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| Midwifery for All  Or  Midwifery for None?  **Marie O'Connor** |  | **An Introduction to the Aachen Declaration**  Dublin,  October 2000 |
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Midwifery for All

            Or

                Midwifery for None?

Maternity care is in crisis throughout Europe, yet maternity policy rarely forms part of national or international health agendas.  Some countries, notably Ireland and France, have been experiencing a veritable 'baby boom'.  In some maternity hospitals, standards of service provision have been compromised to an unprecedented degree due to increasing demand, an escalating shortage of scarce resources, and in particular, a growing shortage of midwives.  Such are the current shortfalls in hospital care, both in Western and Eastern Europe, that the physical and, indeed, mental health of women in childbirth, and their babies, may be at risk.

**Maternal and infant mortality**

Maternal mortality in European hospitals continues to be a matter for concern. In Ireland, maternal deaths accounted for 8 per cent of all maternal negligence claims taken against obstetrician/gynaecologists from 1978-1998 **(**The MDU Ireland**,** 1998).  There is some evidence that shortfalls in standards of service provision may result in perinatal fatalities.  In 1995, the British Confidential Inquiry into Stillbirths and Deaths in Infancy analysed the deaths of 873 normal term babies who died in labour: in over half of these cases, it was estimated that better care *would reasonably have been expected* to have made a difference to the outcome  (Department of Health, Britain, 1998).

**Postnatal health**

Little is known about the health of women after birth.  For many women, the transition to motherhood can be difficult. Although no reliable national data exist, studies on postnatal depression give rates varying from 8 to 25 per cent (O'Connor, 1995:186).  Postnatal depression is associated with the use of obstetric technology in birth (Oakley, 1992:277-279).  Although the promotion of breastfeeding forms part of health care policy in many Member States, breast-feeding rates continue to be low throughout much of Europe.    In Member States where the breast-feeding rates are lowest, such as Ireland, community-based postnatal care does not form part of official health care systems.   Spiralling health care costs have led to the introduction of cost-cutting measures in hospital  care, such as early postnatal discharge, with mothers leaving hospital sometimes within hours of giving birth.  Such measures, without the concomitant provision of midwifery services at community level, result in significant deficits in postnatal care for new mothers and their babies.

**Centralisation, rural women and induction**

Maternity care is the only sector in health care where, with the exception of The Netherlands, the primary health care provider has been all but obliterated. Despite the fact that as many as 80-85 per cent of women have uncomplicated pregnancies and births, many European national health and insurance systems favour specialist obstetric care for pregnant women.

The 'new' public health, dating from the late 1970s, recognising the right of citizens to autonomy in matters of health, and transforming the 1950s curative, hospital-based approach into a strategy of prevention and promotion at community level, has yet to be fully implemented in most Member States.  In some countries, official health care policies compel healthy, pregnant women to place themselves under specialist, obstetric supervision.  Such policies require the centralisation of the birth services.  There is some evidence to suggest that centralisation may be increasing.  In France, for example, maternity hospitals with as many as 1,500 births  annually are now being closed (Les Dossiers de l'Obstetrique/Espaces Naissances, 2000).

National health policies centralising maternity services discriminate against childbearing women in rural areas.  They deny women access to safe, appropriate maternity care.  Centralising birth results in unplanned out-of-hospital births. In Ireland, for example, a national study shows that the rate of planned to unplanned out-of-hospital birth is 1:1 (O'Connor, 1992:10-11).  Unplanned out-of-hospital births carry very high mortality rates.  Centralising birth also results in the targeting of rural women for induction. Local obstetric protocols underpin national health policies: many women in rural areas have their labour induced for geographical rather than medical indications.

The recent EU Directive, adopted in June 2000 (2000/34/EC), will reduce the working time of doctors in training to 48 hours per week by 2009.  This Directive is widely expected to result in the closure of obstetric units throughout Europe, thereby exacerbating the established trend towards centralisation of maternity care throughout the Member States.  This will result in more and more babies being born in fewer and fewer units, with more and more women travelling further and further to give birth.  In Britain, for example, plans for the closure of almost 200 obstetric units are well advanced.  Despite the anticipated closures, however, maternity care policies in the vast majority of countries are still being framed within the traditional specialised medical, hospital  care model.

