SAVE THE MIDWIVES

19 WINTER 89

CONTENTS:

CHANGING TIMES:

Women views must be making a significant impact " somewhere ", as according to Dr Tony Baird the immediate past chairman of the NZ Medical Association, when addressing a recent meeting of the Wellington Obstetrics & Gynaecology Society.....

" The 3 greatest threats to modern obstetrics are
consumerism
feminism
and midwives "

I can't help but wonder if there are any women not threatening "modern obstetrics" !

I would like to extend a special thankyou to Joan Donley who continues tirelessly to provide copious quantities of ongoing information for this newsletter. Thankyou Joan.

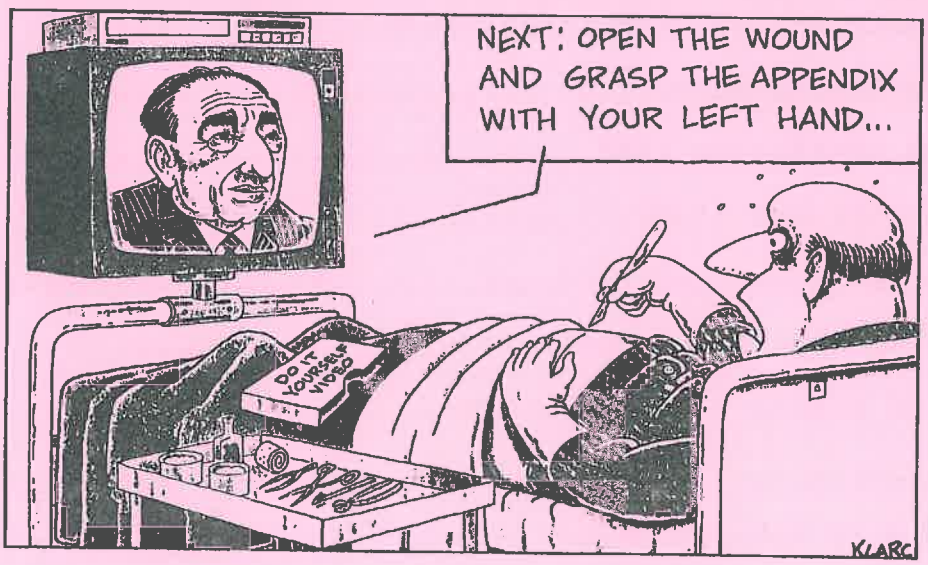
All of us have been very aware of the rapid chain of events as the health services restructure - some areas being more dramatic than others. However, questions have to be asked about the motive for many changes.....are they to provide a move from the institutions into the community because this is more appropriate and provides better health care.....or is the chief priority in balancing the budget?

And what has happened to the process of CONSULTATION?

Predictably, those who are most at risk from the changes are those who are most vulnerable - women and babies, children, psychiatric and elderly people; and equally predictable, the caregivers who are mostly women, will end up with the burden currently being rapidly unloaded by Govt. Health Services.

However, you CAN make your views known by writing to your MP, Area Health Board, community health committes, service development groups, Minister of Health, Women's Ministerial Advisory Committee (c/-Health Department) and Ministry of Women's Affairs. * * Make it this Wednesdays letter * *

Judi Strid



HERALD 19.5.89

New Zealand

College of Midwives

* Auckland Region presents CULTURAL AWAKENING with Social Anthropologist Frazer McDonald - Marion Davis Library,Auck.Hosp July 20th, 1900 hrs - All Welcome - $2 admission

* The first College JOURNAL is due out within the next month and will be obtainable from each Region of the College of Midwives.

* 1990 NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE - Dunedin 31 Aug-2 Sept. WANTED - abstracts, ideas, theme, fundraising Contact: Conference Cmttee,Otago Region of College, PO Box 243, Dunedin North

* SWEATERS in black, white, maroon, bright red, dark red, royal blue, navy blue, light blue, bottle green, emerald green, gray, pink & teal with WOMEN NEED MIDWIVES MIDWIVES NEED WOMEN or SAVE A MOTHER EDUCATE A MIDWIFE or MIDWIVES FOREVER with picture of mw & babies send size, colour $32 with order + $2.50 p+p to Auckland Region of College c/-Denise Knapman,28 Rotoiti Ave,Pakuranga,Auckland

* Self-adhesive bumper stickers **MIDWIVES MAKE IT A LABOUR OF LOVE** are available at $1.50 plus 40 cents postage from the College PO Box 21 106, Christchurch.

* Midwives and Student Midwives are entitled to full membership to the College, non-midwives associate membership and groups affiliated membership. * HAVE YOU JOINED YET? *

NEW ZEALAND COLLEGE OF MIDWIVES - Membership Application
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- Non-midwives/Associate(unwaged)- $26
- Affiliated Membership - $26

'Midwifery Today'

26th July - 30th August, 1989 NATIONAL WOMEN'S HOSPITAL

26 JULY Sharing The Power In Midwifery

Welcome & Introduction 0845

EMPOWERMENT 0900

What Is It ?

Who Has Power ?

