AIMS

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Association for Improvements in the Maternity Services Quarterly Newsletter

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SPRING 1980

The Dawning of a new Era in Maternity Services

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EDITORIAL

And now it's the turn of the highly regarded 60-bed West London Hospital maternity unit to be threatened with closure and converted to geriatric use whilst the special care baby unit at Charing Cross is shut down. The Area Health Authority concerned (Ealing, Hammersmith & Hounslow) attempts to justify such a proposal on the basis that there are 100 too-many maternity beds in the area with a corresponding deficiency of geriatric beds - this however appears to be based on out-of-date figures as although in 1974 there were only 600 births, last year there were 2,000. It's also forecast that this year will see a boom in the numbers of babies born and the projected figures are not likely to drop for quite some time. Yet here we have another example of cost cutting - not too dissimilar to the outrageous lack of research into drugs like Debendox where, once again, the consumer suffers instead of the 'administration'. This time, we cannot allow this exceptionally humane maternity unit to go and it's time to show, once more, that A.I.M.S. has got teeth. Come on, members - you joined in order to improve maternity services, let's hear more from YOU so that we can all do just that.

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REMEMBER?

Annual General Meeting, Saturday, 19th April, at 10 a.m. Room 16, Friends Meeting House, Euston Road, London NW1 (opposite Euston Station) Do Come!

Next year, A.I.M.S. will be celebrating its (21st) Coming of Age and it's my intent to publish an account of what we've been doing all that time. It would be lovely to hear from some of our more "mature" members who were active in the "good-old, bad-old days" so we may include some personal accounts from those of you who had to campaign so long and hard to make maternity services improve to the state they are today --- which, believe it or not, is one heck of a long way from where they were in 1960!

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In line with our increasing age, the newsletter will take on a different look shortly - as you will see, this one is slightly different already and, I hope,

easier to read. In order to keep costs down but so we can afford to improve presentation, a small amount of non-controversial advertising may be accepted. If you or your partner or a friend you know, either working privately or in a large concern, would like to help yourselves/themselves by taking advantage of this, and thereby help the Association, please contact me as soon as possible.

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AIMS leaflet No.4 is now available, "A 'Leboyer' Style Birth: Guidelines for Parents seeking a tranquil birth". Written by Christine Beels, - price 20p from Mrs. Beverley Beech, 21 Iver Lane, Iver, Bucks. SLO 9LH. Our 'Home Birth' Leaflet had a mention in 'The Guardian' and in the Birth/Baby magazines with the result that a reprint is being done shortly. Also available from Beverley, price 30p. A number of other leaflets are being prepared - anyone with a particular interest is invited to make themselves known to anyone on the Committee so they might lend an active hand!

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At the end of last year, I went to the United States, (complete with my 3 year old and, as then, 6-week old daughters!) and took the opportunity of making contact with our American counterparts, the American Foundation for Maternal and Child Health; the International Childbirth Education Association and the Maternity Centres Association. It was quite a struggle with my 2 little ones in tow but very worthwhile. I hope to have sufficient space in the newsletter one of these days to tell you more about what's happening on the American scene, but, for the moment, the following might cheer us all up. Doris Haire, the President of the AFMCH (see above) author of 'Cultural Warping of Childbirth' (a major work (available from the N.C.T.) which made many stop and think about so-called obstetric improvements), and Chairwoman of the Committee on Health Law & Regulation of both the National Women's Health Network and the ICEA (above) writes:- "I feel that AIMS has the spirit of challenge so necessary if women are to gain more control of their obstetric care in the U.K. and I am anxious to share what I have learned with AIMS." She offeres information about current research and practices which AIMS members are welcome to (full transcript £1 + s.a.e. but resume will be included in next newsletter). She concludes, "I am very proud of your movement and I am very anxious to work with AIMS". ---- a bit more strength for our elbow, and much welcomed.

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Our hard-working secretary, Christine Beels, has been working hard helping develop more contacts and potential AIMS groups. There are no Secretary's Notes this time and by the time the next newsletter is compiled, we shall have a new secretary. However, we are fortunate that Christine is going to continue her connections with AIMS and we should all like to thank her for the enormous amount of energy and time she has already given towards furthering, most effectively, the aims of AIMS.

AIMS GROUPS

Bristol Group News In January the Bristol AIMS Group hosted a weekend meeting of the Association of Radical Midwives. About 25 midwives and pupil midwives and other women involved in childbirth came and we got a lot of insight from talking to them. Chloe Fisher came for the day on the Saturday and showed 2 films: the first called 'Five Women, Five Births' by Suzanne Arms (authoress of 'Immaculate Deception') and describes the feelings of the women and their experiences of birth (see Page 18) The midwives present were all moved by the film because it showed the importance of the emotional side of childbirth which they often miss in obstetric care in this country. Those of us who are involved in AIMS Groups tend to forget that most womens impressions of childbirth these days are of a clinical, medical process and seeing this film would help to redress the balance. Chloe went on to show two reels of a film she and Aiden MacFarlane are making in Oxford on early infant awareness and mother/infant bonding. This was really good, one mother was filmed daily for 5 days and the change in her relationship with her baby as she realised what he could see and hear was amazing. Chloe said it had been shown to women on a post natal ward and they had rushed back and picked up their babies afterwards. Again the film would go a long way to encouraging mothers to enjoy their babies and do what feels right regardless of what the books say.

The Bristol Group has at last drafted a leaflet on giving birth in Bristol which we might just get pro-

duced in time for our stall at the International Women's Day Celebration.

Wendover Maternity Hospital which I reported on last year is again under threat but the birthrate is rising even faster and the 2 major units are both fully booked for May so more use will have to be made of G.P. obstetricians.

Research is going on at the Bristol Maternity Hospital into the effect of endorphines in labour. These are naturally produced enzymes which seem to have an effect on the control of pain thresholds. Women with a high level ask for less pain killers. If the researchers could find out how to stimulate the secretion of endomorphines it would be a great advance and avoid the heavy dependence on pethedine in our hospitals.

I would like to know how many other maternity units at our hospitals are designed on the 'racetrack' system since we have received complaints from women about being stuck in internal rooms whilst labouring. The design is to have an outside corridor, surrounding all the delivery rooms, which is used by the patient, and her attendents and an inside corridor encompassing the medical stores and operating theatres which is used by the medical staff. This means there are no windows except on the outside corridor and patients and staff have to suffer artificial light and ventilation. I think this design (obviously done by a man who knew nothing about it) was conceived about 20 years ago but it is still being repeated without question.

I would like to recount my experience of being appointed onto Avon Area Health Authority as an example to other women. AIMS were asked to help a local CHC with a campaign about a maternity hospital and at one of their meetings soon afterwards they were asked for nominations to the AHA. Not being able to nominate their own members they decided to nominate me. I had an interview with the Chairman of the Regional Health Authority - I was the only person they had never heard of! - and they appointed me in September 1979. The fact that I am young (26) and female and not a Tory went in my favour because they are instructed to ensure a balance in appointing what they call 'general' members like me. Amongst the appointments from District and County Councils and professions and unions. The work takes up about 1 day a week (I can claim expenses and subsistence for taking time off work) and involves meetings and visits to hospitals. The latter is very interesting especially as I usually get to write the reports (non-one else being keen!) and can put in what I like. I can also ask questions of the Officers on behalf of other peopke I know - I am still finding my feet a bit here.

I would urge other AIMS members to have a go. There is no reason why an AIMS branch should not write to the RHA and make a nomination (as I say they are always looking for young women!) I don't know how the AHA structure will be affected by 'Patients First' but if District Health Authorities are set up there will be even more scope for our involvement.

Angela Sutton.

Irish Group set up in late summer of 1979, now consists of 35 members. Main problem is that they are scattered over the whole country, so basically we are a 'postal' group, and we try to overcome this by producing a bi-monthly newsletter (though due to ever-rising costs, this will probably become a quarterly issue). However, besides those of us in Dublin who are able to meet together, we seem to have the nucleus of groups in Galway and Limerick, and it is hoped that during 1980 they will be able to work on specifically local issues.

We have run a preliminary survey on the maternity services here, the results of which are to be sent to all the hospitals concerned, the Health Boards, the Minister for Health, the various nursing bodies etc.

Proposals for 1980.

We intend to run a survey on the maternity services over the whole year - (copies available from Dee Nelson, 48 Wyvern, Killiney Road, Killiney, Co. Dublin).
We would like to produce some information leaflets on various aspects of the maternity services - our health services are organised quite differently to those in the U.K., so unfortunately we cannot use yours!

