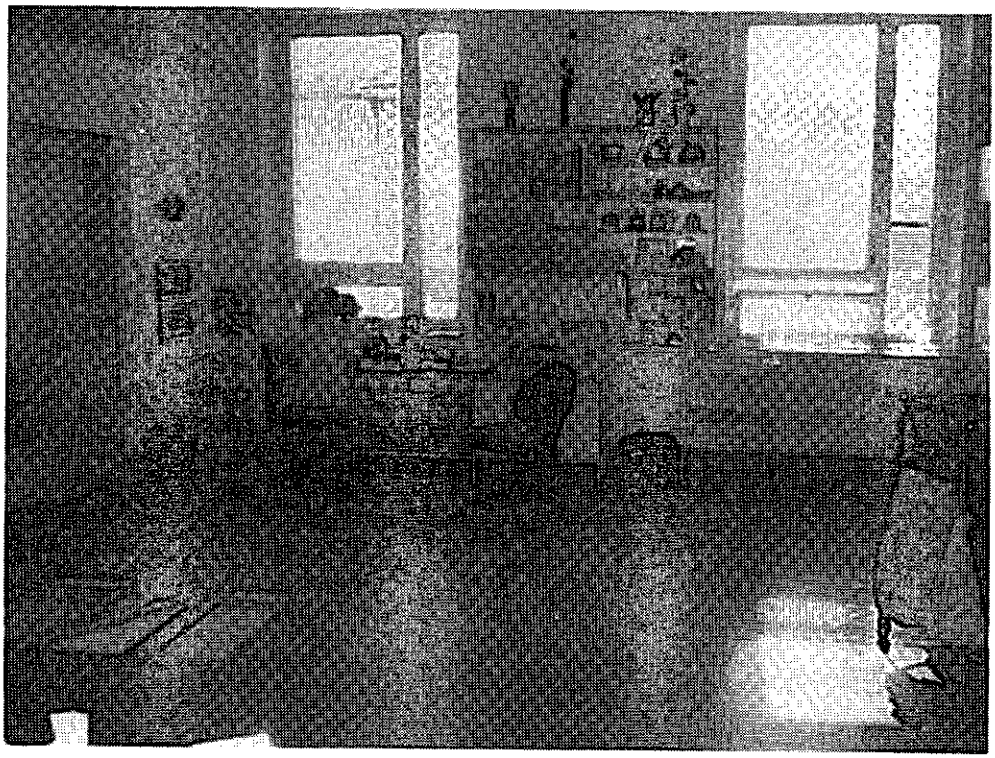
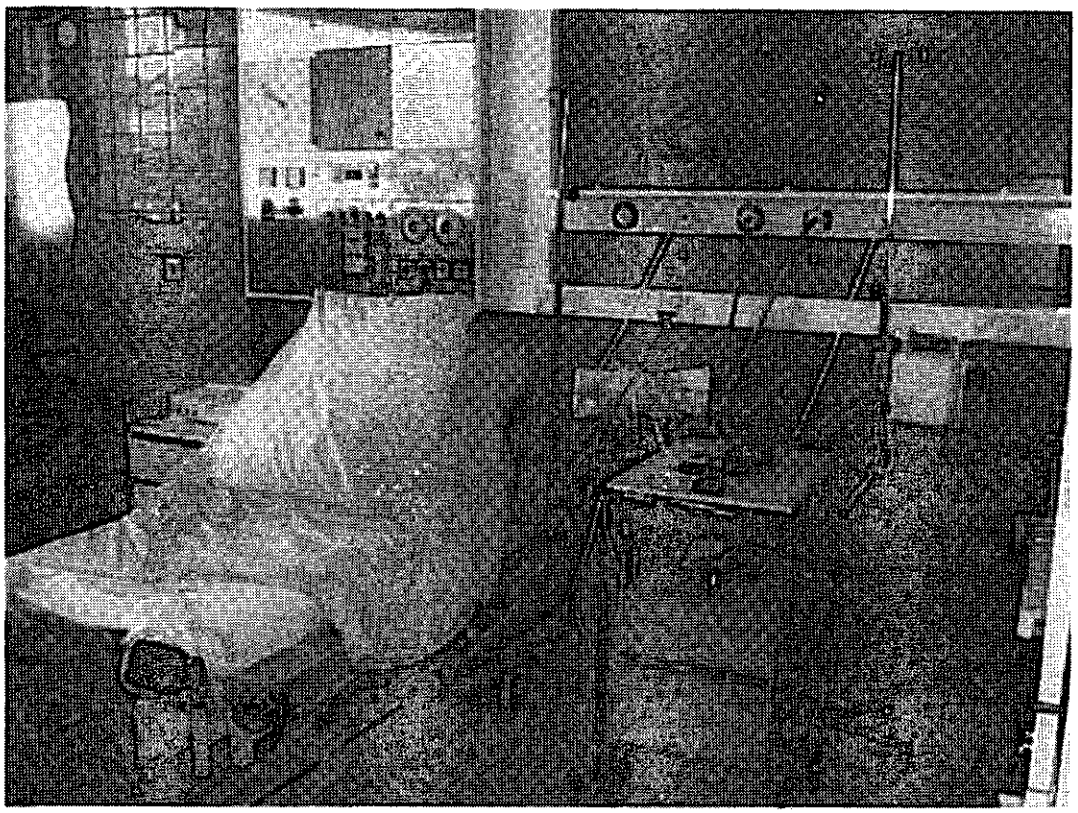
ターミサーリ産院の助産婦