Accepting The Responsibility For Power

Empowering, A Feminist Philosophy of Sharing

1230 LUNCH

Sharing The Power of Midwifery 1330

Discussion *Teresa Bradfield*

Val Fleming

Treaty of Waitangi 0900 2 AUGUST

A Midwifery Perspective

- *Pauline Fitgerald, Staff Nurse, Clinic 2*

The Whanau Room 1100

- *Kathy Manga*

Maori Expectations of Childbirth 1145

- *Elameine Emery, Guest Speaker*

LUNCH 1245

Customs of Childbirth 1345

Speakers From Various Cultures

Midwives In A Multicultural Setting

- *Discussion Facilitator - Val Fleming*

Midwifery Assessment Skills of The Newborn 0900 9 AUGUST

- *April Higham, Coordinator, Neonatal Course*

Cyanosis of The Newborn 1000

- *Dorothy Cooper, Neonatal Education Coordinator*

Grief, Separation & Dying 1130

- *Sandra Budd, Nurse Manager, Neonatal Unit*

LUNCH 1230

Early Discharge 1330

The Cost of Economics

The Effects of The Post Natal Period

Panel Discussion

- *Julie Knox Ward 8*
- *Jenny Callis Ward 3*
- *Elise Macdonald HCMS*

ENVIRONMENTS FOR PRACTICING MIDWIFERY 16 AUGUST

The Midwife As A Practitioner 0900

- *Bronwen Cox, Quality Assurance, Obstetric*

Role of The Midwife In A GP Practice 0930

- *Charlotte Diggle, Practice Nurse Midwife*

Where To Give Birth 1100

- *Lou O'Leary, Principal Nurse, Papakura*
- *Sheree Moran, Delivery Suite, NWH*

Post Natal Facilities Available 1145

- *Joan Donely, Domiciliary Midwife*

LUNCH 1230

The Midwife As A Teacher 1330

- *Sharing Information*

Technical Institute 1345

- *Liz Smyth, Midwife*

The Midwife As A Manager 1445

- *Pam Hayward, Nurse Manager*

The Midwife As A Researcher 1500

- *Val Fleming, Divisional Nurse Manager*

Coordinated By:

Teresa Bradfield
INSERVICE EDUCATION COORDINATOR
NATIONAL WOMEN'S HOSPITAL

23 AUGUST

ADAPTING MIDWIFERY TO ENVIRONMENTAL CHANGE

Parent Education 0900

Preparation For Parenthood - Do We Do The Right Thing ?

- *Jill Mitchinson, Patient Education Coordinator*

LUNCH 1200

The Risks We Carry 1300

Infection Control Perspective
- *Francie Morgan, Infection Control Nurse*

FINISH 1600

This programme has been developed to promote midwives and their roles within National Women's Hospital and other obstetric areas.

$10.00 per day

30 AUGUST

An Historical Look At Midwifery 0900

- *Betty Jenkins, Divisional Nurse Manager, Obstetric*

Current Midwifery Practice Internationally 1030

- *Glenda Stimpson, Delivery Suite*

"What's Gone Wrong In New Zealand" 1130

- *Joan Donely, Domiciliary Midwife*

LUNCH 1230

Re-Expanding Our Horizons As The Primary Caregiver

Discussion 1330

- *Val Fleming*
- *Teresa Bradfield*

AUCKLAND WOMEN'S HEALTH COUNCIL

10 Carlton Gore Rd, Auckland.

presents

"A DAY OF RECKONING"
THE CARTWRIGHT REPORT — ONE YEAR ON

SPEAKERS

Clare Matheson
("Ruth" of the Unfortunate Experiment)

Sandra Coney

Phillida Bunkle

Presentation to Dame Silvia Cartwright

CONSUMER WORKSHOPS
VIDEOS
BOOK STALL

Conference to be opened by Dame Cath Tizard

WHEN: Saturday 5 August 1989
TIME: 9 a.m. – 4.30 p.m.
WHERE: Freeman's Bay Community Centre, 52 Hepburn Street, Ponsonby, Auckland.
COST: Supporting — $20 plus
Waged — $20 ($15 if registered by 22 July)
Unwaged — $10

BRING LUNCH TO SHARE
WOMEN ONLY

From Birth to Death II The Second Overview Report of the Planning Council; Social Monitoring Group, prepared by Judith Davey and Micheal Mills.

Available from the Planning Council for $29.95

This is a major report emanating from the Planning Council which examines the lifestyles of New Zealanders and the trends in family formation, education, housing, employment and unemployment, health and general welfare. It focuses on the differences between Maori, Polynesians and other New Zealanders and looks at the implications of these trends for policy development.

As the foreword indicates, "Social Monitoring involves not only the updating and refining of available material, but also commentary on both the social trends themselves ..... this report provides information which can be used for discussion and decisions relating both to social trends and policy development."