Talks are currently in progress with the Dublin Well Woman Clinic for a joint seminar/discussion on pregnancy and childbirth, involving the NCT as well.

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I find our main problem is having members over such a wide area - do any

other groups have this and how do they cope with it? Any comments very welcome!!

ELDERLY PRIMIGRAVIDA - A time for change?

Imagine that you are 34 years old and expecting your first baby. You have arrived at the hospital's ante-natal clinic and during your first examination the staff refer to you as an elderly primigravida. How would you feel? Unmoved, irritated, embarrassed, annoyed, infuriated?

What does elderly mean? The dictionary defines it as getting old, yet even those members of the population who could be said to be getting old i.e. pensioners, refuse to be called elderly. They prefer the title senior citizens, and has anyone ever tried referring to a mature student as an elderly student? There would be a riot. So, why do we continue to accept the derogatory, subjective, insulting, and, for that matter, completely inaccurate title of elderly primigravida?

The time has come for action, and we can begin by refusing to accept the use of this label. Why not refer to these women in a more accurate way? Why not mature primigravida? After all, that is precisely what they are.

The medical and midwifery professions are being urged to listen to the consumer. They can begin 1980 in a very positive way, by amending this description and referring to all primigravida at present referred to as elderly as mature primigravida. At lease that label (if we have to have one) is a clearer reflection of the truth.

Beverley Ann Beech.

LETTER TO THE MIDWIVES

The excellent leaflet 'Choices in Childbirth' written by the Association of Radical Midwives, c/o Haringay Womens Centre, 40 Turnpike Lane, N.8, contains a suggested letter to be attached to one's hospital notes to ensure the parents wishes are respected. It is reproduced here:-

Please attach this document to my notes so that it can be read by the midwife who attends me in labour and by any other interested party.

"Dear,

I am writing to make clear my feelings about my forthcoming labour and stay in hospital. I want to look on my labour as a normal event rather than a medical disorder. Although for various reasons I am booked into .. ... hospital, I would still like to feel that it is possible to have my baby with just the help of a midwife and no help from equipment and drugs, unless my labour proves complicated and abnormal in which case I would be very grateful for a continuous discussion about the complications and the medical expertise and equipment in the hospital.

Throughout my pregnancy I have been careful to have good ante-natal care and am practised in the psychoprophylactic technique of preparation for childbirth. The baby's father is also familiar with the technique and I wish him (or a close friend of mine) to be by my side at all times throughout my entire stay in the labour suite (whether or not there are complications).

I do not want and do not consent to the following:-

1. Shaving of my public hair.
2. An enema unless I have constipation.
3. A routine episiotomy
4. Any drugs given to me or my baby without adequate discussion and my expressed permission in each instance.
5. Any mechanical fetal monitoring.

Also I request the following:-

1. I would like very much to help deliver my baby onto my stomach.
2. For the cord to be cut after it has stopped pulsation, unless there is a specific reason why it must be cut early.
3. That after delivery, and provided all is well, my baby is left with me for as long as I want so that we may get to know her/him and she/he may suckle at my breast.
4. I would like to keep my baby with me during my stay in hospital so that I can breast feed on demand, although I would be grateful for help from the staff at any time. Should the baby need any water in the first couple of days I wish to give her plain boiled water (no additives) from a cup with a spoon. I do not want my baby to be given a bottle at any time.

I do not wish to appear antagonistic or agressive towards you and your staff but I think you will agree it is a good idea to state my wishes clearly in writing, in order that there shall be no misunderstandings when the time comes. I would appreciate it if you could confirm to me in writing that

this letter has been placed in my file.

Many thanks, sincerely yours,"

We should be most interested to get some idea about what readers and midwives reaction is to this letter.

CONTINUITY OF CARE??

I had a normal, healthy pregnancy (baby due January 1978) and saw different doctors at every visit (to York Maternity Hospital) and never met my consultant. On Boxing Day my baby girl died at birth strangled by her own umbilical cord, and I still did not see my consultant for any post-natal care or help. The doctor I saw at my 6 week post-natal check I had never met before, and only knew of my baby's death on reading the notes she was handed as I was brought into the examination room. As there were many questions I wanted to ask I feel strongly that I should have seen someone who had either delivered the baby, performed the post-mortem, or at least previously read my notes.

Post-mortem After the birth of my baby I was asked if a post-mortem could be performed while I was still heavily sedated and I agreed. The Houseman came to see me 12 hours after the baby's birth and told me that a Caesarian Section would have saved the baby as there was absolutely nothing wrong with her - but as there was no resident anaesthetist at the hospital they could not get him there in time. I asked to see my baby and was told I could not now the post-mortem had been performed as she was "not a pretty sight".

Discharged I was discharged 2 days later and my mind was full of questions with nobody to answer them. My Health Visitor came on the 10th day to see the baby as some administrative mistake had happened and she had been told I had been delivered of a girl baby but not that she was dead.

Information My main complaint about the whole event is that information about the case is so hard to obtain - and rarely volunteered. To rid you of doubts, you must see your baby and know exactly the cause of death, and to have a good discussion with your consultant where you can see your notes is essential. In fact, the hospital now has 2 resident anaesthetists (mainly due to the rise in epidurals) and I recently had another baby and was treated well throughout the pregnancy by a very sympathetic lady consultant who answered all my questions and did not assume that I was ignorant.

Ed: This AIMS member in York wishes to remain anonymous.

Ed: Continuing our policy of welcoming the contribution to the AIMS newsletter of articles by eminent and interesting people, we are very pleased to include the following, by Marjorie Tew (which has been slightly edited). As many of you will know, Marjorie has applied her expertise with published statistics to prove that large consultant hospitals are by no means as "safe" as the obstetricians would like to believe.

TOWARDS GOOD OBSTETRIC CARE

Under this title the North West Faculty of the Royal College of General Practitioners organised a day symposium on Sunday, March 2nd at Manchester University. In all 210 doctors from the region booked to attend; most were G.P's, but 16 obstetricians and 16 paediatricians were persuaded to take part,

The programme was that in the morning five speakers should address the assembly, each talking for 20 minutes and answering questions for a further 10 minutes. After lunch the participants were to divide into small discussion groups, each under a G.P. leader and including an obstetrician and a paediatrician. Then the groups were to reassemble and have a further opportunity of questionning the speakers.

I was too excited to make more than the scrappiest notes of what was said, but I believe that my recollections describe fairly the sense of the proceedings.

Women's Experience of Childbirth

The first speaker was Sheila Kitzinger. As a social anthropologist she was concerned that the process of reproduction was being directed away from being a natural stage in the continuing development of the family and society to being a medical crisis whose management must be dominated, not simply by doctors, but by highly specialised experts, whose training is disease orientated and makes them more ready to regard childbirth as a problem in applied surgery or endocrinology. The expensive equipment they use, both in antenatal and peri-natal care, is more conveniently provided in large units, to

which mothers must be encouraged to come, even if 'encouragement' is achieved by removing the choice of alternative care. She mentioned common complaints of mothers; no opportunity for informed discussion, feelings of inferiority and discontinuity of care. The latter also affects the staff who are deprived of the experience of sharing in the development of an individual normal pregnancy. Without which, where their role is to help and support, but rarely to dominate, they do not realise that the normal is not only possible but desirable.

Evidence that one act of intervention leads to another was mentioned and all forms of intervention are associated with higher risk of death and illness of the infant and of illness of the mother. The adverse consequences of undermining the mother's confidence in her own ability to cope with pregnancy and delivery may last long after the child is born; they may undermine the confidence of both mother and father to fulfil their role as parents. The objective of maternity care should be, not simply to promote the birth of healthy babies, but to encourage mothers and fathers to take continuing responsibility for caring for their whole family.

The questions which followed seemed directed less at her speech than at her book 'The Good Birth Guide', which had obviously irritated some members of the audience who claimed that middle-class mothers were now clamouring to get into the top-rated hospitals. Sheila Kitzinger observed that the obvious remedy was to improve standards in the lower-rated hospitals.

Where to be born

I was the second speaker. My approach was, as usual, entirely statistical. Using data mostly from the nationwide peri-natal survey of 1970, which was directed by the Royal College of Obstetricians and Gynaecologists, I set out to measure how much of the higher crude peri-natal mortality rate (PNMR) in hospital, which was $5\frac{1}{2}$ times the PNMR at home or in G.P. Maternity Units, could be explained by the greater proportion of births in hospital at high risk for any reason.

Some risks to the infant are because the mother is older, or has already had several children, or is of lower social class, or has had an adverse obstetric history, or has certain diseases. But even though a greater proportion of births at these moderate and high predicted risk, took place in hospital than in GPMU's or at home, this explained only a very small part of the higher PNMR in hospital.

