the survey.
Please contact asap Beverley Beech - 0753-652781 - if you are interested in being involved.

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### Flying Squads 2

As a result of the Janet Jenning's case, and the attention drawn to the inadequacies of the flying squad service, a group of parents in Islington have decided to gather information about flying squad activities.
Bobbie Baker (Tel: 01-607-1859) would

like to hear from any mother who has had an obstetric emergency (eg: ante-partum haemmorhage, post-partum haemmorhage, miscarriage etc.) and who has had to call or use the emergency services. She is also interested to hear from any mother who had been told to call a taxi or an ambulance in this kind of circumstance.

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Consent to Treatment

Jean Robinson of the Patients' Association is undertaking research into consent to treatment and would like to hear from women who have been given treatment against their wishes. She would also like to hear from parents whose babies have been given treatment without their consent or against their wishes. Common examples are women who have been given pethidine and babies who have been given a bottle of milk against the wishes of the parents. Please contact Jean Robinson, 56 Lonsdale Road, Oxford. Tel: 0865-52276.

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Stillbirth

Christine Beels welcomes ideas and information for her Health Visitor course project on stillbirth, particularly counselling and guidance for professionals. Contact: 19 Broomfield Crescent, Leeds, Yorks. LS6 3DD

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Ante-natal Care

The National Council for Voluntary Organisations is planning a project to increase and improve the contributions by the voluntary sector in the field of ante-natal health - both in providing services, and acting as advocates to planners and professionals. They plan to review the work of voluntary organisations, to supply information about local health initiatives, and to establish working groups in some areas to being together planners, professionals, and users of services. Anyone with information on voluntary work in ante-natal health is requested to contact Rosemary Allen, Policy Analysis Unit, National Council for Voluntary Organisations, 26 Bedford Square, London WC1 (Tel: 01-636-4066)

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Home Birth

Yvonne Baginsky (Birth Rights, Edinburgh) and 2 other mothers are making a 30-minute video presentation on the subject of home birth expectations and experiences. They are hoping to portray the current situation, including interviews with parents having difficulties arranging for a home birth. The film is ready to go, but they are desparately short of funds for materials. Any contributions, however small, would be very welcome. Please contact Yvonne Baginsky, 2 Forth Street, Edinburgh 1. (Tel: 031-5570960).

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QUOTATION CORNER

Professor Richard Beard, St.Mary's Hospital, Paddington, at a symposium on 'Role of Technology in Pregnancy and Childbirth': "A mother's main purpose is to have a healthy baby. To hell with the pleasure of having a baby. She needs a baby in the best possible condition. Safety comes first and everything else comes after".

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Reporting on the consipicuous absence of obstetricians at the recent RSM conference: "They may well have felt that their time was better spent caring for their patients than being haranguedby a group of vociferous, middle class women in whom a blanket, anti-establishment prejudice too often masquerades as a genuine, discriminating desire for reform". Acknowledging the emotional aspect of birth, the reporter continues: "If women were routinely delivered under general anaesthetic presumably few of the pressure groups for improvements in the maternity services would have emerged". ---
Jeremy Laurance, 'World Medicine' 13.6.81

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A community nursing officer discussing nurses' training in the importance of respecting individual mother's wishes: "For instance, they are to ask the patient's preference for tea or coffee, and if the answer is tea then it should be noted and the patient will not be offered coffee again." (Care, or catering?)

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Peter Huntingford has resigned his post as professor of obstetrics and gynaecology at Bart's and The London Hospitals, and in August will be taking up a consultant post with the Maidstone Health District in Kent. Prof. Huntingford has chosen to make the move because "it should be easier to try some fundamental changes."

Explaining that his views are more and more at variance with those of his

colleagues, Prof. Huntingford continued, "I am very interested in taking maternity care out of the hands of consultants and putting it back into the hands of midwives and G.P's. You can't do that in a teaching hospital; there are too many constraining forces." In Maidstone, he says, "I will have fewer colleagues, who will have less reason to be threatened by such things."

Asked if he would like his infant son to be a doctor when he grows up, Prof. Huntingford replied, "No. I would want him to care for people on their terms and not on the profession's terms. I don't think you can be a doctor and still do that." ('World Medicine' 21.3.81)

(Note: Many would dispute that Prof.Huntingford has found it impossible to provide such humane care. His efforts on behalf of responsive services for women have been much appreciated by AIMS members and others.)

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If you would like to become a member of AIMS but cannot afford the membership fee then please send us what you can afford. We value your involvement and support.

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While the information published in this Newsletter is freely available for use, the Editor asks that due acknowledgement to AIMS should be made and a copy of the appropriate publications forwarded.

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Copy for the Autumn issue should reach the Editor by Friday, 25th September 1981 at the latest. Copy should be (preferably) typed please, on one side of A4 paper with double spacing. Articles, news items, accounts and views are all welcomed.

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