DATES TO REMEMBER

CHANGE WITHIN MAORI SOCIETY - Dr Ranginui Walker/Public Lecture
July 19, 1300-1400 hrs at Maidment Theatre,Auckland University

THE MONEY MAZE - A workshop on funding for Community Groups
July 19, 0900-1500 hrs - Te Atatu Sth.Community Ctr,Edmonton Rd
Enquiries: Mereanna Johnston ph. 8373700 Ext 8781

CULTURAL AWAKENING - with social anthropologist Frazer McDonald
July 20, 1900 hrs. Marion Davis Library, Auckland Hospital
All welcome - admission $2 - Enquiries: Auckland Region of the
NZ College of Midwives, PO Box 24403, Royal Oak, Auckland

MIDWIFERY TODAY WORKSHOPS - July 26/Aug 2,9,16, 23 & 30
National Womens Hosp.,-Auckland Enquiries: Teresa Bradfield
Inservice Education Coordinator, National Womens Hospital

IS THERE A CURE FOR THE HEALTH SYSTEM? Judith Bassett
July 26, 1300-1400 hrs at Maidment Theatre, Auckland University

EVALUATION MODELS FOR HEALTH PROMOTION PROGRAMMES/At all levels
Health Education Liaison Group - July 27, 1000-1200
Cancer Society Lecture Hall, 41 Gillies Ave., Epsom, Auckland

BIENNIAL INTERNATIONAL ALLIANCE OF WOMENS CONGRESS - August 1st
Venue: TBA - Victoria, Australia
Enquiries: 58 Broadway,Camberwell,Victoria 3124. ph.(03)8180747

A DAY OF RECKONING - THE CARTWRIGHT REPORT - ONE YEAR ON
Conference for women only & bring lunch to share $10 - unwaged
$20 waged ($15 if reg.by July 22) August 5th - 9am-4.30pm
Freemans Bay Community Centre, 52 Hepburn St,Ponsonby, Auckland
Enquiries: Auck.Women's Health Council,10 Carlton Gore Rd.Auck.

NZNA WINTER SERIES ADDRESSING BI-CULTURALISM - August 7/14/21
To examine the concept of honouring the Treaty of Waitangi in
relation to nursing & health - $5 workers/$3 students/unwaged
Gonzaga Hall,Mercy Hosp.,Mountain Rd.,Epsom,Auckland - 5.30pm
7th - Heather Thompson/Bi-cultural Officer for Auckland AHB
14th- Lesley Smith & Rose Lightfoot - Carrington Tech.Educators
21st- Irihapeti Ramsden/Dept.of Education Nurse Advisor

WORLD FEDERATION FOR MENTAL HEALTH 1989 WORLD CONGRESS-Auckland
21-25 August " Mental Health - Everyone's Concern "
Enquiries: Convention Management Services, PO Box 12-442, Auck.

NATIONAL FEDERATION OF PARENTS CENTRE CONFERENCE - 26-27 Aug'89
New Plymouth High School. Enquiries: PO Box 11310, Wellington.

MIDWIVES DAY - September 1st **Tell us what you will be doing**

FRAMEWORK FOR HEALTH CARE IN AUCKLAND - evening of Setember 5th Harold Titter, John McLeod, David King. Further details, contact Eugenia McCullagh, Auckland University, Dept. of Community Health

SHELIA KITZINGER VISITING NZ - September 17th

SUFFRAGE DAY - September 19th

PROMINENT BRITISH FEMINIST, SOCIOLOGIST & WRITER *ANN OAKLEY* WILL TOUR NZ - Sept'89. She is well known for her work in the area of women's health & childbirth issues, and for her books "The Captured Womb" and The Sociology of Housework & Housewife September 21 - Auck. University Conference Centre, Symonds St. WOMEN'S HEALTH RESEARCH WORKSHOP - Keynote speaker Dr A Oakley Enquiries: Medical research Council, PO Box 5541, Wellesley St.

CHILDBIRTH EDUCATORS ASSOCIATION XIII BIENNIAL CONFERENCE- Sydney 6-10 Sept'89 "Birthing - Toward 2000" Contact: Conference Committee, Suite 11, 127 Forest Rd., Hurstville, NSW 2223, Australia (ph. 574927)

FREEDOM FROM HARASSMENT CONFERENCE - Auckland 9-10 Nov'89 To address issues of equal opportunity and sexual harassment. Enquiries: PO Box 6751, Wellesley St., Auckland (ph.390874)

1990 NATIONAL HOMEBIRTH CONFERENCE - Whangarei Calling for ideas & input, suggestions, fundraising etc. Contact: Agnes Hermans 24 Pah Rd, Onerahi, Whangarei

NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE - Aug 31-Sept 2 1990 Enquiries: Conference Cmttee. NZ College of Mws, Otago Region PO Box 243, Dunedin North. (Calling for abstracts/ideas/theme)

INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS: October 8-12 1990 Kobe, Japan Enquiries: ICM International Congress, Nursing Association International Relations, 8-2, 5-Chrome Jingumae, Shibuya, Tokyo.

EARTH FIRST EXPO - an environmental awareness event planned for October 1990. If interested in participating, exibiting or performing write to : P O Box 8371, Symonds St., Auckland

FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES: 8-10 November 1990 - Massey University, Palmerston North

2ND INTERNATIONAL HOMEBIRTH CONFERENCE - 1992 Sydney Calling for ideas & input, suggestions re. areas of concern, specific people to be invited & fundraising. Open planning meeting 21.10.89 - 77 Albert Drive, Killara, NSW 2071, Australia Enquiries & Input: Jane Thompson, 12 Thornton St., Fairlight, NSW

WOMEN'S HEALTH RESEARCH WORKSHOP

KEYNOTE SPEAKER:

DR ANN OAKLEY

Thursday, 21 September 1989

University of Auckland Conference Centre, Symonds Street, Auckland

TOPICS FOR WORKSHOP SESSIONS

Older Women
Reproductive Health
Maori Health
Mental Health
Movement in Health Research
The Role of the Consumer

For further information and registration forms please contact

THE MEDICAL RESEARCH COUNCIL OF NEW ZEALAND

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Auckland, New Zealand

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SPEAKER:

SOCIAL ANTHROPOLOGIST FRAZER McDONALD

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Dr P.J. Saunders
c/o Medical Aid Abroad
P O Box 3983
AUCKLAND,1

LETTERS:

Thank you for your letter about the risk of re-using plastic disposable specula. I apologise for my delay in replying.