**The Caesarean epidemic**

As health care budgets career out of control, the economic and social costs of this centralised model of maternity care for physiological birth are becoming increasingly unsustainable. Nonetheless, the provision of maternity care at primary level by midwives is uncommon, except in The Netherlands.   Within the specialised, hospital or tertiary care model which is  in force  elsewhere, birth is treated as a medical problem.  This has led to huge amounts of unnecessary and costly medical intervention.  Rapidly rising Caesarean section and instrumental delivery rates have become the norm throughout Europe.  Since 1980, national Caesarean rates in some countries have doubled, and in some hospitals, they have gone up four-fold.  France currently has a national Caesarean rate of 30 per cent (Lonzac, 2000), while the combined operative and instrumental delivery rate in Spain is 40 per cent (Wagner, 2000).

A call for the surveillance of operative births was made by WHO as far back as 1985 (WHO, 1985:21).  Despite the considerable variation in local and national Caesarean rates, neither local nor national surveillance systems have been implemented in Europe. Moreover, in many Member States, the collection and publication of data on operative and instrumental deliveries, both in publicly funded and privately owned hospitals, is discretionary.

The continuous use of electronic fetal monitoring (EFM) in labour is still commonplace in many countries,  despite substantial evidence and national guidelines contraindicating its routine use (RCOG/NCT, 1993). EFM is used on 90 per cent of all women in labour in Spain (Wagner, 2000).  In Ireland, the routine use of EFM on admission to the labour ward (Cuidiu, 1999:12) has increased. Electronic fetal monitoring has been identified by British obstetrician/gynaecologists as one of the main factors in the growth of Caesarean rates, second only to fear of litigation (Francombe and Savage, 1993). The variation in individual obstetric Caesarean rates has been estimated at 0-50 per cent (Sakala, 1993).

**Active management of women in labour**

Although high rates can no longer be regarded as good practice, the induction of labour continues to be common, as does the practice of acceleration.  There is some evidence to suggest that these practices are becoming more widespread.  In France, for example, recent years have seen a doubling of national induction rates, from 10 per cent in 1981 to 21 per cent in 1995 (Desbouvrie-Bertaud, 1999).

Both induction and acceleration in hospital are accomplished by means of the same drugs and/or interventions.  Amniotomy, for example, is used both to induce and to accelerate labour.  Amniotomy involves puncturing the protective waters surrounding the baby in the womb with an instrument resembling a crochet hook.  While women's views on the management of their bodies in labour are rarely sought, some studies show that women find this procedure repugnant.

The acceleration of labour is a cornerstone of the 'active' or aggressive management of women in labour so prevalent in many Member States.  *Active management* is a set of obstetric protocols  standardising the medicalisation of first births. It comprises early amniotomy, high-dose oxytocin (Frigoletto, 1995) and one-to-one 'nursing', the term it uses to denote midwifery.  At the National Maternity Hospital, a leading Dublin hospital dedicated to active management, 50 per cent of all first-time mothers (Cuidiu,  1999:35) have their labours artificially accelerated for 'failure to progress'.

Oxytocin is a central element both in the acceleration and induction of labour.    Oxytocin, Kieran O'Driscoll - the inventor of active management - admits, causes painful contractions whether or not a woman is in labour (O'Driscoll *et al,* 1993:176).  Oxytocin can therefore be seen to increase the demand for epidural anaesthesia, as women under active management strive to make labour more tolerable.  Epidural anaesthesia, however, is estimated to multiply by four a low-risk  woman's chances of having a Caesarean section (Frigoletto, 1994).   This form of anaesthesia is often accompanied by continuous electronic fetal monitoring, thereby compounding the risk of Caesarean section in uncomplicated labour.