Normal births

But hospitals have also to deal with unpredicted risks - with emergencies and cases where an abnormality has developed bringing risk beyond that already predicted. From the data of the 1970 survey a fair estimate can be made of the births and deaths with abnormality and hence, by subtraction, of the births and deaths without abnormality. The PNMR for these normal births in hospital turns out to be nearly three times the PNMR outside. Nor did the hospitals have an excess of births of low weight or with fatal congenital malformation sufficient to explain much more of the difference. Therefore I concluded that the statistical evidence casts overwhelming doubt on the claim that delivery in hospital is safer for normal births - and normal births made up about 80% of all births in 1970.

Reaction to Marjorie Tew

Such a conclusion is devastating to established belief and practice, so I feared that my speech would have a cold, if not hostile, reception. To my immense relief it received loud and prolonged applause. Clearly I had interested all my audience and delighted some of them. I answered a few questions and then, against protests, the Chairman insisted that it was time for coffee. But I was besieged by questionners, some sympathetic, some in frank disbelief.

Intervention or Interaction?

The third speaker was Michael Moore, a wise and gentle obstetrician from St. Mary's Hospital, Manchester, who questioned whether more was to be learned about the fetus and the mother by means of sophisticated instruments than by careful observation and sensitive palpation. The direct contact between doctor or midwife and mother gave a more favourable atmosphere for the mother to discuss her hopes and fears and to be reassured. There was no evidence that serial scannings were appreciably more effective in detecting stillbirth or helping to prevent it or that scientific obstetrics at delivery, were in general more effective in reducing peri-natal mortality. He stressed the importance of the community midwife in building up the confidence of

the mother in the setting where she would, after all, have to bring up her child, but the present organisation of the maternity services made it difficult for community midwives to learn and practise their total role.

Territorial rites

John Davis, Professor of Child Health at Cambridge, was next to speak. Childbirth proceeds most smoothly when the mother feels secure and relaxed. It is natural for her to feel safest in her own home. In hospital she is very much not in charge; she is anxious to win the good-will of the hospital staff by accepting their rules and following their instructions, even when seeming inappropriate. Here, however, she is less likely to feel relaxed. Obstetricians and paediatricians on the other hand are on their own territory and they feel safest there. There may be an element of professional self-interest in their advocacy of hospital as the safest place of birth. Yet it is true that after interventions, such as the induction and augmentation of labour, the use of anaesthetics and surgical procedures, the baby is more likely to have problems and in some centres paediatricians have found it necessary to treat a considerable proportion of new-born babies in special care units. But the importance of the immediate contact between mother and baby is being increasingly appreciated and special care increasingly reserved for the really frail babies. There needs to be a network of well-equipped hospitals around the country for this work. G.P.'s too should be trained to look after the new-born and to resuscitate when necessary.

Before and After

The final speaker was Luke Zander, Senior Lecturer in General Practice at St. Thomas's Hospital, London. He compared the advantages and disadvantages of the general practice and hospital settings for ante-natal and peri-natal care. The G.P. setting is less li ly to have advanced diagnostic and obstetrical equipment, but more likely to be familiar and relaxed, where the mother can develop personal and continuing contact with the doctor and midwife, with the reassurance that can bring to the whole family, He described a scheme operating in the area served by St. Thomas's, whereby the G.P's and hospital obstetricians co-operate to offer the mother the best of both worlds. Members of the audience, however, doubted that such a scheme would be practicable in districts where the obstetric hospital and the general practices were not so closely linked.

Reactions to the morning's proceedings provided animated conversation throughout lunch.

I was only able to listen in to two of the afternoon discussion groups, whose assigned topic was ante-natal care. They were concerned about the unsatisfactory organisation of their local community midwife services and about the problems of health education of expectant mothers, especially with regard to diet and smoking habits.

Unfortunately Sheila Kitzinger and John Davis had to leave after lunch and Michael Moore was called to an obstetric emergency. Thus the panel to answer questions at the resumed plenary session was reduced to Luke Zander and myself. All were, very properly, trying to find loopholes in my analysis. But all the possible explanations they had thought of I had already investigated and had the information ready to show that they were not valid. Occasionally Luke Zander, most kindly and most helpfully, took the questions in order to relieve the pressure on me, but it was clear that my statistics had aroused immense interest.

Some doctors, were obviously convinced and delighted. But I felt that I had made a real impact when an obstetrician finally said, "Though I cannot accept her interpretation, I do not challenge Mrs. Tew's careful statistics nor her obvious integrity". After so many aspersions on my competence and my motives, I cherish that tribute. But until the speaker, or anyone else, manages to show me where and how and why my interpretation is wrong and manages to produce valid evidence that a contrary interpretation is right, I shall continue to advance my own conclusions.

Summary

The day's proceedings, formal and informal, were summarised by David Metcalfe, Professor of General Practice at Manchester. The feeling of the symposium seemed to be that it was now right to doubt that, in the management of childbirth, the methods of scientific obstetrics were beneficial in all, or even most, cases. Indeed, doctors could do much to obviate the need for active intervention by their sound advice, help and support in building up the mother's health and confidence in her

own competence to cope with pregnancy and reproduction.

Personal View

I think that the North West Faculty of the Royal College of General Practitioners is to be congratulated on organising this symposium on obstetric care, probably the first of its kind in the country. My only regret was that no midwives nor administrators were invited to take part. I personally was very grateful to be offered this unique opportunity to present and defend my work before general practitioners, obstetricians and paediatricians.

Marjorie Tew, M.A.,
Research Associate,
Dept. of Surgery (Orthopaedic)
University of Nottingham.

March 1980.

PERI-NATAL MORTALITY

A quite amazing little publication by the Office of Health Economics has been published (December '79, price 30p) called 'Peri-natal Mortality in Britain - A Question of Class'. It really is quite splendid and is wholeheartedly recommended to everyone interested in this area. It attempts to illustrate some of the difficulties inherent in making accurate comparisons between nations about their peri-natal mortality rates (concluding we're really not doing quite as badly as some would have us believe) and, against Sweden's record, which has been consistently better than ours, our social class I & II rates of peri-natal deaths compare well with the Swedish average. "It is thus apparent that influences particularly affecting women in the less advantaged occupational groups throughout their pregnancies should be of special interest to those wishing to raise the British performance level".

Recommendations

Some degree of scorn is showered on British statistics, and improvements are recommended. The Briefing comments, "The government prepared statistics (OPCS) shown are based on a simple cross sectional analysis which fails to adjust for the fact that high parity, for instance, is linked to low social class. Examination of individual records actually indicates falling risk with increasing numbers of children, at least up to a total family size of 5"(!) Further, ".. the inability of English authorities to provide adequate weight data across the entire range of births stands out internationally as a surprising fault, although information is available for Scotland."

A further recommendation is "an examination of the financial support of mothers and the possible effects of cash incentives on their behaviour". It comments, "The relationship between maternal economic hardship and peri-natal mortality needs special attention as it relates to nutrition, general living standards and patterns of activity during pregnancy".

The Briefing's fourth recommendation is concerned with ante-natal care which should be designed for the poorest and most isolated mother-to-be. Local facilities with domicilliary backing are clearly desirable". Regional confidential enquiries to peri-natal death are also recommended as is "research into the most efficient organisation of services around the time of and immediately after birth". This is seen as four areas: the optimum care of high-risk mothers-to-be; the size of obstetric/neo-natal practice; the evaluation of costs and benefits of intensive care in terms of subsequent child handicap of survivors and lastly, "the subjective experience of mothers themselves" - so that "individual security and personal communcation can be fostered even within the relatively large units where at risk mothers can best be cared for". It continues, ... "for the section of the population service planners should now be most concerned with, home or near-to-home ante-natal care is the most important issue".

This is an extremely welcome document by the Office of Health Economics and appears to be recommending sound and worthwhile policies whilst revealing a number of previously suppressed points. (OHE, 162 Regent Street, London W1.)