Charlotte Paul and I wrote that letter to the Lancet in 1986, because we were concerned about the theoretical risk of infection from this practice. Our letter prompted some microbiologists in London to conduct experiments which were reported in the Lancet on 4 October 1986 (copy enclosed).

We have not outselves done any further research on this hypothesis. The risk of transmitting the human papilloma virus remains a theoretical one, but I believe that there is no justification for the re-use of plastic disposable specula.

Yours sincerely,

UNIVERSITY OF OTAGO
DUNEDIN · NEW ZEALAND
Department of Preventive and Social Medicine
Medical School

David Skegg

D.C.G. Skegg,
Professor of Preventive and Social Medicine.

RISK OF TRANSMISSION OF HUMAN PAPILLOMAVIRUS BY VAGINAL SPECULA

SIR,—In response to Skegg and Paul's warning[1] we investigated the risk of iatrogenic transmission of human papillomavirus (HPV) via specula inserted into the vaginal vault of women with subclinical HPV infection. We investigated the possibility that HPV could be detected in cells adhering to specula after colposcopic examination of women with premalignant disease of the cervix (cervical intraepithelial neoplasia [CIN grades I to III]) associated with HPV infection. Many of these women also have HPV infection in other areas of the lower genital tract. The specula, after colposcopic examination and removal from the vaginal vault, were rinsed briefly in an aqueous solution of chlorhexidine to remove excess mucus and then washed thoroughly in phosphate buffered saline to remove adherent cells which were collected in a clean sterile container. The cells were then transferred to nitrocellulose filters and the presence of HPV genomes investigated by in situ DNA-DNA hybridisation.[2] Twenty-nine specula from different women were examined and HPV16 DNA sequences were detected in 4 cases with 3 other equivocal results (fig 1). This HPV type is associated with most of premalignant and malignant disease of the cervix.

To confirm these findings cells from a further 16 specula were examined by Southern blotting. Total DNA was extracted from the adherent cells washed from the specula and digested with the restriction enzyme *PstI*. HPV16 DNA sequences were detected in 1 instance (fig 2): 5–20 copies per cell were detected. This small study shows that HPV infected cells can be found on instruments inserted into the vagina of women with HPV infection, and if these instruments are not cleaned and sterilised properly they will be a potential source of infection for subsequent patients.

Papillomaviruses are stable viruses and we recommend that all instruments be autoclaved between patients. If this is not possible the instruments should be washed and then put in boiling water for 10 min. Disposable spatulas should be used when a smear is taken, and used once only. Plastic reusable spatulas which can be disinfected between patients are not recommended because the duration and type of disinfection may vary and the efficacy of disinfection is not known and difficult to test due to inability to propagate HPV in vitro.

Department of Microbiology,
UMDS of Guy's and St Thomas's Hospitals,
Guy's Campus,
London SE1 9RT — D. J. MCCANCE

Department of Obstetrics and Gynaecology,
Whittington and Royal Northern Hospitals,
London N19 — M. J. CAMPION, A. BARAM, A. SINGER

1. Skegg DCG, Paul C. Viruses, specula, and cervical cancer. *Lancet* 1986; i: 747.
2. McCance DJ, Campion MJ, Singer A. Non-invasive detection of cervical papillomavirus DNA. *Lancet* 1986; i: 558–59.

THE LANCET, OCTOBER 4, 1986

Pages 816-7

News

Birth option has second chance

The Northland Area Health Board has won support from a group of health consumers for one of the measures introduced as part of its cost-cutting round.

The Whangarei Home Birth support group says it is delighted the board is to reintroduce the domino option, whereby a domiciliary midwife provides continuity of care before, during and after birth, at Northland Base Hospital.

Hospital manager Mr Ron Gutschlag reckons the option could save $60,000 a year. More importantly, around 20% of women surveyed recently indicated they preferred the option.

The scheme was tested at the hospital earlier, but withdrawn.

Moves for midwives

Greater autonomy for midwives could be possible following a review of the Nursing Act ordered by Health Minister Helen Clark.

Ms Clark said yesterday she had decided the act should be reviewed by the Health Department.

"At present the Nurses Act prevents midwives from carrying out obstetric nursing if a doctor has not undertaken responsibility for the care of the woman requiring childbirth services.

"The need for this provision has come under challenge from both consumers and midwives. Many midwives see themselves as independent practitioners," Ms Clark said in a speech to the Nurses' Union.

The review would also cover the increasing role being played by nurses in private practice and the profession's disciplinary procedures.

The regulation of nursing would also be reviewed by the Government's working group on occupational regulation.

The Northern Advocate, Saturday, June 10, 1989

Hospital gains reprieve on closure plans

HERALD 8-6-89

Pukekohe Hospital yesterday gained a reprieve when the Auckland Area Health Board commissioner, Mr Harold Titter, met the hospital action committee.