**Iatrogenic damage**

In any specialty, medical intervention inevitably leads to a proportion of iatrogenic damage.  Episiotomy, an incision enlarging the vaginal opening, provides one such example.  The obstetric belief was that episiotomy prevented tearing, and a surgical incision was considered by obstetricians to be preferable to a naturally occurring laceration, however minor. The midwifery view of episiotomy was that it was  'comparable with the wound of a second degree tear' (Myles, 1975:562).  (Second degree lacerations involve muscle as well as skin.) The obstetric view prevailed, and episiotomy duly became a standard intervention in birth.  Its adverse physical and sexual consequences have been known for many years.  Over the past two decades,  evidence as to its futility in preventing perineal lacerations has been widely accepted.  Nevertheless,  episiotomy continues as an obstetric routine. The national episiotomy rate in Spain, for example, is 89 per cent (Wagner, 2000)

Since the beginning of the last century, infection, pulmonary embolism, anaesthesia accidents, and haemorrhage have been the principal causes of maternal death in Caesarean section (Shearer, 1993:1226-1227).  National surveys on maternal deaths in the United Kingdom (Hall and Bewley, 1999) show that while the mortality rate for all Caesareans is six times that of vaginal birth, the fatality rate in  elective Caesareans is three times that of spontaneous or unassisted birth. The principal risks posed by  Caesarean to the baby are iatrogenic prematurity and respiratory distress syndrome.  National rates for Caesarean babies admitted to neonatal intensive care are unavailable.

The absence of outcome-oriented research in maternity care means that national data quantifying morbidity, whether iatrogenic or otherwise, are often  unavailable.  The existence, if not the scale, of iatrogenic damage can be gleaned from individual research studies, where these exist,  and from malpractice insurance reports, as obstetric accidents, or 'adverse events' as they are known, occasionally lead to litigation.  Almost two-thirds of maternal negligence claims in Ireland are brought on the grounds of psychological injury, with, additionally, one woman in twelve claiming against obstetrician/gynaecologists for brain damage (The MDU Ireland, 1998).

Widely used both to accelerate and to induce labour, oxytocin features strongly in obstetric negligence claims (The MDU Ireland, 1998). Oxytocin has been identified as a salient factor in infant brain damage (Taylor, 1998:7) and in intrapartum fetal deaths (Department of Health, Britain, 1995:36-37). Maternal deaths have also been reported in connection with its use (Parke-Davis, 1993:1813).  The response to oxytocin is highly idiosyncratic. Its American manufacturers, Parke-Davis, observe that the response depends on the sensitivity of the individual woman: they recommend fetal scalp electrode monitoring  lest  contractions become too powerful or too prolonged either for the baby or for the mother.

At the National Maternity Hospital, where active management was developed, more than one newborn baby in six - nearly two-thirds of whom are term - is admitted to intensive care following birth (National Maternity Hospital, 1993:48)ospitalHH.  Clinical data show that respiratory distress syndrome, transient tachypnoea of the newborn, and sepsis are the principal indications for admission (National Maternity Hospital, 1993:48).  Staff at the hospital are indemnified against 'cephalopelvic disproportion, rupture of uterus and injury to the child' (O'Driscoll et al, 1993:55-56).

**The waltz of obstetrics with litigation**

Within the spiral of intervention, with its pain-epidural-monitoring- Caesarean dynamic, the waltz of obstetrics with litigation goes on: the more obstetrician/gynaecologists intervene in birth, the more birth injuries occur: the more obstetricians get sued, the more actively they manage women's bodies in labour.  Litigation anxiety, as we have already seen, has been identified by obstetricians themselves as the main factor in the escalation of Caesarean rates.  Over 70 per cent of all British and American obstetricians have been sued (Wagner, 1998).  Litigation increases the cost of professional indemnity or malpractice insurance.  In Britain, obstetric claims cost the National Health Service over �150 million every year (Cumberlege, 2000).

In 1999, malpractice insurance for obstetrician/gynaecologists in Ireland increased by 88 per cent (*Irish Medical Times*, 1999:1), more than seven times the percentage increase levied on other medical consultants in the State.  The Government's  response has been to propose no-fault compensation, aimed at infants brain-damaged at or around the time of birth.   This scheme is designed to replace the concept of individual practitioner liability with the concept of enterprise  or institutional liability underpinned by extensive risk management schemes.  If introduced, enterprise liability is widely expected to erode  even further the autonomy of midwives and of women in childbirth.  Whether or not the scheme would improve the quality of care at or around birth is not known.