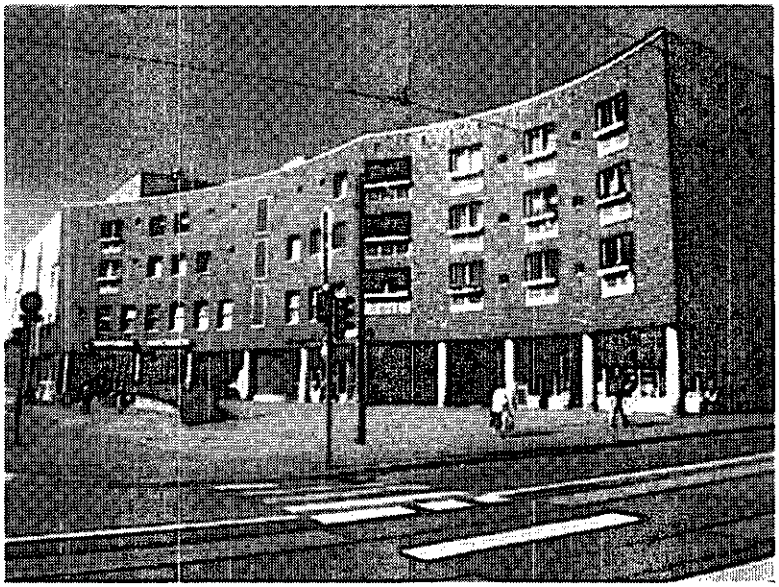
ターミサーリ産院の助産婦



完全母子同室のため使わなくなった新生児室



ヘルシンキ大学付属病院分娩室



妊婦検診を受ける保健センター

STAKES　フィンランド国立社会福祉保健研究開発センター

マースデンワグナー博士招聘

ワグナー博士招聘報告書

1．招へいされた外国人研究者

所属・職名　　：プライベートコンサルタント
（元 WHO ヨーロッパオフィス母子保健部長）
：Private Consultant

氏名　　：マースデン・ワグナー
：　Dr. Marsden Wagner

2．招へい申請者　　：　国立公衆衛生院　院長
小林　秀資

3．受け入れ研究者　　：国立公衆衛生院　疫学部主任研究官
三砂ちづる

4．招へい期間　：　平成 13 年 7 月 14 日から平成 13 年　7 月 23 日まで

5．研究課題　　：
「妊娠、出産状況が ADHD の発症に及ぼす影響についてのバースコホート研究デザイン」

6．研究活動の概要　（公衆衛生院関係者敬称略）

7 月 15 日（日）午後 2 時から 4 時まで、港区白金の都ホテルにおいて、受け入れ研究者と日程の確認、研究内容の確認を行った。

7 月 15 日　午後 4 時 30 分より 6 時まで文京区本郷の医学書院助産婦雑誌のための対談を国立公衆衛生院　疫学部　三砂ちづると行った。本対談は、「これからの出産ケアに必要な研究とは？」というタイトルで、助産婦雑誌に掲載される予定である。

7 月 16 日（月）より 7 月 21 日（土）まで、受け入れ研究者（公衆衛生院疫学部　三砂ちづる）と暫時、コホート研究デザインに関する研究に従事した。

7 月 16 日午前 11 時より午後 1 時まで、国立公衆衛生院院長　小林秀資、疫学部　三砂ちづる、公衆衛生看護学部　福島富士子と証拠に基づいた出産ケアと、バースコホート研究の必要性について意見交換を行った。

7月 16 日午後 6 時より、新宿区市ヶ谷のホテルグランドヒル市ヶ谷でおこなわれた、「Prof. Wagner 氏を囲む会」において、日本母性保護産婦人科医会幹部 12 名と、出産のケア、WHO のガイドラインなどについて意見交換を行った。