Mr Titter agreed at the meeting, held behind closed doors, to allow a review to be undertaken of the geriatric and obstetric hospital's operations, to find ways of saving money without closing it.

The MP for Maramarua, Mr Bill Birch, who is a member of the action committee, said afterwards that the committee had made plain its dismay at the plans for closing the hospital, announced by Mr Titter last month.

The meeting was arranged because of strong local concern that the closure of Pukekohe Hospital would leave a gaping hole in the community's wellbeing.

Mr Titter was told yesterday that the hospital provided maternity and geriatric care for a potential 40,000 local people.

"He came out to persuade us that the hospital should be closed, but I think we gave him a lot to think about," Mr Birch said.

"The services were built up with a strong community network support.

"To remove those services would take us back 50 years."

He said Mr Titter agreed to some of the points the committee made, and that the local people and hospital and other board staff should review its operation.

Areas where savings could be made were in better use of beds, particularly obstetric and also in wages.

Mr Titter admitted that closing the geriatric ward would save the board only $800,000 a year, Mr Birch said.

The review of the hospital's operatons would be started immediately.

But at St Helens . .

HERE TODAY, GONE TOMORROW

Hospital axe over Waikato

HERALD Wellington Staff 20·5·89

Two Waikato towns may lose their hospitals as the health axe prepares to swing through the region.

Te Kuiti and Tokoroa hospitals are facing possible closure when the Waikato Hospital Board decides exactly which services will fall under expected budget cuts.

At a special board meeting yesterday, figures presented by the board manager of policy and development, Dr Alec Sinclair, showed that the two hospitals were high over budget.

The acting general manager of the board, Mr Glen Garlick, said last night that the fate of the hospitals would not be known until Government funding commencements in July.

The board must also find money to cover new projects such as implementing the Mason Report, cervical cancer screening and ethical issues reaching almost another $6 million.

During the meeting, Dr Sinclair said the biggest savings could be made if the board adopted a policy of reducing the number of days patients stayed in hospital and discharging them earlier.

"We cannot keep people in hospital one hour longer than is strictly necessary because we simply cannot afford it."

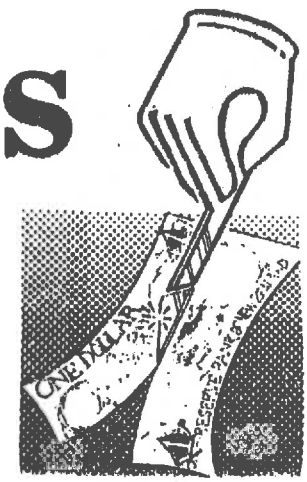
The second biggest saving would come from reducing the number of qualified staff and employing differently.

"We could make huge savings by employing casual workers and we must work hard with the unions at the negotiating table to change the conditions of employment. They are making this country into a bankrupt society," said Dr Sinclair.

The board will meet again on Monday to decide whether it will accept yesterday's proposals and to discuss the possible closures of Tokoroa and Te Kuiti hospitals in detail.

It looks likely that Tokoroa will be the first to go because it is closer to Rotorua and Taupo hospitals than is Te Kuiti.

Cuts



Not allowed

Sir,—Maybe all remaining hospitals should erect the sign — "No tittering allowed on these premises."

Olive Harricks.
Epsom.

Helensville vows to fight for a third time

HERALD 18·5·89

By CARYN WILKINSON

Helensville area residents are not about to call a truce in a battle they have waged against the former Auckland Hospital Board for 14 years.

The defiant community, which has weathered two earlier threats to close its district obstetric hospital, is bracing itself to fight a third time — this time against one of many cost-cutting proposals planned by the new Auckland Area Health Board.

Members of the Helensville Hospital Community Committee will meet tonight to discuss "practical alternatives" to the closure.

The committee, formed 14 years ago to keep the hospital open, would not give up now without a fight, said the chairman, Mrs Alison McKenzie.

"I think we'll find some way around it," she said.

In 1981, the hospital came within a day of closing, but the community warded off the threat by raising $14,000 to redecorate and adapt it to accommodate a wider range of activities.

The hospital, which has an annual budget of about $400,000, had already survived a threat of closure in 1976, when public health funds were cut back.

About 100 babies are delivered each year at the 33-year-old hospital, which houses six obstetric beds and has a staff of 16.

Dr Adrian Gane, one of two Helensville doctors who deliver babies at the hospital, said the closure would be disastrous because it would rob pregnant women without transport of vital pre-natal classes and care.

"We are trying to save money, but it's hard to assign dollar value to teaching good mothering skills."

Training ground lost say GPs

The loss of three of Auckland's outlying obstetric hospitals means the removal of a valuable training ground for young doctors, says the Royal New Zealand College of General Practitioners.

The college chairman, Dr Derry Seddon, said he was concerned there would be problems with the removal of the obstetric learning environments at Helensville, Pukekohe and Howick.

Dr Seddon said he hoped the rationalisation of services would allow a rethink of the training of junior doctors and their educational requirements.

Top Aussie tipped for Bonham job

SUNDAY STAR 25·6·89

By JOANNA WANE

Australian specialist Dr Judith Lumley is hot favourite for the key National Women's post left vacant by the retirement of Professor Dennis Bonham.