**Public costs and private profits**

In the past, Caesarean sections were estimated to cost three times more than vaginal births (WHO, 1986).  Today, Dutch health insurance data on the cost of birth shows that, in 1997 a Caesarean rate of 9.5 per cent accounted for 44 per cent of the total cost of maternity care in Amsterdam, while home birth, at 26 per cent, made up only 5 per cent of the total bill for birth in that city (Klinkert, 1999). British figures show that an increase of 1 per cent in the Caesarean rate adds �5 million to maternity care costs.  This, as Baroness Cumberlege has observed, is the equivalent of 167 midwives  (Cumberlege, 2000: 16).  In France, Jean-Marie Clement, Professor of Hospital and Medical Law at Paris VIII University and former hospital administrator, estimates that birth in a French hospital costs between FF2,000-5,000 per day, according to hospital size: the larger the institution, the more expensive the birth  (Clement, 2000).  In the United States, it has been calculated that utilising midwifery care for 75 per cent of births would result in an annual saving of 8.5 billion dollars (Wagner, 1998).

Obstetrics can be a lucrative business, as the Irish experience demonstrates.  Public and private care operates side by side, often on the same site.  Within this system, state-employed midwives care for obstetricians' private patients.  Midwives are paid approximately 8 per cent of what obstetricians earn, but this may be an over-estimation. The market for private maternity care (Republic only) is worth approximately �20 million.  This is divided among 88 obstetricians, and is additional to their State salaries. Private medical care is heavily subsidised by the state, and obstetricians have unlimited access to the full range of public hospital facilities, including midwifery time, without charge, for their private patients. Obstetric incomes average �275,000 annually, but this may be an under-estimation, as costings on surgical and operative deliveries are unavailable.  Caesarean section rates are known to be significantly higher among private patients.

**The benefits of midwifery care**

The recognition (ten Hoope-Bender, 1997) that midwifery care can result in shorter labour, less medication, and fewer interventions such as surgical or operative deliveries is growing.  In 1996, WHO concluded that midwives are the most appropriate, and cost-effective caregivers in normal pregnancy and birth (WHO, 1996).

 Midwifery care has been shown to be as safe, or safer, than care provided by doctors.  A recent American study of 4 million low-risk births (MacDorman and Singh, 1998) showed that the outcomes of midwife-attended births were significantly better than those of medically supervised deliveries.  The risk of having a neonatal death was 33 per cent lower  with a certified nurse midwife than with a doctor, while the risk of infant death was 19 per cent lower in midwifery births than it was in physician deliveries.

Midwifery has also been shown to have salient advantages in the area of preventive health.  Modern obstetrics has failed to reduce the number of low birthweight babies being born.  In Britain, where the percentage of low birthweight babies is higher than it is in Albania or Latvia (Cumberlege,  2000), Ann Oakley has demonstrated that the provision of social support by midwives has a markedly beneficial effect on the physical and emotional health of high- risk mothers and on their babies' well-being: these effects are still measurable one year after birth (Oakley, 1992: 277-79). In the United States, MacDorman and Singh (1998) showed that the risk of having a low birthweight baby was 31 per cent less with a certified nurse-midwife than with a doctor. Small babies are associated with significantly increased perinatal mortality rates.

**Discrimination against midwives**

Whatever the benefits of midwifery care, laws and regulations discriminating against midwives are widespread throughout Europe. National health and insurance systems sustain medical monopolies, even at primary health level, in areas of midwifery expertise such as antenatal care.  In many countries, official health care policies prevent midwives - the specialists in normal birth - from assuming responsibility from the care of healthy women in childbirth.

Structural and legal barriers to midwives' equality in the workplace are common.  Many midwives are forced to work as obstetric nurses, and births become deliveries conducted according to obstetric protocols. In many Member States, midwives are hindered from practising their profession to the full.  European Directives on midwifery, adopted 20 years ago, have yet to be fully transposed into national law.  In some States, for example, midwives do not have prescribing rights, although such rights are to be inferred from the Directive of the European Parliament and of the Council of 21 January, 1980 (80/155/EC).  In Ireland, where midwives are governed by nurses, midwives are further prohibited by the Nursing Board from 'prescribing' non-prescription or 'over-the-counter' medication to their clients (An Bord Altranais, 1999:13).  Midwives in Ireland who work at primary care level lack the basic requisites to practise their profession.  They are obliged to beg, borrow, or contrive to get essential drugs, and other requisites necessary for the safe practice of their profession.