7 月 17 日（火）午前 10 時より、公衆衛生院公衆衛生看護学部　平野かよ子、福島富士子、疫学部　三砂ちづると、ヨーロッパの女性政策に関して意見交換をした。

7月17日午後6時より、大阪の医療系出版社メディカ担当者、バースエデュケーター、河合蘭氏　周産期ケアについてのインタビューを受けた。

7月18日（水）午前11時30分より、厚生省母子保健課　新野由子氏と日本の母子保健政策について意見交換を行った。

7月18日午後2時より公衆衛生院　丹後俊郎と、研究デザインの統計妥当性について意見交換を行った。

7月18日午後3時30分より母子愛育会にて日本母性保護産婦人科医会会長　坂元正一氏と会談を行った。

7月18日午後5時より広尾の日赤看護大学講堂において、日赤医療センター産科部長杉本充夫氏主催の講演会「ヨーロッパにおける出産事情」を開催した。（参会者　約９０名）

7月19日（木）午後1時30分より、国立公衆衛生院講堂において、公開講義「公衆衛生の視点から見た妊娠と出産」を開催した。（参加者　約120　名）

7月29日（金・祝日）午後1時30分より午後4時30分まで、青山にある東京ウィメンズプラザ　ホールにおいて行われたJIMON（Japan Independent Midwife Organized Network）主催の「ブラジル光のプロジェクト報告会」に参加し、周産期ケアについてブラジルで行われた1985年の会議の影響などについて、スピーチを行った。(参加者　約300名)

7月21日（土）　午後2時　より東京ウィメンズプラザで開催された「EBMに基づいた出産ケア」に関する助産婦の集まりにコメンテーターとして参加、日本の出産ケアのありようについて意見交換を行った。

7．研究課題の成果

「健やか親子 21」が発表され、21 世紀に向けた母子保健活動が展開されようとしている。安心できる子育て、こども、青少年の健やかな成長は国民全体の望むところである。しかし、現実には「キレる子ども」、青少年犯罪、虐待、ADHD など、子どもに関わる多くの社会的問題と、育児不安を抱えている孤立した母親の存在は、日常を生きるわれわれの多くの憂慮するところとなっている。これらの子どもの状況に関わりがあるのではないか、と近年重要視されているのが ADHD(attention-deficit/hyperactivity disorder)であるが、実態、原因については十分に理解されていない。将来の日本社会を担っていく子どもの安らかな成長と、母親の幸いな人生のありようは、国民的課題であり、ADHD に関しても各分野専門家の意見を考慮しながら公衆衛生の視点から包括的に解決策を求めていかねばならない分野であると考える。

具体的な証拠できる研究活動の成果がさまざまなライフサイクルのポイントで行われる介入活動に取り入れていく必要があるが、特にいのちの始まりである妊娠の状況とそれを取り巻く環境、出産の状況とそれを取り巻く環境の母子の健康への影響、特に長期的影響については世界的にもまだ研究が十分になされていない分野である。ADHD のみに関しても、妊娠中の喫煙、薬物中毒、妊娠合併症の影響などについてはいくつかの研究が見られるが、証拠に基づいた政策（Evidence Baced Policy）の基礎となりうるような、よくデザインされた大規模な調査は存在しない。また、スカンディナビア諸国が 90 年代から整備し始めている詳細な Birth Registry のシステムのような詳細な妊娠、出産に関するデータ収集に関しても努力が始まったばかりである。

また、Birth Registry に記載されるような産科関連のデータのみでなく、女性の妊娠出産の経験についての長期的影響を見るような研究もまだ少ない。お産の状況（birth events）が産後の抑うつ症状と関係があり、また、産後の抑うつ症状が、母子関係と関係があり、母子関係がその後のすこやかな小児発達状況と関わりがあることは、それぞれに先行研究で示されている。しかし、「お産の状況」そのものについては、「帝王切開などの医療介入」、「産前検診への不満」など個々のケアについては、抑うつ症状と関連があるとされているが、実際どのようなお産の状況が、産後の抑うつをはじめとする母子の状況にプラスの影響を及ぼすのか、はっきりした定義も、研究も行われていない。また、「健やか親子２１」が提唱され、より効果的な母子保健のありようについて議論が重ねられている。妊娠、出産については、「安全性と快適さの確保」が主要な課題であり、「妊娠出産に満足する」女性の割合が 2010 年には 100%になることが取り組み目標のひとつとなっている。しかし、「快適な出産」「満足のいくお産」とはどういうことか、国際的にも、はっきり定義づけはされていないし、その後の母子への長期的影響についての研究もない。

本招聘事業のきっかけとなった研究課題では、前向きコホート研究を行うことにより、妊娠、出産の状況（Pregnancy and birth events）がADHDの発生率に与える影響について明らかにすることを目的とする。スカンジナビアのBirth Registryを参考とする詳細なBirth Registryおよび、女性の経験をふくめた詳細な妊娠、出産状況ををベースラインとすることにより、ADHDのみならず、妊娠、出産の状況がその後の短期的な母子の身体、精神健康指標、母子関係、家族関係、子供のやすらかな成長に及ぼす関係、また長期的に、子供の青年期までの発達、社会問題的行動（薬物中毒、アルコール中毒、犯罪等）に与える影響も調査することができる。このような研究は日本のみならず、国際的にも多くの政策的示唆、特に効果的な母子保健サービスの提供上の示唆を与え得ると考える。