The *Sunday Star* believes the Auckland University has offered her the postgraduate chair of obstetrics and gynaecology and is waiting a response.

Dr Lumley lectures in obstetrics at Monash University in Melbourne and is a consultant epidemiologist at the Department of Health's perinatal data collection unit.

She is a past medical editor of the *Australian Family Physician* and in 1980 co-authored, with clinical psychologist Dr Jill Astbury, *Birth Rites Birth Rights, Childbirth Alternatives for Australian Parents.*

The book explores the options open to pregnant women and raises concern over issues such as the increasing rate of caesarean births and inadequate communication between patients and the medical profession.

Dr Lumley visited New Zealand last week, heightening rumours that she is a strong contender for the position.

Medical School dean Professor Derek North says an overseas applicant with a broad involvement in matters related to women's health was interviewed last week and offered the post.

He would not reveal the applicant's name but says he expects an answer within the next fortnight.

"The candidate is a person of distinction and, if she accepts, we will be very fortunate," he says.

The chair was targeted as a key post by Judge Silvia Cartwright in her report on the National Women's Hospital cervical cancer inquiry and the appointment has attracted widespread interest and speculation.

It is understood the university is offering a four-year tenure, with the opportunity to renew the contract then open to either party.

Auckland test tube baby pioneer Dr Freddie Graham is aware Lumley has applied for the post and says she would be an excellent choice.

More Otago women using alternative birth positions

Alternative birth positions are becoming the hoice of more Otago vomen.

Professor R. J. Seddon, hairman of the department of obstetrics and ynaecology at the University of Otago, said about ne in 20 women who gave irth at Queen Mary Hospital were opting to use an alernative birthing method.

"Women were given the hoice here about five ears ago. Since then, some ave chosen to crouch, neel on all fours, or use irthing stools," Professor eddon explained.

Although the figure was ow, he attributed it to the act that Queen Mary Hospital was the only hospital in the Otago Area Health Board equipped to cope with difficult deliveries.

"Therefore, we get a lot of complicated births."

He said the positions women favoured changed frequently but alternative methods were becoming more popular.

Many women chose to use these positions during labour, but opted for the traditional delivery.

Bean-bags and baths were used for relaxation purposes, Professor Seddon said.

A good proportion of the women admitted to Queen Mary used all the birthing positions during labour.

"So long as it's safe for them and the baby, they can choose any position they wish," he said.

Many of the 4,000 women who had babies at Auckland's Middlemore Hospital gave birth in crouching positions or on bean-bags, the Press Association reports.

Birth attitudes were becoming more relaxed, and it was not unusual for entire families to be at the bedside when a woman gave birth.

Professor Seddon said Queen Mary Hospital had facilities — a special delivery suite — for the whole family.

"About 30 to 40 families use it each year," he said.

Queen Mary Hospital catered for 1,700 babies, on average, each year.

Midwives Chronicle & Nursing Notes

January 1989

Parliamentary Report

PARLIAMENTARY PROTESTS over midwifery clinical regrading brought the Commons' old session to a stormy close. In the last but one motion on the old Order Paper before the new session began, Opposition MPs pressed the Government to review urgently the way midwives had been regraded.

Pointing out that the entire exercise had left midwives seething in "outright anger" over the way they had been treated, the MPs called on Ministers to think again—and they warned that morale, already low, now threatened to hit further recruitment into the profession.

The MPs reminded the Government that the review had originally been promised to reward training and experience.

They were therefore appalled that many qualified midwives had been appointed at a level below grade E and many midwifery sisters below grade G, despite the RCM's recommendations.

According to the MPs the result meant that not only were midwives not being rewarded as promised but unfair anomalies had been created between different health authorities. It would result, they forecast, in new difficulties in maintaining a team approach and hit recruitment, which was already nearly 18% below establishment.

Obstetric update

Domiciliary obstetrics

Hugh Carpenter

In the present climate of Australian opinion, home births are unacceptable to the majority. This paper attempts to justify a responsible plea for moderate reform in this sensitive area; sensitive because it involves conflicting opinions about a fundamental human experience.

Conflict

Three major points are relevant to this appraisal of home birthing.

First, whether we like it or not and whoever we are — doctors, politicians or the public at large — a minority of women are sufficiently motivated to insist on home births despite all manner of threats and persuasions to stop them.

Home births continue (*Figure 1*) despite comments such as: 'Do you want your baby to be born dead?'; 'If something went wrong and your baby died you would be a murderer'; 'That will be your funeral'; 'I will not do your antenatal care'; 'I am committed to stamping out home births'.

Are we dealing with reckless fools?

Apparently not. The women who insist on home births are at least

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average in their attention to antenatal care and parenting and in their general behaviour.[1] They are by no means a bunch of drop-outs. One must conclude that these are women of strong conviction who will not be stopped, who will not go away and who need to be accommodated in the overall scheme of things.