Most European midwives do not have hospital 'privileges', that is, the right to admit a client to hospital, to assume responsibility for her care, and to discharge her thereafter.   Many midwives do not even have referral rights, that is, the right to refer a midwifery client to another professional practitioner.  Nor are midwives commonly allowed to certify a woman's unfitness to work in pregnancy, or after the birth of her baby.  While midwives are generally permitted to notify births, they are usually  precluded from signing perinatal death certificates.

In some countries, there is a growing midwifery shortage.  In Britain, for example, only 34 per cent of registered midwives are currently in practice (Emerton, 2000:19).  Working conditions are poor for many midwives, and unequal pay structures persist in many countries.  National health and insurance systems continue to discriminate against midwives - equal pay with doctors for equal work, or for work of equal value, introduced in New Zealand in the 1990s at primary health care level, is virtually unknown in Europe.  There is further evidence to suggest that European midwifery is lagging behind midwifery in other parts of the world.  Most European midwives, with the exception of The Netherlands, have yet to be given equal powers and responsibilities with general medical practitioners in maternity care. In Ontario, Canadian midwives were given such powers as far back as in 1994 (Shroff, 1997: 205-239).

**Working conditions  in Europe**

European midwifery, in contrast, is distinguished by discriminatory short-term, temporary, and part-time work contracts; non-recognition of years spent working in the home, or abroad by public service superannuation schemes; lack of parity with other health professionals in areas such as pension entitlements; lack of career development and inequitable promotional opportunities. In England, in recent years, the proportion of midwives working part-time has increased to 40 per cent (Sandall, 1995).  Pervasive discrimination in the workplace is leading to increasing discontent.  Hospital midwives frequently complain of bullying in the work place (Commission on Nursing, 1998:181), a command and obey model of management, a preoccupation with hierarchy and bureaucracy, and a tendency towards information control (ibid.:123-125),  within an overall culture which can no longer distinguish between midwifery and nursing.  All of this has led to low morale among midwives, and high migration from the profession.

In 1999, in a break with tradition, Dutch midwives, in an endeavour to secure better pay and working conditions, marked the advent of the third millenium with a midnight strike (de By, 2000). Overworked, and underpaid, midwives in The Netherlands point out that there has been an increasing shortage of new midwives in recent years. With an annual  caseload of 155 clients (Klinkert, 1999), many are suffering from burnout.  The home birth rate in The Netherlands has fallen from 60 to 35 per cent over the past 25 years (de By, 2000).

**The overshadowing of midwifery by nursing**

WHO has recently described midwives' lack of influence on national health care policies as an 'anomaly' to be corrected (WHO, 2000).  Invisibility *is* a major difficulty for midwives, and for midwifery. In many countries, educational requirements underpin and reinforce the overshadowing of midwifery by nursing.  Despite the fact that nursing and midwifery are two separate and distinct professions, entry into midwifery is often restricted to qualified nurses. In some countries, midwifery is officially classified as a medical profession.  In Ireland, the term *nurse* may legally refer to a midwife (Nurses' Act, 1985).  Furthermore, Irish medical practitioners are legally deemed providers of midwifery services (Spruyte and Wates v Southern Health Board, 1988).  In Britain, legislative change weakening the already fragile boundaries around midwifery, and leading to the submergence of midwifery within nursing, has recently been proposed  (NHS Executive, 2000).

**Gender mainstreaming**

In some States, the adoption of 'gender mainstreaming' in the public service  requires the building in of a gender perspective into state policies, services, and structures to make them 'gender sensitive'.  Gender mainstreaming, however, has yet to lead to equality of midwifery representation in maternity care. Midwifery is often 'represented' by nursing, and equality of representation with nursing and medical interests is rare.  In some countries, midwives lack both the regulatory and trade union structures which would enable them to participate effectively in planning.  Throughout most of Europe, midwives are excluded from policy-making, overshadowed by adjacent professions such as nursing, and obstetrics.  This exclusion is evident in regulatory bodies, professional associations, government ministries, maternity hospitals, university faculties, and in health and other agencies**.** The non-representation of midwifery in elected and appointed bodies at local, national, and international levels has serious implications for the development of woman-centred maternity care.

**The democratic deficit**

Neither has gender mainstreaming led to adequate consumer representation in maternity care.  The democratic deficit extends from service providers to service users who are themselves female.  Women,  -as 'patients' - are often denied choice and freedom in birth. Midwifery is almost exclusively a female profession, while obstetrics is, in the main, a male occupation.    The adoption of  a gender perspective would suggest that, at this most female time of their lives, women have the right to a choice of midwife as well as a choice of doctor.