招聘者マースデン・ワグナー氏は、母子保健の公衆衛生専門家、疫学者として国際保健機構（World Health Organization – WHO）ヨーロッパオフィスの母子保健部長を長くつとめた。在任中、"Having Baby in Europe"をはじめとする多くの著作、論文を残し、ヨーロッパの安全で自然な出産のありように貢献してきた。定年退職後、現在は、出身地であるアメリカをベースに出産に関する専門家として世界中から招聘されている。

また、ワグナー氏は、人間の自然な営みとしての出産にどのように女性と男性が主体的に取り組めるか、またそのために医療はどのようにかかわることができるか、ということをテーマとしてずっと追ってきており、出産分野のEBMの推進に取り組んでおられる。1985年には、ブラジルにおいて、WHOヨーロッパオフィスと汎アメリカ保健機構（Pan American Health Organization-PAHO：WHOアメリカオフィスといえる）の主催で"International Conference on Appropriate Technology for Birth"を主催する。この会議の結果は「出産技術に関する勧告」としてランセット誌に掲載され、その後の出産におけるEBMのひとつの指針となり、つぎつぎと勧告を裏付ける調査がおこなわれ、発表されてきた。1996年にWHOから発表された、出産の分野のEBMの集大成"Care in Normal birth: A Practical Guide"にも大きな影響を及ぼした会議である。

世界の妊娠、出産とその後の影響に関して、著作、研究も多く、当研究分野でなされた先行研究のデザインと結果についても熟知されているので、具体的アドバイスを受けるのに最適の研究者の一人であると考えられた。

今回の招聘では、

1. 研究デザインへのアドバイス
2. 日本における出産のEBM推進についてのアドバイス

を受けることが目的であった。

1の研究デザインへのアドバイスに関しては、従来の研究で明らかにすることができなかった、出産時の長期的影響について、どのような調査をするべきか、ADHDなどを中心とする研究に必要とされるエントリー指標、アウトカム指標、フォローアップ時期、などについて詳細に検討し、必要な文献、コンタクトすべき研究者などが明らかになった。統計

専門家を交えて、サンプルサイズ、分析方法などについて十分な議論を行い、国際的な研究水準に見合うものに仕上げることができた。

日本では出産の分野にかかわらず、EBM （Evidence Based Medicine—根拠に根ざした医療）の導入ははじまったばかりである。EBM の祖の一人である Archie Cochrane 博士によると、産科の分野はもっとも EBM の導入がおくれている分野である、といっていた。現実に、国際的にも、妊娠、出産における分野ではルーティンとしておこなわれているケア、使われている技術とに乖離が見られるため WHO は上記のガイドラインを発表したという経緯もある。今回、ワグナー氏に公衆衛生関係者、産科医、助産婦、病院関連など広範囲の母子保健関係者と会談および、講演をおこなってもらい、出産分野の日本の EBM のありかたについて熟考する機会が得られた。

ワグナー博士訪問レポート原文

（日本語訳はこの原文の後に添付した。）

Several years after the WHO International Conference in Fortaleza, Brazil made evidence based recommendations for all countries (including Japan) on appropriate technology during birth (see appendix A), and after another WHO International Conference in Trieste, Italy made evidence based recommendations for all countries on appropriate technology following birth (see appendix B), WHO held another meeting and produced "Care in Normal Birth". These 59 newer WHO recommendations on care during birth, which build on and expand the earlier WHO recommendations, also are based on the best scientific evidence, also are meant for every country in the world, including Japan and have been translated into Japanese. (give reference here for Japanese article "59 WHO---")

Using these WHO recommendations, significant progress has been made in recent years in many parts of the industrialized world to move toward evidence based medicine in maternity care. Because there has always been large numbers of strong, independent midwives in Western Europe, the WHO recommendations have been used widely there to improve maternity services. For example, German midwives joined with women's groups, scientists and journalists to expand choices for out-of-hospital birth as recommended by WHO. Ten years ago there was one out-of-hospital birth house with midwives in Germany, today there are sixty. The number of planned home births is steadily rising in Germany, England, Denmark and other countries and in the Netherlands, planned home birth remains at around 30 %.

The trend in Europe, as recommended by WHO, is to more independent midwives, trained without previous nursing training, working in the community. Midwives working in hospitals are gaining ground in practicing true midwifery rather than serving only as doctor's assistants. As a result, there is a decreasing gap between the scientific evidence and hospital birth practices in Europe with, as only one example, far less unnecessary episiotomy--now approaching 20 % of all births in many places as recommended by WHO. Rooming-in of all normal newborn infants in their mothers' room, as recommended by WHO, is now available everywhere in Western Europe and newborn nurseries for healthy newborns are fast disappearing. Because shaving women and giving them enemas during labor are now known to be against scientific evidence, WHO strongly recommends against them and they are a thing of the past in Europe. Science also has shown that putting a woman flat on her back with her feet up in stirrups during labor is the most dangerous position for birth and so WHO strongly recommends against it and it is still done in only a few places in Europe.