IN BRIEF - a resume of news about maternity services

The Health Education Council has mounted a 6-week national publicity campaign including Television and Press advertising and a pregnancy testing kit to increase public awareness on the importance of ante-natal care at a cost of £600,000. It is directed especially at women in special risk categories (i.e., social classes IV and V, young, older, unmarried and immigrant mothers),

the main message is to see a G.P. in the first 8-9 weeks of pregnancy and to encourage continued attendance at all a[illegible] appointments. A Pregnancy Care Card is al[illegible] available which is designed to hold the co-op card and pose a series of questions about the pregnancy and birth. For instance, "Have I checked with my doctor about taking pills and medicines while I'm pregnant? (You must be careful not to take any medicines now unless they're prescribed by your doctor)." "Have I thought about all the questions I want to ask at the clinic? (There's space on this card where you can make a note of them)". "Am I sure I'm eating sensibly? (What you eat is especially important now. So have a look at the booklet 'Pregnancy, What you need to know' for some hints on healthy eating)". "Have I made arrangements for the family while I'm in hospital?" etc. There is also space available to make a note of the birth-day details and important telephone numbers. Leaflets, posters (in English and 5 Asian languages and a newspaper called 'Baby') are also being made available and, all in all, the H.E.C. has mounted a worthwhile and timely campaign. It covers England, Scotland and Wales, concentrating on the North, but not N. Ireland. The report on Infant Mortality and Handicap there is expected in the summer and will be followed by a local campaign. Copies of the Pregnancy Care Kit can be obtained by sending a postcard with name and address, to the H.E.C. (Mother & Baby), P.O. Box 1, Sudbury, Suffolk, CO10 6SI.

A new org[illegible]sation concerned with improving the survival chances of premature or otherwise sick babies has been formed called BLISS. It hopes to fund-raise for intensive care equipment and eventually sponsor the training of medical and nursing staff of critically ill babies. Further details of this well intentioned organisation from Susanna Cheal, BLISS, 50 Sumatra Road, London NW6.

The 1977 low birthrate of 11.6 per thousand has been turned about and it is projected that 1980 will be a boom year for babies with a birth rate of 15 per thousand - the highest since 1972. Currently it is 13 per thousand, an average of 12 000 new babies each week. Nice to know the Year of the Child continues.....

A symptomless, unsuspecting carrier of hepatitis, who unfortunately also happened to be a gy[illegible]aecologist, passed on the disease to seven women following various gynaecological operations and thus made medical history. Transmission from doctor to patient has not been reported before, and the report argues that routine screening of hospital staff would create enormous difficulties and offer little advantage. ('Lancet' 5.1.80.)

1158 appeals were lodged against decisions not to award compensation under the Vaccine Payments Act. About 300 children have received ex-gratia payments of £10,000 out of a total of 2,500. Between 500-700 of the children have been damaged to the 'required' 80% disability by vaccination against diseases including rubella, tuberculosis and whooping cough. The Government decided not to pay compensation despite a long campaign by parents for disablement pensions. (Parliament 28.11.79; 'Guardian' 15.1.80.)

Vitamin tablets for expectant and nursing mothers, sold through the Welfare Food Scheme, rose in price from 24p to 30p per container on 1st January. Childrens vitamin drops also rose from 10p to 14p per bottle. The Government has also announced that large families are no longer entitled to free milk and vitamins by virtue of numbers of children alone.
Savings are expected to be £1.8M with £2.5M saved each subsequent years. An alleged £125M is being saved through the low take-up of free welfare foods, milk, vitamins. Currently only 2.5% of those eligible are taking advantage of the scheme, said to be due to ineffective advertising, although £22,000 is spent on advertising. ('CHC News' Feb.80, 'Guard[illegible]an' 11.12.79 and 'Parliament' 6.2.80)

Two new-born baby girls were given to the wrong parents at a hospital in Almelo, Holland in November. A series of tests were underway when one died of a heart ailment at three months; her cremation was attended by both sets of parents as it was not until later that it became clear a mix-up had occurred. A health official said "One could not have expected the parents to have reacted as well as they did under the circumstances". A thorough enquiry to prevent similar incidents has been launched, ('The Guardian' 5.3.80).

The 12th report on smoking by the U.S. Surgeon General indicates a major surge in the incidence of lung cancer amongst women and the deleterious

effects on babies are again confirmed. Babies born to smokers are 6 oz. lighter on average and the more the woman smokes the lighter the birth weight. Smokers show 70 per cent higher spontaneous abortions, 36% more early births, 98% more birth weights of less than 88 oz. (5.5 lbs) and 25% more deaths close to delivery. ('The Guardian' 14.2.80)

Nurses and midwives unions are demanding an immediate cut in the standard working week from 40 to 37 hours to complement the recent Clegg pay comparability award and, unusually, this will be negotiated separately from the annual pay claim. However, it is not expected that much progress will be made. ('The Guardian' 6.3.80. et al).

The Churches Council for Health and Healing held a seminar in November on Women and their G.P's and women discussed their experiences of help given or not given in time of childbirth, in relation to family planning and in aftercare following abortion, miscarriage and stillbirth. The proceedings will be the basis of a booklet shortly to be published by the Council.

The risks of radiation to unborn children and to either of their parents is discussed in a new leaflet on 'Radiation Hazards in Hospitals', prepared by the Hospital Hazards Group, part of the British Society for Social Responsibility in Science and an advisory service to staff in the NHS. Copies obtainable from BSSRS, 9 Poland Street, London WIV, 3DG, 20p each, incl. p&p.

Britain is 22nd of 27 countries in the amount it pays in maternity grants, which has been £25 since 1969 - worth only 91p more in real terms than when introduced at £1.50p in 1911. Other countries - Norway pays £273 to single mothers £93 to married ones, Austria pays £567; France £385; E.Germany £279; Czechoslovakia £106; Iceland £94; Bulgaria £315; Hungary £72; Luxembourg £278; Albania £43; W.Germany £65; Spain £27. ('Spastics Society')

The Royal College of Midwives publishes a bi-monthly Current Awareness Service which lists all current publications on midwifery and allied topics - books journal articles, Parliamentary and other reports. £1 a single copy, £5 p.a. Free sample (February 1980 issue) for a large A4 s.a.e. (13½p) to The Librarian, R.C.M., 15 Mansfield Street, London WIM OBE. An excellent service.

A report by the standing medical advisory committee, chaired by the president of the Royal College of hysicians recommends screening (ie., amniocentesis) of all pregnant women for open neural tube defects (spina bifida, etc.) in well-equipped centres. The Government has welcomed the report but is making no extra money available. Vaughan said it is up to each AHA to decide whether to implement screening (this is currently increasing: 32% in April 1978 now 46%). The report comments about the possibility of wrong diagnosis - leading to terminating a healthy feotus, about 1/10,000) - and the possibility of spontaneous abortion or death shortly after birth following amniocentesis, and commends very careful counselling of the parents. Early attendance for ante-natal care is, of course, also critical as these tests have to be done during 16-18 weeks pregnant.

The Ministry of Agriculture has started an enquiry on the highly toxic herbicide 245T which has been linked to miscarriages stillbirths and birth deformity in the U.S. and elsewhere and is a proven carcinogen (cancer-inducing). It is banned in 5 countries, although still used here. Mixed with 24-D, another chemical linked to birth defommities in the U.S. and elsewhere, 245-T made up 'Agent Orange' widely used in Vietnam.

A video camera has been installed to enable mothers who have had difficult or premature deliveries to view their babies immediately after birth. The £1,700 needed to buy the equipment was raised by the Friends of St. Peters Hospital, Chertsey and Walton, Weybridge and Woking Round Tables. Philip Norris the Consultant Gynaecologist commented that it is invaluable in promoting the bonding process. A built-in sound link also allows the mother to question nursing staff about the infant's progress ('On Call' 13.12.79).

According to preliminary experiments by the Welsh National School of Medicine, screening for neural tube defects would cost between £5.50 and £6 per pregnant woman. This includes alpha-fetoprotein assay, genetic counselling and amniocentesis, with ultrasound. Their diagnostic success rate is 67% for spina bifida and 82% for anencephaly although these are the first, tentative results. ('Hosp. Dt.' 12.12.79).

A 'Test Tube Baby' clinic is to be established at Norfolk General Hospital, in Virginia, U.S.A. ('Guardian' 10.1.80).

The manufacturer and distributor of Morhange talc powder which killed 33 babies and paralysed another 45 have been given suspended gaol sentences from 1-20 months by a French Court after a 2-month trial and an 8-year legal battle. ('The Guardian' 12.2.80)

A reminder that 'The Loss of Your Baby' leaflet from the Stillbirth and Perinatal Death Association is available from Hazel Ann Lewis, 15a Christchurch Hill, London NW3 (01-794-4601)

The Reading Branch of the National Stillbirth Association has recently been formed whose aim is to visit and talk to recently bereaved parents. Volunteers and contacts are invited to contact Mrs. Aileen Davis, 30 Edenham Crescent, Reading. Other branches are being formed all over the country (many by AIMS members) and contact can be made via Mrs. Lewis.