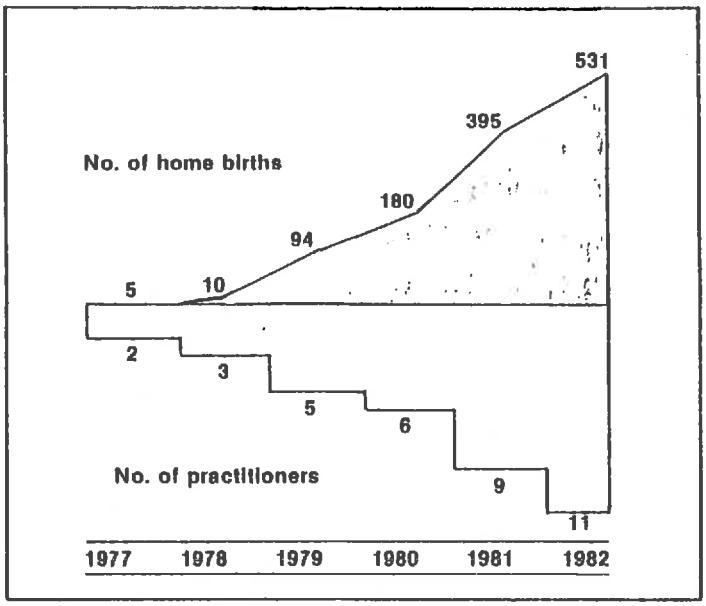

Figure 1. Rise in number of home births and practitioners, 1977-1982. (Lecky-Thompson M: unpublished data, 1982).

Second, the opinions of the Royal Australian College of Obstetricians and Gynaecologists should be considered. The following quote is the full text of *An appraisal of changing community attitudes to birth* by the Family Health Committee of the Royal Australian College of Obstetricians and Gynaecologists (RACOG) concerning home births.[2]

"Irrespective of screening to eliminate risk factors, home births are deemed to be unsafe. Medical care in the home and backup facilities are never adequate nor are these ever a justification for home births. A definite but small percentage of low risk pregnancies suffer significant complications during labour which may endanger the wellbeing of the mother or the fetus. It may not be possible to recognise, treat or transport the patient to a traditional unit in time to avoid morbidity or mortality.

"It would appear that the home birth movement has gained momentum, not in small part due to a tardiness of many obstetricians to empathise sufficiently well with the emotional expectations of their patients. The technology and specialisation of modern hospitalised obstetrics aims to ensure the safety and efficiency of birth for a large number of mothers. In the past not enough consideration has been given to an individual patient's needs. The ideal birth situation must surely take into account both aspects, and most obstetric hospitals now endeavour to do so. Having a baby should be a safe and an emotionally fulfilling experience. The home birth situation is not able to ensure the former nor guarantee the latter.

"Patients should be discouraged from home confinement. They should be made aware that there is no obligation for the obstetrician to provide services outside the hospital. If obstetricians demonstrate a willingness to conduct home deliveries then clearly the popularity of domiciliary obstetrics will increase.

Patients should be discouraged from but not denied responsible home confinement.

"Similarly the formation of obstetric 'flying squads' to cope specifically with home birth difficulties should be considered only if such a community need is seen to exist. The premature establishment of such a service would legitimise and popularise domiciliary confinement in the community."

Third, the unanimous resolution of the final plenary session of the 1983 National Convention of the Royal Australian College of General Practitioners (RACGP) in Devonport was that "The College should acknowledge its responsibilities in the area of home births and develop suitable policies."

Impasse

The views of the National Association of Parents and Professionals for Safe Alternatives in Child Birth (NAPSAC) and of the RACOG are diametrically opposed. They represent an impasse with no common ground for constructive discussion. NAPSAC exists primarily to promote home births.

The position of the RACGP is less intransigent. To acknowledge responsibilities and develop suitable policies suggests at least a willingness to evolve responsible protocols to meet the realistic demands of contemporary society.

Analysis

The accidental; the irresponsible; and the responsible.

Most statistical surveys of perinatal morbidity and mortality for home births fail to distinguish between these categories of extra hospital confinements. Consequently, misleading comparisons arise in both medical journals and the lay press. Invariably they are unfavourable to home births.

In good conscience, no doctor can deny help to accidental home births. Equally in good conscience, no doctor could support the irresponsible intention for home delivery.

The demand for home births is based on a positive desire to conduct the major events of life at home (*Figure 2*) and a critical rejection of some important aspects of hospital confinement.

Table 1
Home birth statistics NSW 1981[5]

	Home births Per cent of total	Royal North Shore Hospital Per cent of total
Caesarian section rate	3.5	12.0
Forceps rate	1.7	16.0
Induction rate	0.9	33.0

Lecky-Thompson M: unpublished data, 1982.

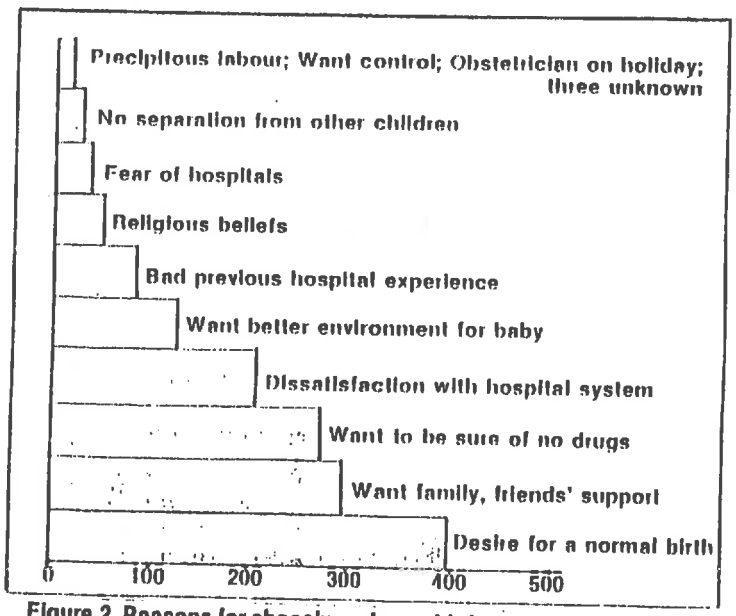

Figure 2. Reasons for choosing a home birth. (Lecky-Thompson M: unpublished data, 1982).