One hundred years ago doctors in the U.S. wanted to control all births and have them for their own profit so they labeled midwives as witches and drove them out. When midwives attempted to return in the U.S. 40 years ago, the doctors only allowed midwives to return if they were first trained as nurses because nurses take orders from doctors and are controlled by doctors while midwives who are not first trained as nurses are independent and do not take orders from doctors. So nurse-midwifery started in the U.S. and still exists today although it is gradually being replaced by independent midwives without nurse training. Indeed all countries which in the past trained some of their midwives first as nurses are gradually replacing nurse-midwives with non-nurse midwives. In the U.S., obstetricians are still trying to manage all births, including normal births, because of their wish to control maternity care and because this is often still an important source of their income. Because the U.S. has not had a large, strong, independent group of midwives, there has been no counterbalance to the tendency of obstetricians to extreme forms of medicalization of birth leading to the bad situation found today in American maternity care. Between 1990 and 2000, the rate of induction of labour with powerful, dangerous drugs increased in the U.S. from 10 % to 20 % of all births and during this same ten years the number of births occurring Monday through Friday also increased, proving that the dangerous induction, while very risky for both woman and baby, was done for the convenience of the doctors. (www.cdc.gov/nchs/birth)

Caesarean section is also increasing again in the U.S., now approaching 25% of all birth, which is at least double what it should be according to WHO and the scientific evidence. Because elective induction for non-medical reasons such as convenience, epidural block for normal labor pain and elective (non-emergency) caesarean section all have increased risk that the woman will die at the time of birth, the maternal mortality rate in the U.S. has been steadily rising the past 15 years. There are now 14 countries loosing fewer women around the time of birth than the U.S. and 25 countries loosing fewer babies than the U.S.

One hundred years later in the new millenium, U.S. obstetricians are still trying to label midwives as witches and again trying to marginalize them and maintain their control all maternity services. But American midwives are growing in number as women learn the truth about the dangers of doctor-attended birth with all the unnecessary, dangerous obstetric interventions. American women are angry at the way they are treated by obstetricians and over 70 % of all U.S. obstetricians have been sued one or more times by families, a rate of litigation far above any other medical specialty. No one should wish to copy the U.S. maternity care system.

In 1996, JICA started "Project Luz" in Brazil. The goal of Project Luz was to promote humanized maternity care leading to healthy birthing. Humanized maternity care includes: 1) care which is fulfilling and empowering both to women and to their care providers; 2) care which promotes the active participation and decision making of women in all aspects of their own care. 3) care provided by non-physicians and physicians working together in harmony as equals. 4) care which is evidence based including evidence based technology use 5) care in a decentralized system of birth attendants and institutions with high priority to community based primary care 6) care with cost benefit analysis for financial feasibility.

Humanized birth means understanding the woman giving birth is a human being, not a machine and not just a container for making babies. Showing women---half of all people---that they are inferior and inadequate by taking away their power to give birth is a tragedy for all society. On the other hand, respecting the woman as an important and valuable human being and making certain the woman's experience while giving birth is fulfilling and empowering is not just a nice extra, it is absolutely essential as it makes the woman strong and therefore makes society strong.

Why is medicalized birth necessarily dehumanizing? In medicalized birth the doctor is always in control while the key element in humanized birth is the woman in control of her own birthing and whatever happens to her. No patient has ever been in complete control in the hospital---if a patient disagrees with the hospital management and has failed in attempts to negotiate the care, her only option is to leave the hospital. When doctors give women choice about certain maternity care procedures, the doctors are not giving up control since doctors decide what choices women will be given and doctors still have the power to decide whether or not they will acquiesce to a woman's choice.

An increasing number of obstetricians in many countries are now understanding the importance of evidence based medicine and the need to humanize birth.

Project Luz was very successful in bringing more humanized birth to Brazil. The Project culminated in an international conference "Humanization of Birth", held in Fortaleza, Brazil in November 2000 on the fifteenth anniversary of the first WHO Conference in Fortaleza. There were 2000 participants from over 25 countries, including a large group from Japan, and including a large group of obstetricians from many countries. The conference strongly endorsed the six principles of humanized birth (see above). A global movement---an international wave of humanized birth has started traveling around the world—giving birth back to the woman, family and community.