The eighth triennial report on maternal deaths ('73-'75) has been recently published by the DHSS (£3). Maternal mortality rate for the 3 years was 11.5 per 100,000 (56/100,000 in the early fifties) but with considerable regional variation. For the first time since 1955 the main cause of death was not abortion (2) but hypertensive disease (eg., pre-eclampsia) (39) followed by pulmonary embolism (clots - 35). Haemorrhage ectopic pregnancy and sepsis caused the death of a further 21 women whilst 14 died from amniotic fluid embolism, 11 from ruptured uterus and 44 from "other causes". There are a number of instances where the women did not seek early ante-natal care or did not keep her appointment and this is indicted as a cause of death - which is most convenient for the reports' compilers.

The DHSS recognises that mother and baby units should be provided for the treatment of puerperal depression and psychosis (post-natal depression to us!), and has advised health authorities building District General Hospital psychiatric units that "in a 30-bed ward one or two of the rooms should be made available for mothers with babies". ('CHC News' Jan. '80).

A new fully-equipped maternity unit of two wards (34 and 28 beds) has opened at Leicester General. Last year a 15-bed labour suite, obstetric theatre and special care baby unit and ante-natal clinic were opened. Do AIMS members approve?

The total number of congenital malformations notified in 1978 was 12,906 - that is, 214 for every 10,000 live and still births and 12,906 defects too many. Of the major sites, 1,763 were malformations of the central nervous system, 1,090 of the external genitals, 4,199 of limbs and 841 hare lip and cleft palate. Chromosomal defects numbered 512. (Office of Population Censuses & Surveys)

The Governments decision to delay implementing the Nurses, Midwives and Health Visitors Act has been reversed. An order is to be laid in Parliament allowing the National Boards to be set up by the summer and the Central Council to follow in the autumn.

Papers from the 1979 conference on 'Obstetrical Management and Infant Outcome : Implications for Future Mental and Physical Development', arranged by the ICEA in New York last year can be obtained from Mrs. Rosemary Fost, 126 Church Road, London SE19. Please enclose a large s.a.e. and return any papers back to Rosemary quickly.

The Council for the Education and Training of Health Visitors has decided that the minimum amount of obstetrical knowledge and experience necessary before a student Visitor commences training is the satisfactory completion of a 12 week post registration obstetric course. This applies from the academic year '80-81. Thus the minimum midwifery experience will be 4-8 weeks maternity care and care of the newborn and general training plus the specifically designed course.

You must all, by now, have heard of the controversy raging in the American courts about Debendox, (U.S. Bendectin) the nausea-reducing drug prescribed in the early months and, until recently, freely available over the counter. In Britain the DHSS and the Committee on the Safety of Medicines considered the drug one year ago and decided there was no "hard" evidence against it. Judging from the press, who are having a field day, it seems unlikely that judgement will be in favour of the multi-national pharmaceutical company, Richardson-Merrell, who also happened to distribute Thalidomide and 3 employees of whom received suspended sentences for

falsifying reports on a drug which, it was known, provoked eye cataracts in hundreds of people. The results of the case are expected after this newsletter is complete.

STOP PRESS: As you may have read, monies have been awarded in this case, both applicants are claiming victory. The Committee on the Safety of Medicines have not withdrawn the drug, but there is a query as to whether or not they had access to all the information.

The Committee of Safety of Medicines are studying the research on Depo-Provera before approving it for general contraceptive use, despite general expectations that the manufacturer's present 3-month licence would be extended. Upjohn's application is of great interest to Schering, the worlds largest Pill manufacturer, who have developed a contraceptive injection called Noristerat. It has a similar licence, the injection lasts 2 months and it is thought the side effects are less severe.

Did you hear about the breast feeding sit-in at Harrods in February? This followed the expulsion of Anna Bowman who was asked to leave for breastfeeding her six-month old.

The DHSS Working Party on lead effects on children is due iminently. It is expected to give due recognition that the level of lead in the atmosphere is high enough to affect the intelligence of young children and may be producing harmful behavioural effects - even at blood levels well below those regarded as dangerous. The all-important aspect of the effect of high blood-lead levels in the mother on the developing foetus is also thought to be included as there is evidence that high lead concentrations are related to stillbirths. ('The Guardian' 10.3.80/'Dev.Medicine & Child Neurology' March '80).

Dr. Archie Cochrane, the distinguished Medical Research Council epidemiologist, has awarded obstetrics a wooden spoon for slow scientific development. He says: "The profession missed its first opportunity in the Sixties when it failed to randomise the confinement of low-risk pregnant women at home and in hospital (to find out if hospital really is the safest place in which to be born). Then, having filled the emptying beds by getting nearly all pregnant women into hospital, the obstetricians started to introduce a whole series of expensive innovations into the routines of pre and post-natal care and delivery, without any vigorous evaluation.

AIMS and CHC News: A comprehensive report on maternity services has been produced by Waltham Forest CHC, calling for improvements both in quantity and quality with intensive domicilliary ante-natal care for mothers in most deprived localities, better education for parenthood and a more enlightened approach to running ante-natal clinics. High Wycombe CHC has prepared a report on ante-natal services and Manchester CHC is collecting information about successful ante-natal clinic appointment systems. Macclesfield CHC conducted a survey of 328 mothers with young babies and children about the community clinic. Dudley CHC has prepared a report, 'Centralisation of Maternity Services - A Consumer Viewpoint' following a survey of 3,700 mothers and their views about the proposed closure of 2 self-contained G.P. maternity homes. One of our members, who is now Chairman of the Families (i.e., Maternity) Committee for their CHC is involved on the District Planning Team for Maternity - let's just hope (and rebel and rant and rave!) that our CHC's are maintained and not swept away in a cost cutting operation. (See also British Group News)

RESEARCH

Expectant mothers affected by hypertension may be wasting their time if they follow traditional advice and take to their beds to rest as the value of hospitalisation or rest in bed is unproven except for women with very severe symptoms which can be self-diagnosed, according to 'Drugs and Therapeutics Bulletin' (Vol.17, No.24 1979). It concludes, "There is no proof that rest improves the outlook in women with moderate non-proteinuric hypertension, and some evidence that it does not."

Doctors in both Britain and the U.S. have determined that sexual intercourse during pregnancy, particularly the last month is associated with an increase in birth complications, such as breathing difficulties or juandice. The findings suggest advice generally given that intercourse is harmless during pregnancy needs to be revised. Of 70 primips studied at Barts, 75% had intercourse until the 32nd week dropping

to 33% in the last few weeks. Of 13 babies distressed at birth - mainly respiratory, 11 were from mothers who had had intercourse during the preceeding four weeks. Evidence from 27,000 pregnancies studied in U.S. suggests an increased risk of womb infection resulting in pneumonia, septicaemia or premature birth - causing about 1 in 5 deaths of babies before birth or during the first week of life. The placentas were examined and it was found that the risk of infections and of babies dying was about doubled when women had had intercourse in the last 4 weeks prior to the baby's birth, irrespective of whether the baby was premature or full-term. This was particularly so after the 38th week when the baby's head had engaged.

The fluid intake and weight gain of 39 breast-fed and 23 artifically fed babies were compared by test weighing in ward conditions in a study at Birmingham Maternity Hospital. All were fed every 4 hours, 6 times a day and the breast fed babies only received dextrose supplements. It was found that the average intake and weight gain of the breast fed group was significantly less than that of the artifically fed group. The study concludes that a four-hourly regime provides insufficient stimulus to lactation for their (i.e., the babies) needs in the first week of life. If more than lip service is to be paid to the mother who desires to breastfeed in hospital, early and more frequent feeding should be practised. (BMJ. 13.10.79)

A Glasgow study suggests that breast-feeding may be safe with modern anti-thyroid drugs, providing the dosage is small and the baby's circulating anti-thyroid hormones are closely monitored. ('Lancet' 10.11.79)

A West German study suggests that thyroid hormone administered to critically ill low birth weight or premature babies lowers mortality and protects against respiratory distress syndrome. ('Lancet' 1.12.79)

An Australian study on the season of birth of babies born with congenital abnormalities indicates a possible link between excessive heat in the first 3 months of pregnancy and disorders of the central nervous system.

The 'Lancet' (23.2.80) queries if there is a "danger of causal intervention casual?" (Something that AIMS has been seriously concerned about for some while.)