In some Member States, both midwifery and consumer representation in maternity care policy structures are virtually unknown.  In addition to the relative powerlessness of being a patient, many women face additional barriers in childbirth because of poverty, ethnicity, language, religion, sexual orientation, disability, migrant, or refugee status.  These barriers reinforce these women's fundamental exclusion as full and equal participants with providers in maternity care.  Some women still lack control over the services they receive for birth, finding themselves excluded from the decision-making process by midwives who themselves are often powerless to offer alternatives to medical management.  This exclusion from decision-making of both service providers and service users, reproduces, and is reproduced by, their joint exclusion at higher levels, in a process of mutually reinforcing circles of powerlessness.  Gender equity, it appears, has yet to be brought into the birth chamber.

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Written on behalf of Pegasus, the Academy for the Further Education of Midwives, Aachen, Germany, The European Workgroup of Independent Midwives**,** Epen, The Netherlands**,** and the European Institute of Midwifery, Dublin, Ireland.

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**References**

 An Bord Altranais (1999*) Review of Scope of Practice for Nursing and Midwifery.*  Dublin: Author.

 Clement J-M. (2000) *La naissance respectee - une exigence citoyenne?*  (Respect for birth - a civil right?)  Presented at the *Naissance et Citoyennete*  (Birth and Citizenship) International Meeting,  Nantes, France, May.

 The Commission on Nursing. (1998) *Report of The Commission on Nursing: A blueprint for the future*.  Dublin: The Stationary Office.

 Cuidiu - Irish Childbirth Trust.  (1999)  *Preparing Together for Birth and Beyond: A Consumer Guide to the Maternity Services in Ireland.*  Dublin: Cuidiu - Irish Childbirth Trust.

 Cumberlege, Baroness.  (2000) House of Lords Debate concerning the  Maternity Services, January 12, 2000, Hansard.  In *Midwifery Matters*, No  84, Spring.

 de By C. (2000) Midwives on Strike*.*  Presented at The Fourth International Home Birth Conference*, Quality of Midwifery Care Given Throughout the World,* Amsterdam, The Netherlands, March.

 Department of Health.  (1995*) Confidential Enquiry into Stillbirths and Deaths in Infancy  - 1993:* Annual Report, Parts 1 and 2.  London: HMSO.

 Department of Health.  (1998) *Confidential Enquiry into Stillbirths and Deaths in Infancy :* Annual Report, Parts 1 and 2.  London: HMSO.

 Desbouvrie-Bertaud I, Goffinet F, Humbert R, Clerson P, Philippe H J, Breart G, Cabrol D. (1999)  Notions d'epidemiologie: les chiffres du declenchement -. Enquete de pratique nationale aupres des obstetriciens sur le declenchement artificial du travail. (Epidemiological issues: the induction rates - A national enquiry into the practice of obstetricians of the artificial induction of labour).  In *Les Dossiers de l'Obstetrique,*282, avril: 36-40

Emerton, Baroness.  (2000) House of Lords Debate concerning the  Maternity Services, January 12, 2000, Hansard.  In *Midwifery Matters*, No  84, Spring.

 EEC Directive of the European Parliament and of the Council of 21 January, 1980, concerning the coordination of provisions laid down by law, regulation or administrative action in respect of midwifery �and the activities that midwives are entitled to take up and pursue. 80/155/EEC. Luxembourg: Author.

 EU Directive of the European Parliament and of the Council of 22 June, 2000, amending Council Directive 93/104/EC concerning certain aspects of the organisation of working time to cover sectors and activities excluded from that Directive. 2000/34/EC. Luxembourg: Author.

 Francombe C, Savage W.  (1993) Caesarean section in Britain and the United States: 12 or 24 %, is either the right rate?  In *Social Science and* *Medicine,* 1993, 37, Vol  10.

 Frigoletto FD Jr. (1994)  The Boston randomised controlled trial of active management of labor.  Presented to *The Centenary Scientific Meeting of the National Maternity Hospital*, Dublin, March.

 Frigoletto FD Jr, Liberian E, Lang JM, Cohen A, Barss V, Ringer S, Datta S.  (1995)  A clinical trial of active management of labor.  In *New England Journal of Medicine,* 333 (12) :745-50. Sept 21, 1995.

