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1983

MINUTES OF SPECIAL MEETING HELD AT EXTRAMURAL HOSPITAL ON THURSDAY 17 FEBRUARY 1983 AT 1730 HRS TO DISCUSS THE REPORT OF THE BOARD OF HEALTH NO. 30 "THE MOTHER AND BABY AT HOME; EARLY DAYS".

PRESENT: C. Cox, J. Donley, R. Hasler, A. McQueen, G. White G. Williams.

APOLOGIES: A. Nightingale, A. Mellsop

This meeting was called as a result of concerns expressed at the February meeting of the Auckland Branch N.Z.N.A. held on Wednesday 2 February. It was felt that some of the recommendations in the above report could undermine the professional status of midwives, and that they could set an undesirable precedent for control of nursing practice and standards outside of nursing.

The report was briefly discussed in general, and each of the recommendations was considered individually. A summary of the opinions expressed is given below. The number(s) preceding each paragraph refer to the recommendation of that number in the report.

1. Normality has not been defined. Rather than set rigid rules a judgement could be made on the health and suitability of individual clients by an obstetrician and/or midwife.

3. If facilities, e.g. napkin service, are to be provided for patients having an early discharge from hospital those should be provided for those having a home confinement as well.

10. The domiciliary midwives feel that as their practice is essentially concerned with healthy families it is more appropriate for them to be attached to the Health Department which promotes health than to the Hospital Board. They also feel that the benefits of being attached to the Hospital Board e.g. access to sterile supplies, would be outweighed by the disadvantages e.g. greater control of their practice.

11. It is seen as inappropriate that review committees for midwives should consist mainly of obstetricians rather than nurses/midwives - peer review should be promoted.

13.1 There is no purpose for H678 being retained by the obstetric unit, as midwives records are available upon request, just as other units medical records are available upon request.

14. This recommendation effectively removes clients choice of midwife. It can be left to the midwife to judge the travelling time involved and to accept/reject bookings as appropriate.

15.3 There should be payment for antenatal visits as well as for more post natal visits, to enable midwives to provide a better service. Payment should be per visit rather than per day.

18. Whilst it is common sense that at least two professional persons should be present at any delivery, in case of an emergency, there is no reason why this should not be two midwives. In most cases the doctor is present but no reason could be seen to make the doctor's presence mandatory.

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20. Although it is obvious that for the most part midwives and medical practitioners work in harmony in the best interests of their clients it is not always desirable for the midwife to defer to the doctor, if a difference of opinion does occur. The midwife is an independent practitioner, within the realm of normal child bearing, able to make judgements as to the proper care and referral treatment for her clients. (It must be pointed out that medical practitioners do not always make the right decisions concerning patient care.)

22. While the intentions of this recommendation are aimed at safe obstetric care six months in an antenatal clinic plus one year in a delivery unit, plus six months postnatal does not guarantee a midwife is ready to undertake domiciliary work. To attach time regulations as a criteria references is naive.

23 and 25 No other group of nurses have their practice prescribed and evaluated by medical practitioners. Moreover, no other group of nurses, other than those attached to private practices, require approval by medical practitioners in order to gain employment. The control of nurses and midwives is properly carried out by senior members of their own profession. These recommendations are clearly discriminatory and could be interpreted as an insult to the nursing profession.

26. Standards of professional competence are essential for all nurses. It this recommendation is accepted it must apply to ALL midwives.

27.5. Persons present at a home birth are the prerogative of the family and the birth attendant(s).

28. The Maternity Services committee is itself not seen as an appropriate body to be commenting on midwifery practice as it is mainly composed of medical practitioners with only two midwives being members.

Representation on the maternity services committee was seen to be heavily biased in favour of the medical profession rather than midwives and mothers who could have provided a more balanced viewpoint.

CHAIRPERSON _____ DATE _____

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[illegible] editorial on home births [illegible] says the maternity services committee "has had the good sense to acknowledge that they (home births) will continue, and wisely has recommended ways to reduce risks to both mother and baby." This only appears to be so. In fact the recommendations are a catch-22 situation!

As far back as 1980 the Medical Council set up an Obstetrics Standards Review Committee (OSRC), a [illegible] pressure group "with an Orwellian ring" because so many births were taking place outside hospitals. It is this OSRC which will monitor all obstetric hospital contracts.

Since the obstetricians as a body oppose home birth, how many doctors doing home birth are going to get their contracts approved? It is a legal requirement in New Zealand for every woman having a baby to be under the supervision of a doctor — so eliminate the doctors doing home birth and you eliminate legal home birth! Even now peer pressure prevents many doctors from doing home births, even though they do not disapprove of them. How many doctors will be able to stand up to the peer pressure of the OSRC?

Furthermore, domiciliary midwives are to be assessed by this OSRC. Already two midwives who are openly opposed to home birth have been appointed to the Auckland committee. There are no domiciliary midwives on it. Is the OSRC so afraid of home birth that they cannot afford to have a domiciliary midwife on their committee?

As for safety, official reports make no pretence about safety. When Sir William Fletcher Shaw was invited to New Zealand in 1946 to help set-up the O and G powerbase, ie the Post-Graduate School of Obstetrics and Gynaecology and the National Women's Hospital, at taxpayers' expense, he never mentioned safety in his report.

But he did point out that the high incidence of hospital births, reinforced by the Social Security Act which provided free hospital care under a doctor of the mother's choice, favoured doctors doing obstetrics, while the shortage of home

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beds undermined any competition from midwives doing domiciliary midwifery. He also advised that it would be possible in time to limit the "open" maternity beds to those who had special post-graduate experience in obstetrics — thus squeezing out the general practitioner obstetricians.

Today Shaw's forecast is significant. Under advice from a maternity services committee report released in 1978 closure of the small maternity units was begun. The small cottage hospitals, Bethany, and finally the Mater maternity wing went. These closures eliminated the operational base of the GP obstetrician, thus funnelling all women into the specialist obstetric base hospitals.

Now the coup de grace is about to be administered to the few hardy GP obstetricians still holding out, again on recommendation from the maternity services committee, which is a professional body dominated by the leading obstetricians. It advises the Board of Health on all matters of maternal and infant welfare. The committee has one token consumer representative.

In the face of the strong feminist health movement, which includes home birth, the committee is far too shrewd to openly "reject" home birth out of hand.

Let's not kid ourselves and the public on the real issues involved in the debate over home birth. It is a power struggle between obstetricians-hospital boards, with their huge investment in architecture and technology aggravated by a falling birth rate, and women who are trying to regain control over their bodies.

If the committee really wants to appear sincere in its "safety" claims, why not ask the epidemiology advisory committee to investigate the comparative well being of mothers and babies in hospital and home births? They could start with the recent Board of Health Report on Child Care, which states that 1 in 10 women suffers from postnatal depression; this leads to child abuse because it disturbs the parent-child relationship.

The report also states that abnormal labour is one of the contributing causes of postnatal depression. This is one of the reasons women want to have their babies at home — so there is no unnecessary or routine technological interference which leads to abnormal labour.

In a computerised survey of 1153 home births over a period of seven years, our postnatal depression rate was 0.5% — one 20th of the going rate. And as the report says, a good parent-child relationship lays the basis for the child's future physical and mental health.

JOAN DONLEY

Domiciliary midwife

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16