Birth in Japan in 2001

The people of Japan can be justly proud of having one of the lowest infant mortality rates in the world. Unfortunately Japanese obstetricians have tried to take credit for this by telling the public that it is their newer, high technology obstetric interventions which have saved so many babies lives. The truth is that scientific analysis of the improved infant mortality shows that by far the greatest cause of fewer babies dying is not medical advances but social advances. (see Chapter 3) Japan looses the fewest babies because Japan has eliminated poverty, improved the housing and nutrition of families, and most importantly, Japanese couples are using family planning to reduce the number of women with large numbers of pregnancies and reduce the number of very young and very old women having babies. Furthermore, the smaller contribution of medical care to lowering infant mortality is because of basic medical advances such as antibiotics and safe blood transfusion, not because of high technology obstetrics. It is misleading and false to use "safety" as a justification for having all births in hospitals and for using high technology obstetrics on all pregnant and birthing women rather than on selected cases with serious complications.

In July 2001, while in Tokyo, I met with the fourteen leading obstetricians from the Japanese Society of Obstetricians and Gynecologists. In our discussion of obstetric practices in Japan today, they admitted a big gap between what the scientific evidence says is best practice and therefore recommended by WHO and what is done in Japanese hospitals at birth. The following table of Japanese hospital birth practices, based on information from these leading obstetricians, illustrates this tragic gap between evidence based medicine and Japanese obstetrics.

Estimates of hospital

birth practices in Japan		Scientific Evidence		WHO
Shave and enema	yes	no		no
Withhold food	yes	no		no
Routine IV	yes	no		no
Routine CTG	yes	no		no
On back in stirrups	yes	no		no
Episiotomy	50 – 90 %	< 20 %	< 20%	
Baby away from mother first 30 min. after birth	yes	no		no
Rooming-in all babies	no	yes		yes

When I asked the leading obstetricians why they were not following the scientific evidence and the WHO recommendations, they replied that WHO recommendations do not apply in Japan. I was shocked and told them that, as a Director in WHO for fifteen years, I had been responsible for the meetings which made these recommendations which were meant for all industrialized countries, including Japan. They then tried another excuse for the gap between evidence and practice: Japanese women are different. I asked if they have data to show women in Japan are different and they said they have no data. I said Japanese women have the same anatomy and same physiology as women everywhere.

The obstetricians then tried another excuse for not following the evidence and WHO, saying that they were only doing what Japanese women want. I asked if they have data from a scientific survey asking Japanese women what they want. They have no survey and have no data so, in fact, they do not know what Japanese women want. I told them that for many years the obstetricians in Brazil explained their extremely high cesarean section rates by saying it is what the women want but finally a survey has been done by Brazilian obstetricians which clearly shows the women in Brazil do not want all those unnecessary cesarean sections. I explained that blaming the patient for a practice which is not based on evidence is extremely dangerous and urged them to read my article published in the November 11, 2000 issue of the leading international medical journal The Lancet, which reviews the ethics and dangers of such an excuse.

The gap between obstetric practices in Japan and evidence based practice is illustrated when these obstetricians insisted to me they must routinely monitor every woman giving birth with an electronic fetal monitor or CTG.strip of the baby's heart. I said such routine electronic monitoring of all births is not supported by evidence, is not done in Europe and is not recommended by the British Royal College of Obstetricians nor by the American College of Obstetricians nor by WHO. The Japanese obstetricians replied that without this electronic monitoring it is impossible for them to know how the baby is doing. I explained that using a stethoscope, feeling the woman's abdomen, carefully watching the face and movements of the woman and asking the woman for her feelings (the methods using by midwives) has been scientifically proven to be a safer method of monitoring the woman's baby during labor than the electronic method. The Japanese doctors said that without the electronic strip they are afraid. Their statements suggest they do not believe the scientific evidence and do not believe in the abilities of women's bodies but only believe in technology.

Taking babies away from women at the time of birth and placing normal

newborn infants together in one central room for babies only (the nursery) has been shown scientifically many times to be extremely dangerous as it causes epidemics of life threatening infections and prevents the attachment of baby and mother which is necessary for normal development of both mother and baby. Using such central nurseries is one of the biggest medical mistakes of the twentieth century causing deaths of thousands of babies and, except in a few places such as Japan, has been replaced by rooming-in of all normal babies with the mother. This is why the WHO conference in Trieste recommended abandoning central nurseries (see chapter 7) and this is why WHO, UNICEF and the Baby Friendly Hospital Initiative recommend only rooming-in. Some Japanese hospitals give the mother choice between putting the baby in the nursery or rooming-in. But hospitals do not offer women other choices which are dangerous---asking a woman if she wants to put her baby in a nursery is like asking a woman needing surgery if she chooses to have the doctor who will operate on her first wash his hands or not wash his hands.

Why is Japan at least ten to fifteen years behind many other countries in developing maternity services which are humanized, evidence based and thus truly modern? First, maternity services in Japan are controlled by surgeons (obstetricians are gynecological surgeons). Childbirth is not a surgical event but Japanese women giving birth in hospital are managed by surgeons using surgical practices such as shaving, enema, withholding food, IV, women placed on back with legs up in stirrups, episiotomy with surgical knife.