 Hall M, Bewley S. (1999) Maternity Mortality and Mode of Delivery in *The Lancet*, 354: 776,  August, 1998.

*Irish Medical Times.* (1999) Vol 33 August 13, 1999.

 Klinkert J.  (1999) Modelling first line obstetrical care in Yburg. Unpublished thesis for a Master's Degree in Public Health.

 Les Dossiers de l'Obstetrique/Espace Naissance. (2000) Introduction to  *Naissance et Citoyennete*  (Birth and Citizenship) International Meeting,  Nantes, France, May.

 Lonzac M F D. (2000) Moins de cesariennes? (Fewer Caesareans?) In *Enfant.*  (2000)  novembre, 2000.

 The MDU Ireland.  (1998)  *Lessons in Litigation - Irish Obstetric Claims.* Dublin: Author.

 Myles M F.  (1975)  *Textbook for Midwives*.  Eight edition.  Edinburgh: Churchill Livingstone.

National Maternity Hospital Dublin (1993) *Clinical Report for the Year* 1993.  Dublin: Author.

 NHS Executive.  (2000)  *Modernising Regulation - The New Nursing and Midwifery Counci: A Consultation Document*. August.  Leeds: Author.

 Oakley A. (1992) *Social Support and Motherhood: The Natural History of a Research Project*. Oxford: Blackwell.

 O'Connor M. (1995)  *Birth Tides: Turning towards Home Birth..*

London: Pandora.

 O'Connor M.  (1992) *Women and Birth: A National Study of Intentional Home Birth in Ireland.*  Dublin: Department of Health, unpublished.

 O'Driscoll K, Meagher D, Boylan P.  (1993)  *Active Management of Labor.*  Third edition.  London: Mosby

 Parke-Davis (1993).  In Physicians' Desk Reference.  FDA.

 Sandra Spruyte and Jeremy Wates (plaintiffs) v Southern Health Board (defendants): High Court Judicial Review: Judgement of Mr Justice Finlay, 12 0ctober, 1988.*Judicial Review UK* , 1988 : 283.

 Shroff F.  (1997*) The New Midwifery: Reflections on Renaissance and Regulation.*  Ontario: Women's Press.

 RCOG/NCT (1993) *Guide-lines for Fetal Monitoring:*  Recommendations produced by a joint RCOG/NCT Study Group.  London: Authors.

 Sakala C.  (1993) Midwifery care and out-of-hospital settings: how do they reduce unnecessary Caesarean section births?  In *Social Science and Medicine,* 37: Vol 10.

 Sandall J. (1995) Choice, continuity and control: changing midwifery towards a sociological perspective.  In *Midwifery*, 1995, Vol. 11, pp. 201-209.

 Shearer E.  (1993) Cesarean Section: Medical Benefits and Costs.  In  *Social Science and Medicine*, Vol. 37, No 10, pp. 1223 - 1231,1993.

Taylor R.  (1998)  In *Quick birth drug can kill babies*, Simon Cooper, *The Observer*, 19 April, 1998.

 ten Hoope-Bender P.  (1997) The demedicalization of childbirth.  *World Health,* 50th year, No 2, March-April, 1997.

WHO. (1996)*Care* *in Normal Birth: a practical guide*.  Document WHO/FRH/MSM/96.24, Division of Family and Reproductive Health.   Geneva: Author.

 Wagner (1998)  The Politics of Birth.  In *International Midwife*, Spring, 1998.

 Wagner M. (2000) General situation of obstetrics in the world: How the *scientific-medical* power helps to perpetutate the concept: *They shall deliver with fear*.  Presented at *1st Congrese Internacional de Parto y Nacimiento en Casa*  (First International Congress on Home Delivery and Childbirth), Jerez de la Frontera, Spain, October.

  World Health Organisation.  (1985) *Having a Baby in Europe*, p.21. Copenhagen: Author.

 WHO. (1998) *Health21: an introduction to the health for all policy framework for the WHO European Region*, European Health for All  Series; No.5, p. 13. Copenhagen: Author.

 World Health Organisation (2000) *Conference Scope and Purpose.*  Second WHO Ministerial Conference on Nursing and Midwifery, Munich, Germany, June. EUR/00/5019309/2.

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