The article goes on, "A survey of caesarian-section rates in Australia suggests this possibility. In 1963 the rate was 2.2% increasing to 12.1% by 1976 and 14.6% in 1978; this trend seemed to reflect the increasing number of obstetric specialists over these years. Such an increase in operative delivery night have been undertaken to improve peri-natal mortality, but this does not seem to have been the result. In Tasmania 90% of all births in the private sector are managed by specialists rather than general practitioners and the section rate is 7.3%; yet Tasmania achieves a similar peri-natal mortality rate to Queensland where 20% of the private births managed by specialists ends in a section". It is suggested that "the pattern of obstetric care in Australia are being determined by fashion and other non-clinical factors quite as markedly as by new developments in obstetric care".

Peri-natal deaths in Scotland have been investigated; out of 1,012 deaths, 265 were due to feotal abnormality, which in 140 cases was malformation of the central nervous system. Of the 747 normally formed infants, 446 weighed 1500 g or more, of whom 82 died intra-partum and 154 were born alive. The largest single cause of death was low birth weight in normally formed babies who mothers had no complications of pregnancy (302 cases). Of these babies, 103 (34%) were growth-retarded. Rhesus incompatibility (16 deaths) and maternal diabetes (7 deaths) were not major causes of peri-natal loss. (BMJ 3.11.79)

The human placenta is likely to be used in toxicity testing of drugs and chemicals rather than the sacrifical animals currently used. The proceedings of a round table discussion on the placenta by several research institutes around the world was held at Bedford College, London are now published, 'Placenta - a neglected experimental animal'. Permago Press, and an article on Induction in the 'Journal of Maternal and Child Health' (Jan.'80) comments, "During the last three years there has been considerable doubt about the wisdom of the liberal induction policies which have been in vogue recently. We believe (Williams & Studd, Registrar and Consultant at Kings College and Dulwich Hospitals) that the common 40% induction rates create many cases of abnormal labour and consequently

are responsible for higher caesarean section rates. These policies cannot be justified. Our induction rate ... has been 8% from mid-1977 without any stillbirths being attributed to this "active non-induction policy". Bravo!

Very welcome news is of a project based at Leeds University which has indicated that neural tube defects can, at last, be prevented - by the taking of a standard multi-vitamin preparation called Pregnavite Fort F. This was taken for 4 weeks before conception and continued until at least 2 periods were missed by women who had previously had a least one child with a neural defect and for whom the likelihood of having a child with the similar condition was above average. Amniocentesis was used mid-way pregnancy to check, for both the control and the experimental group. Of the 178 women taking the preparation, only one baby had a neural tube defect, whereas 13 babies/foetuses were delivered to the 260 comparable control group (i.e., the normal 5% recurrence rate). It is speculated that further research will show that some women should take the vitamin longer before pregnancy. ('The Lancet' 12.2.80/ 'Times' 17.2.80)

Apparently, oxygen in the baby's scalp bears scarcely any relation at all to the oxygen in the blood. ('Lancet' 24.1.80). What then, are our obstetricians doing as they continue to wire-up labouring women and push electrodes into the as-yet unborn babies heads? This newsletter (Summer 1979) carried reports that foetal monitoring was unsafe and that heart rate changes were not found to be related to the Apgar score and yet monitoring seems to continue unabated - and with how many unnecessary Caesareans ?

HOME DELIVERIES

'The General Practitioner' (11.1.80) carried an article 'The Gooseberry Bush, the Stork and the G.P.' by Dr. Robert Rouse of Colwyn Bay who calls for the abolition of the G.P. obstetric list. He comments, that home births are far rarer even than deaths in the home and that despite the vocal minority for home births hospital deliveries are on the increase and even if a 3-fold increase in home confinements hospital deliveries will still account for 95%. He feels G.P. obstetrics have been hit by the fear of litigation, group practices allow much more time off whilst home deliveries don't; a lack in experience and practice inevitably brings about reluctance and that anything learnt on a 2-week refresher course will soon be forgotten anyway! 'The General Practitioner' suggests that the logical answer is - "all obstetrics, including home deliveries, should be under the care of the local maternity hospital. The district midwives would become part of the hospital team and any G.P. who wanted to retain the right to deliver his own patients and keep in practice would have to become a clinical assistant, on call at night and at weekends in the hospital. A special team, possibly including the general practitioner, would handle all requests for domicilliary confinements.

This shift of responsibility to the hospital might paradoxically make it easier for women to deliver at home; an obstetrician with up to date experience would be more confident of coping with problems in the home than a general practitioner whose skills are fast becoming dated.
What do you think?

'Pulse' (15.3.80) carries an editorial about 'The Delivery Dilemma' which carries on the above theme in line with the gentle rivalry between G.P's and consultant obstetricians and the ongoing argument about who can best deliver our babies. It suggests that the G.P. who gets real satisfaction from obstetrics should acquire a post as clinical assistant attached to a consultant obstetric unit. It continues: "He can care for his patients unworried by the likelihood of life-threatening emergencies, happy in the knowledge that his practise arrangements allow for his hospital sessions without detriment to his other patients.

His mothers get the rest they require; care from the doctor they know, and his sessional fees are an adequate recompense for the work he has to do.

The argument about who is responsible for the peri-natal deaths will disappear, and both sets of professionals will be able to work together for the benefit of their patients.

Comment from the Office of Health Economics Briefing on peri-natal mortality in Britain, (see page 8): "There can be little doubt that for low risk patients with good housing facilities such care (home deliveries) can be desirable. Indeed, peri-natal and maternal mortality in relation to

such cases is low, in part, perhaps because of reduced risk of cross infection".
Well, Well - isn't that good to hear. At last, Marjorie Tew's message - and that of many, many others, is getting through.

Cambridgeshire Area Health Authority has established a Working Party with medical and nursing representation to consider how best to provide medical support to midwives who attend domicilliary confinements. AIMS help has been sought but local members might also like to have a further say.

BOOK REVIEWS

'The Quality of Life: The Peckham Approach to Human Ethology'
Innes H. Pearse Scottish Academic Press 1979. £6.50

The passing of time, or our sense of it, plays some very curious tricks - we congratulate ourselves (should we allow this optimism to supervene on the confusion in which life is normally clothed) on the marked contrasts between our ideas on such things as home birth, breastfeeding, sex education, contraception, whole food diet, self-regulated learning and community life - in short, the complete 'alternative' pantheon - and those of a previous rather regimented and unenlightened generation.

The book did not initially arouse either my interest or my sympathy. It tells of a discontinued experiment, something passe, smacking even of quaintness and crankiness. But I was in for a humbling. We cherish notions of progress. This account, in oddly unpublicised fashion (it is certainly the stuff of which promoters' bandwagons are made) and most effectively, knocks those notions sideways. It is also an indictment. Behind the Peckham investigations into human health lay a revolutionary idea: that mind and body are an indissoluble whole; and that an individual's environment is as much a part of his/her life, in sickness as in health, as the pain in his chest or the lump in her breast.

The revolution in health care that should have followed is still being postponed, thanks to our National Health Service, its structure and its constraints, politically imposed. Perhaps the revolution cannot happen under its aegis at all - the Minister of Health at the time decided not to rescue the Peckham Health Centre from its financial brink, and for the most perverse of reasons. So it closed. Perhaps the NHS hardly deserves its middle name - National Illness Service would be more appropriate; we are caught up in a sickness spiral, and have no time or cash for health. Ridiculous? Of course.

Health Service

The Peckham Centre was a brave and evidently successful attempt, on a number of criteria, and before the NHS was a beam in anyone's eye, to observe, understand and establish what makes a healthy individual, family, community. Not as preventive medicine, but because it is better to be healthy. Better, not less draining financially nor any other 'concrete' justification; though I don't doubt that there was also a predisposition for some kind of social engineering in the minds and hearts of Innes Pearse and her husband George Scott Williamson. It would be unsurprising and only human if there were, when their scientific view of people was of whole individuals with functions and purposes, not as agglomerations of biochemistry, mechanics and psychiatry. But more of this later.

Imagine, meanwhile, a spacious, airy building in a quiet backstreet of South London, between the wars. Your children come home one day and say they want to go swimming there in the indoor pool - some of their friends already do. You go along; and discover that all of you, all the family, have to join, and you have to pay a small sum every week to do so. What's in it for you? You've just had another baby, and don't get out much, can't be bothered with getting to know new people. And on top of that, you have to have a health examination! But then you take a further look around - you are impressed, despite yourself, with what you see: there is a whole area, safely fenced off for the babies but from where you can see everything else that's going on - it's tea-time, and the tinies are drinking milk and eating apples, or still suckling. Some of the mothers are using sewing-machines; and a couple of women whose pregnant stomachs make them breathless are sitting down chatting to 3 or 4 new mothers. You stay and have a cup of coffee in the cafe - some of the men on early shift are drifting in, for a quick game of darts or billiards. It seems very friendly - and the building is so pleasant, open-plan.... Yes, why not?