Another reason Japan is not up to date in maternity care is because during the occupation, the Americans insisted the birth houses be closed and insisted all midwives must train as nurses and work under the supervision of obstetricians. This resulted in the tragic loss of a large, strong, independent midwifery profession in Japan which until then had always maintained the normalcy of birth as part of the life cycle and part of Japanese family life. Without the midwifery approach to counterbalance the surgical approach, the medicalization of birth has become extreme in Japan.

The occupation has been over for a long time but many of these maternity practices continue, resulting in services which are too similar to the bad system in the U.S. Recent excellent research proves that for the 80% of women giving birth who are not high risk, having a midwife attend the hospital birth (no doctor in the room) is safer than having a doctor attend the birth. (MacDorman M, Singh G "Midwifery care, social and medical risk factors, and birth outcomes in the USA" J Epidemiol Community Health 52, 310-317, 1998) Other good research proves using midwives rather than doctors at low risk birth results in far less unnecessary procedures

including episiotomy, drugs for induction, drugs for pain, forceps or vacuum extraction, cesarean section---procedures which all carry serious risks for woman and baby. (Appendix D)

Evidence shows midwives do not need to train first as nurses, do not need to be supervised by obstetricians and provide the safest care when allowed to work as autonomous health professionals, whether in or out of the hospital.

There are several serious consequences of the medicalization and dehumanization of birth in Japan. First, the maternal mortality (women dying around the time of birth) in Japan is too high, higher than some other countries. It is most inappropriate that a leading obstetrician in Japan tries to blame the birth houses for these excessive maternal deaths when he has no scientific data to support his claim and for which there is no scientific evidence. While the Ministry of Health in Japan recognizes maternal mortality as a problem and has set a goal to reduce the number of women dying around their childbirth, there is no plan in Japan to have an independent audit of every maternal death as is done, for example, in Great Britain. Only with such scientific data can a rational program effect improvement. Meanwhile, it is a reasonable hypothesis that the excessive maternal deaths in Japan, like those in the US, are the result of too many unnecessary obstetric procedures such as induction of labor, epidural anesthesia, episiotomy, forceps, vacuum extraction, cesarean section. All of these procedures have been shown scientifically to lead to an increase in deaths of women giving birth.

A second consequence of the medicalization and dehumanization of birth in Japan is that it takes away the opportunity for woman to be empowered through a transforming birth experience. A woman who feels she can't give birth without doctors, drugs and technology looses her belief in her own body. Such women loose confidence in themselves as women and as mothers. Such women are much easier to control by men and by society. A society with half its members lacking confidence is a much weaker society.

Another consequence of the medicalization and dehumanization of birth in Japan is an increasingly violent society. Extensive research proves that if the baby is taken from the mother in the minutes after birth and kept away from the mother during the first days after birth, there is a significant loss of attachment between mother and baby. This is why WHO and UNICEF strongly recommend abandoning central nurseries for normal babies and using only rooming-in. A woman who has not had the possibility of this fundamental attachment with her baby after birth is much more likely to physically abuse that baby in the months and years to come. (see Chapter 7)

And babies and children who are physically abused are more likely to be violent adolescents and adults and to eventually abuse their own babies and children. A birth which is violent with aggressive, invasive interventions and separation of the woman from her baby leads to violent children, adults and society. If Japan wants a less violent society, it should begin by providing gentle, humanized birth

Japan has every possibility to change its maternity care system and humanize birth. The first step is to work to close the gap between the scientific evidence and the obstetric practices and achieve the new goal of health care in every industrialized country—evidence based medicine. An opportunity to make the maternity services more evidence based is here because the Japanese Obstetric Society will write new recommendation for birth practices in 2002. Previous clinical practice guidelines, made only by doctors from the same medical specialty, have been royalist in sentiment and pompous in tone. Here, an editorial from the prestigious medical journal The Lancet, January 8, 2000, is instructive:

> "Advocacy guidelines developed by a single-specialty group in isolation may be counterproductive, because those disciplines and professions that were not involved in the development of the guidelines but may be required to implement the recommendations mount their attacks and lodge their disclaimers. Some of the guidelines may be of the Good Old Boys Sat at Table (GOBSAT) variety, based on received wisdom rather than current scientific evidence, and may be biased by undeclared conflicts of interests. Studies have shown that the balance of disciplines within a guideline-development group has considerable influence on the guideline recommendations. Widespread multidisciplinary participation is essential not only to ensure that the guideline is valid, but also that it is valued by all the members of the multidisciplinary team, in order to be incorporated successfully into practice "

Hopefully the Japanese obstetricians will work closely with midwives, perinatal scientists and others in ensuring these guidelines are evidence based and approved by the community. (see Appendix C)

The old days are gone when doctors were put on a pedestal and the public believed whatever they said and allowed them to hide their practices. Politicians and the public in Japan will learn to say "where is the data" whenever a doctor makes a statement. The rates of obstetric interventions for each hospital including induction, episiotomy, forceps or vacuum extraction and cesarean section will be available to the people. Public health agencies will publish this information and work to humanize birth.