And you persuade your husband to come along the very next evening.

Investigation

The Pioneer Health Centre in Peckham was a continuing organic investigation - it was indeed health centre, community centre and the best of analytical laboratories rolled into one. The practitioners were the theorists, the subjects were the patients, participants, club members. They were people "living their ordinary lives undisturbed"; this was entirely necessary for the experiment. All the members had to agree to do was to join the Health Centre as a family and to have as a family an initial health examination and subsequent periodic check-ups. The entire approach would seem to fulfil, posthumously, a desideratum of the '70s whose accent has been on alternatives to pills, piecemeal 'treatment' and the mechanistic view of life. But this was no idyllic pastoral commune, but South East London, a predominantly working class population and the 1930s - a decade not remarkable for its economic expansion or its political libertarianism.

Such a break with conventional practice reflected and entailed a different theoretical basis. The book begins uncompromisingly by rejecting outright "the common assumption that an understanding of the nature of health can be wrested from ... the science of disease and disorder." Health is not the prevention of illness and a study of it must take place among ordinary people going about their normal business. Our doctors are accustomed to seeing us only when we are unwell, and our consultants when we are very ill - they have nothing, no criterion save an inapplicably general one, no touchstone of us as individuals, by which they may say how we ought to be, how we have deviated, or how we have not, from that state which is unique to us. They have only their tests, which may prove as fallible, it seems, as tossing a coin where diagnosis is concerned. They have some expert knowledge at their disposal, we have, if we allow ourselves, the particular understanding born of familiarity; Pearse and Williamson and their team closed the gulf a little.

Communication

Pearse unambiguously tells us that their scientifically trained minds had to forgo controllable analysis for dream, to express their findings in 'poetry' rather than statistical tables. Above all, the workers were part of the experiment they were doing - consciously and continuously, they were giving the lie to that jealously guarded fantasy of objectivity with which the medical profession still tries to defend itself. They were attempting to create a new language, too, precise but qualitative rather than quantitative with which to formulate the newly-perceived reality in front of them. Now, some of this language has an odd, almost nineteenth century, ring to it - eutropy, aesthesia, bionomist, the emphasis on the foetal yolk-sac - but much of what they said is more than relevant to us and the crisis in modern health care.

If more argument is needed, there are examples of contributions to more conventional medical knowledge, such as the connection they found between contracted rubella and dysmenorrhea: they knew, of course, about its connection with foetal abnormality, and decided to investigate further. Several adolescent girls who suffered pain with their periods were found to have caught German measles shortly before. I don't think this connection has received wide study. They also found a demonstrable, but as yet unquantified, correlation between immunity to infection and the psychological and social 'environment' of the individual - in other words, catching 'flu' doesn't entirely depend on whether you've sat next to someone who sneezed on you; but on your state at the time, your relationships, obligations, self-image, etc. etc. We have all sensed this to be true at some time or another, but it is not part of orthodox theory. As a final example, at a time when more and more women were staying in hospital for the births of their babies because their own homes were 'unsuitable', Pearse and Williamson arranged with the local hospital, King's College, that the Health Centre should look after its own women, provided they were in good health, except for the actual delivery and for the two days following, when they would would be in the maternity ward of King's. This was the first use in this country of a planned 48 hour admission for labour, and has proved its worth as an alternative to the 5 or 10 day stay in the decades since.

There are things with which to take issue; and here the charge of a bias towards social engineering has to be made. Pea e and Williamson had certain view about humans, males and females, families - and they were of a rather standard type. The two of them stand revealed for good Scottish burghers, trying to make time stand still. But one shouldn't be misled into supposing

that the sexual stereotypes they set up for us to admire and aspire to have no power! Their notion of 'functional complementarity' is alive and unmistakably kicking; we say 'equal but different (and therefore unequal in reality)'. There is a normative view of sexuality - the heterosexual married couple - and a prescriptive analysis of male and female roles within the couple, a unit which 'naturally' goes on to breed a family. This is homespun philosophy masquerading as research nd comes dangerously near propaganda. Had they pursued their more valid materialist approach in this direction also, they might have exposed the idea of accepted gender differences for what it was: another 'common assumption'.

Quick Revolution

But one would be most unreasonable in demanding that these people tackle everything. What they did achieve was astounding, their quiet revolution in scientific theory, medical practice and social relations. Their way had, and has, obvious political implications (obvious to us if not to them) - to put them in the negative, it was non-hierarchical, non-divisive, non-authoritarian. It may be that we are only just now ready for it, but we certainly need the Peckham experiment back. Not as an experiment but as a blue-print for a revived NHS; we haven't the money (or at least the will to collect it and to outlaw privilege) to carry on as we are, which heaven knows is not ideal. We have a number of choices: among them are that we may watch the NHS dwindle into an inefficient pilldispensing automat, not active but palliative; or we may try to use what influence we have to encourage something like 'Peckham' to take root across the country, side by side with self-help groups. But make no mistake - this means we must gain control, power. To quote Williamson, 'Authority and responsibility are mutally antipathetic.' The self-interested apparatus of the medical profession will close ranks against us (and perhaps the original brief even of the nationalised medical programme was never explicitly humanitarian or egalitarian enough). We need confidence in ourselves.

It may therefore help to be aware that it was the parents at Peckham who eventually decided to open and run a 'Peckham' school; and that, even after the Centre itself had to be closed down, the nursery was maintained, for 24 years, by the parents.

It was never a part of the Pearse-Williamson scheme to keep power out of people's hands, but rather to given them access to the knowledge which is power.

Lesley Saunders, Slough.

'Health Rights Handbook' - Gerry & Carol Stimson. Penguin £1.25

A useful little handbook written on the basis that "Your body belongs to you and only you should decide what to do with it and what to have done to it". It covers such things as "How to find and choose a G.P.", "consent to Treatment", "psychiatry", "sexual medicine", "complaints", "the politics of health" and a chapter on "alternative medicine" amongst many others.

The chapter on Childbirth is rather brief and it does have some glaring omissions, AIMS being one of them, but the authors do ask for comments, so hopefully the reprint might be a little longer. On balance a helpful reference book.

Beverley Ann Beech

'Nurseries Now' - Hughes, Mayall et al. Pelican £1.95

This paperback combines a consumer's guide to what nurseries are available with a critique of the gaps, anomalies and divisons in the present system. Mother's views, recent research, international comparisons and examples of new approaches by parents and workers are included.

List of Forthcoming Publications

Richards, Martin.
'Infancy: world of the newborn'
(Life cycle series)
Harpel & Row 1980 £2.25 p.b.
(To be reviewed in next newsletter)

Cobb, John
'Babyshock'
(Problems of the new mother, for first 5 years).
Hutchinson, April 1980. £5.95

Williams, Margaret & Booth, Dorothy
'Ante-natal education: guidelines for teachers'
Longman, 1980 £3.75 p.b.

Mayle, Peter
'How to be a pregnant father'
MacMillan, 1980 £5.95

Noble, Elizabeth
'Essential exercises for the child-bearing year' New edition.
John Murray, 1980. £4.50

Lander, Anne, ed. (for the N.C.T.)
'Pregnancy and parenthood'
Oxford U.P., May 1980. £1.95 Oxford paperbacks. (To be reviewed in summer newsletter)

Feher, Leslie
'Psychology of birth: the formulation of human personality'
Souvenir Pr., 1980 £3.95 p.b.
(Condor books)
(Personality is moulded by manner of birth, e.g., Caesarian, forceps.)

FILMS

'Getting to know each other' (22 mins)

'Changing Days' (19 mins)

Both films were made a Oxford's John Radcliffe Hospital with Dr. Aidan McFarlene as Medical Adviser and Chloe Fisher as community midwifery advisor providing the commentaries. Available for hire with helpful leaflet, one at £7.50 (+ VAT) or both for £10.00 (+ VAT) from Farley Health Products, Torr Lane, Plymouth, Devon PL3 5WA

'Five Women, Five Births' (29 mins) by Suzanne Arms, author of 'Immaculate Deception'

Black and white still photographs celebrating five very different birth experiences (alternative style birth in hospital with obstetrician; natural birth in home with family doctor, Leboyer-style; unmedicated vaginal breech in hospital with obstetrician, caesarean birth for breech, home birth with midwives, family and friends). Available from Concord Films, Namton, Ipswich, Compelling viewing.
(see also page 2)

MEMBERS' VIEWPOINT

We received a very nice letter from one of our American members who comments:

"Two months ago I returned from having completed a year long independent study on northern European midwifery and will be continuing onward to receive training in nurse-midwifery in the United States. Although I am not always pleased by the present situation and developments in maternity care in Britain (that damned Prof. Brant for example), it is very useful to keep in touch with what is happening abroad. (Yours is one of the most informative and up-to-date publications on the subject which I am aware of in northern Europe.)

The resurgence of midwifery and nurse-midwifery in the U.S. is truly exciting - a quiet revolution which is already having a significant impact against the super powers of the MAM and other dastardly organisations. Birth Centres and alternative childbirth programmes are springing up all over the place. I only hope that the impact will be felt in Europe before routine hospitalisation and technical labour and delivery completely take over the maternity scene.

I encourage you to continue your noble struggles against The System, for the improvement of maternity services and applaud your many accomplishments.

Of course I'll renew my subscription!

Best wishes and Good Luck!"

Maggie Willett, Colorado.

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'What do they Really Want' - Two other views

'WHAT DO THEY REALLY WANT'

Sue Dale Tunnicliffe's remarks about fathers (AIMS newsletter, Winter '79) seem to me to be essentially superfluous. As she herself says, there is a vast spectrum of attitudes, from the totally involved to the man who wants nothing to do with pregnancy and birth. I don't see that this is a problem, except that in a few cases where severe emotional disturbance follows the conception of a child.

Why can we not practice what we constantly preach to hospitals, and cater for all individuals, whatever their attitude? I teach couples and unaccompanied mothers together, with no uneasiness. Fathers come to as many of the classes as they like, and are not pressured at all. I find myself doubting the wisdom of teachers who insist on 'couples only', almost as much as those who only have one fathers' evening. Who are we to dictate?

My own husband has avoided the births of all three of our children, by mutual understanding, and yet has been thoroughly involved in their care from birth onwards. On the other hand, if fathers

are a little jealous of the attention and excitement that centres on the mother, who can blame them? A child has two equal parents - many fathers feel they have to fight to claim their rightful share in the baby.

Sue Dale Tunnicliffe's point, that as the mother is the only parent who can guarantee to be at the birth she should therefore be entirely self-reliant is very dubious. I have only encountered two instances where a father has missed the birth after attending all the classes, and in neither case was the mother left high and dry for lack of support. In my classes, both parents practice the relaxing and breathing, not just the fathers!

My plea is for wholesale tolerance and flexibility. We are not here to dictate to people how they should feel, but to help them to develop their own personal reactions, in their own way. No attitude is more valid than any other, in my view.

Rebecca Smith, BA.,
NCT Teachers/AIMS member/
Breastfeeding counsellor,
Pulborough.

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The birth of a baby is much more than the beginning of a single new life - it is also the birth of a family.. As such, shouldn't the first priority of ante-natal education be not to the prospective mother, as Sue Dale Tunnicliffe maintains, but to the family unit that is being created?

Certainly it is the mother who will be most physically involved in labour. But birth is not solely a physical experience. The emotional meanings of birth are deep and powerful, and to relegate fathers to an observant, less informed and responsible role is to immediately establish limits to the sharing of parenthood in all its joys and responsibilities.

Certainly there are some mothers who have no support from the father. But these mothers do not exist in a void; there are other people in their lives who give them support and understanding. In such a situation, the childbirth educator must be sensitive to the fact that the family that is being born may have a different structure from the traditional nuclear family, and encourage the involvement of a significant person to give support to the mother.

Ms. Tunnicliffe is also concerned that by involving fathers there may be cases where the father "takes over the labour", denying his partner the emotional growth of pregnancy and childbirth. Surely such a situation foreshadows problems in sharing all of parenthood - problems that are best dealt with when they first arise, helping the couple to come to a new balance of their roles. rather than by initially avoiding them only to leave the tensions to plague the new family.

For the fathers, it is inadequate to say that they can come along to a session or two for an instant summary of what is being discussed by the mothers, and then have their own discussion groups if they want to talk about being fathers. This is a sort of sexual apartheid that limits the man's possibilities for growth and real participation in the nurturance of his children. We need to talk not ob becoming mothers or fathers, but of becoming parents. And we need to not only allow fathers to be involved if they request it, but to actively encourage and expect their equal participation, if only to counteract the lifelong pressures separating them from involvement and enjoyment in childcare, from their first reader where Jane gets a doll and Peter gets a crane to the notices about a Mother and Toddler group. How many fathers have come along with little enthusiasm to the first sessions of a couple-oriented course, only to emerge delighted to find that it is indeed acceptable for them to have a real and pressing interest in the development and birth of their child?

And for the child - how much better to be born to two parents confident and ready to care for the new life, aware that, however they y choose to allocate daily responsibilities, it is their new family that is being born.

Nancy Stewart.
Choices in Childbirth
Lancaster/Morcambe.

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You might recall, 'Thoughts of Someone Not Yet Pregnant' (AIMS newsletter Autumn 1979) which provoked a reply in the last issue and a great deal of subsequent interest. You will be pleased to hear that Ange got pregnant shortly after writing the initial article and has recently been delivered of a fine healthy daughter. She writes,

after a lovely pregnancy..., unfortunately, during the last 2 weeks, my blood pressure started to rise and kept rising until it reached 160/110 - I'd been resting in bed all morning when it had risen to that figure. My G.P. immediately set about getting me admitted to hospital. I was very upset about going but did not want to insist on staying at home and making things awkward for my G.P. I really do believe my G.P. was prepared to attend me at home and wasn't 'having me on', he was very sympathetic and made it possible for Bob to stay with me all day and every day at the hospital as well as arranging for me to be in a small semi-private side ward. He had told me he had a feeling I'd need a forceps delivery and so, was going to look up and clean his instruments as he hadn't delivered a baby for about 20 years, (he delivered me!), he seemed quite happy about it and made sure I realised the risk involved.

Anyway, I was admitted to hospital with pre-eclamptic toxaemia and have to confess that it was much better than I'd anticipated, I hasten to add though, that I still hated every minute of it". Ange was induced by ARM at 38½ weeks, with her husband present throughout Ange says, "I 'got away' with only (? - never realised QUITE how painful they are), an episiotomy" and she was home the next day. She concludes, "I shall still try for home again next time, hopefully it'll be easier then as it'll be a second baby. This time was a disappointment but Hayley is O.K. and everyone was as pleasant as they could be and for this time, that's the main thing.

As regards the reply to my letter printed in the most recent AIMS newsletter, I didn't feel foolish that my doctor was sympathetic - he knows me very well and is a very understanding person so I didn't expect him to react harshly. I was agreeable right from the start, to going into hospital if it became necessary through medical reasons and as a home confinement had long been my aim prior to pregnancy, one can hardly can hardly call it 'emotional ranting' as it had all been considered and planned very calmly and, I would like to think, reasonably; besides, childbirth is a very emotional thing and one must look at the emotional side, maybe if it was more seriously considered, hospitals would be far more agreeable places to many of us".

Congratulations Ange - and we're pleased to hear of Hayley's safe arrival.

HELP PLEASE

As a mother of 2 young children I am very concerned at the lack of baby feeding and changing facilities available to mothers travelling in this country. Whilst it is evident that mothers manage in this situation, and indeed some deomonstrate great ingenuity in doing so, I am sure that where facilities are available most mothers would prefer to use them - the problem is that of finding them. Because of this I have decided to compile a guide to help mothers locate these babycare facilities which do exist, and I am hoping that members of AIMS might be able to help me with this project.

I need information on a nationwide basis of baby feeding and changing facilities to be found in such places as Shops, Stations, Tourist attractions, Motorway Service Stations, Public Conveniences etc. The type of information I need is:

Names of places, opening times, facilities available in..... place. This will at least save other people looking for them!

Please don't feel that your information is too basic to send me - I need all the details I can get to make this a really worthwhile guide.

I shall be collecting information all this year so take pencils and paper with you when you go on holiday!

Gill Reeves,
3 Malcolm Road, South Norwood,
SE25 5HE

SUBSCRIPTION MEMBERSHIP

I wish to join AIMS, and enclose my subscription (suggested £1.50p minimum for individuals and families, £3.00p for institutions) for one year.

JOIN NOW - IT IS GOING UP IN MAY

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I enclose a cheque/P.O. for .....
To: Ms Leslie Batchelor, Hon Treasurer,
67 Lennard Road, London SE20 7LY

A complete list of officers will be published in the Summer edition following any changes on the 19th April 1980.

Editor.

Whilst 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.

Copy for the Summer issue should reach the Editor by Friday, 6th June 1980 at the latest. Copy must be typed please, on one side of A4 paper with double spacing. Articles, news items, accounts and views are all welcomed.

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