A second major step in improving maternity care in Japan is to strengthen midwifery. The tragic destruction of the time honored, strong, independent Japanese midwifery profession during the occupation can be reversed…midwives can be trained as midwives and not first as nurses. Midwives can practice autonomously and not under control of doctors. More midwives can train in research and replicate the studies of midwifery practices done in other countries which have demonstrated the safety of midwives, including comparisons of midwife attended birth and doctor attended birth. (see Appendix D)

Another step towards humanization of birth in Japan is to expand the options for where women can choose to give birth. The tradition of birth houses, destroyed during the American occupation, is gradually returning as the number of birth houses slowly increases. I have visited birth houses and seen how they serve the women in their community in many ways which help to empower women to believe in themselves. In addition, I visited hospitals which have already begun moving in the direction of more humanization of birth and learned of other hospitals doing the same. Research in Japan by Japanese researchers on birth houses and humanized hospital birth will help to dispel the inaccurate statements of some obstetricians about the safety of these birth choices for women and families.

Another essential step is the education of doctors, midwives, public health officials, politicians and, most importantly, the public of the dangers of present medicalized birth in Japan and the safety and value of humanizing birth. Fish can't see the water they swim in. Doctors, midwives, women and families who have experienced only hospital based, high technology, medicalized birth can't see the profound effect the interventions are having on the birth. They have no idea what a birth looks like without all the interventions, a birth which is humanized. (see Appendix C) Everyone, including obstetricians, midwives, politicians and women need to visit birth houses and also visit hospitals where there are real possibilities for humanization—that is, in places where women giving birth are in control of what happens. Television programs need to show a different kind of birth…not one which looks like surgery with everyone in gowns and masks, lots of technology, lots of doctors and other staff and with women lying passively on their backs in stirrups but rather television programs which show women giving birth walking around, standing or squatting or sitting while surrounded by family. Midwives need to teach children in schools about normal pregnancy and birth…to start the re-education in Japan of birth as a part of the normal life cycle.

A major step towards humanization of birth is to understand that birth

does not belong to doctors and hospitals, it belongs to women and families. Consequently there must be a strong role for women, families and the community inn setting health policy for maternity services. Health services everywhere are becoming less autocratic and more democratic and this evolution is most clear for those health services which assist the family during major events in the life cycle such as birth and death.

The movement to humanize birth in Japan and make it more democratic has already begun. The number of birth houses is increasing and the number of hospitals with real elements of humanization of birth is increasing. There are increasing numbers of midwives and obstetricians who understand the tendency of some obstetricians in Japan to ignore the evidence and WHO and not disclose all the information to the public in an attempt to cling to the old-fashioned obstetrics where they were in control. Slowly but surely there is an increase in Japan in the importance of humanized birth where the women giving birth are in control. The struggle for the autonomy of Japanese midwives continues. Information to the public has already started with the recent publication in Japan of two books, "Guide to Birth in Japan: How and Where to Give Birth" by Ran Kawai and "We need midwives in Japan" by Kumade Makiko. These books provide women in Japan with information on what is happening to midwives and to birth in hospitals. Hopefully the publication of my book in Japan will add to this effort to educate.

In addition, I had the honor to attend a public meeting in Tokyo in July 2001 of perhaps 200 hundred people including midwives, childbirth educators, obstetricians, politicians, public health professionals, scientists, journalists, representatives of women's groups, and individual citizens. Japanese from the JICA project told how they had worked to humanize birth in Brazil. The participants at the meeting understood the irony of the sharp contrast between the humanized birth now started in Brazil by the Japanese and the medicalized, dehumanized birth still so widespread in Japan, their own country. The participants decided to form a non-governmental organization to bring to Japan the international movement to humanize birth. There is no doubt they will succeed. Why? Because a famous scientist, Margaret Mead, said:

> "Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has."

RECOMMENDED READING

WHO on-line perinatal data base

Cochrane Data Base

Henci Goer "The Thinking Woman's Guide to a Better Birth", Penguin Putman, New York, 1999

Ran Kawai "Guide to Birth in Japan: How and Where to Give Birth"

Kumade Makiko "We need midwives in Japan" Recently published book in Japan.

Wagner M "Fish can't see water: the need to humanize birth", 75:S25-S37,2001, International Journal of Obstetrics and Gynecology

Wagner M "Midwifery in the industrialized world" J. Society Obstet Gynecol Canada, 20:13, 1225-34, 1998.