Elisabeth Kubler-Ross describes the family home as "the beloved and familiar surrounding in which birth and death are most naturally and lovingly embodied".[3]

The objection to hospital confinement is in part to do with the institutional surroundings and in part related to the interference rate of hospital confinements. Judith Lumley in 'Patterns of obstetric intervention' (*Table 1*)[4] illustrates the rise in induction of labour, caesarian sections, forceps and epidural anaesthesia for vaginal delivery, in Tasmania and Victoria between 1974 and 1977. She concludes:

"There is a high and rising rate of intervention in childbirth in Australia. There are differences between States. There are dramatic and inexplicable differences between the intervention in public and private patients. The effect on outcome of these high rates

Births are depersonalised by the institutional environment of hospitals.

is not known, though trends in perinatal mortality seem to lack a consistent association with intervention."[4]

One might guess at the explanation for the difference between public and private interference rates; NAPSAC is outspoken in offering its own (*Table 2*).

The case for responsible home births rests on the definition of 'responsible'. The RACOG might say there is no such thing as a responsible home birth. This view is difficult to sustain if one examines the statistics which show that the maternal and fetal morbidity and mortality are not increased, provided careful selection of mothers is made to eliminate risk factors.

A small percentage of complications will occur whether the patient is at home or in hospital. No amount of screening can eliminate these misfortunes, neither can they be eliminated by any choice of birthing place (*Table 3*).[1]

Proposition

In his paper on home births, Peter Lucas[1] established an assessment guide for parent suitability for home births (*Figure 3*).

I would summarise the selection of suitable parents differently (*Table 4*). To be suitable for home birth, both parents must be thoroughly committed to it. It is not the role of the doctor to promote home births, rather it is an option for those women who refuse to go to hospital. The doctor must act by legitimate persuasion. Most women will see reason but they will not bow to unsubstantiated contrary directives from their doctor.

A number of questions should be addressed:

- Is the home clean, warm, well plumbed and convenient?
- Has the mother a satisfactory past medical history?
- Has she had at least one (and not more than two) normal pregnancies and confinements?
- Has she been healthy throughout the antenatal course of the present pregnancy?
- Is there an absence of predictable complications to mother or child in labour?

If all five questions can be answered affirmatively, the determined woman may be confined safely at home by her doctor who should have postgraduate qualifications at least to the level of a Diploma in Obstetrics. There must be an attending midwife. An ambulance service must be not more than 30 minutes away. These guidelines apply for home births in Britain; in

following them for three years in my practice I encountered three unexpected complications in 84 confinements and all had satisfactory outcomes.

In summary, patients should be committed, para one or two, healthy in every respect, in a good home and with a competent doctor and midwife.

Cost

NAPSAC claims that greed is an important motive for the obstetricians' insistence on hospital confinements and the high interference rate which Lumley described as 'inexplicable' in private practice.[4] The cost of a home delivery by a general practitioner with a midwife in attendance, including antenatal and postnatal care, is about $640. The calculation of the cost of a hospital delivery is complicated by the high interference rate. The normal delivery rate is now only about 30 per cent of all hospital births.[1] Carefully costed, the average hospital confinement in Australia is of the order of $1659. The difference of a little over $1000 per birth, applied to the present home birth rate (Australia wide) of 3036 in five years, indicates a saving in excess of $3,000,000 (*Table 5*) (Ligtermoet H; personal communication).

Both parents must make an informed commitment to their request for home delivery.

If responsible home births were promoted, something approaching 30 per cent of total births could fall into this category. The total number of births in Australia is one quarter of a million annually. The saving therefore is potentially of the order $83,00,000. This saving relates to responsible home births only, which would be no more dangerous than their equivalent in hospital.

Outcome

In conclusion, the point must be made that the contents of this article would be unacceptable to the most outspoken proponents of home births. They would certainly want that most exciting of all human experiences, the birth of one's first child, to be undertaken at home. It is recognised also that the article might not be acceptable to the RACOG nor does it conform to the present position of the Council of the RACGP. Neither of these bodies currently accepts any case for planned home births.

This article attempts to meet the intentions of the Convention assembled at the 1983 Annual General meeting of the RACGP. It could provide a responsible basis for discussion between parties who presently share no common ground, the mothers who insist on having home births and the doctors who refuse to accommodate this insistence.

Table 2
Victoria: Public and private patients at one teaching hospital, 1968-76[4]

	Caesarean section (per cent of total births)			Induction of labour (per cent of total births)		
	Public		Private and Intermediate	Public		Private and Intermediate
	Booked	Non booked		Booked	Non booked	
1968	5.0	8.9	14.0	6.2	11.6	23.1
1976	7.2	16.1	14.2	14.7	20.5	28.7

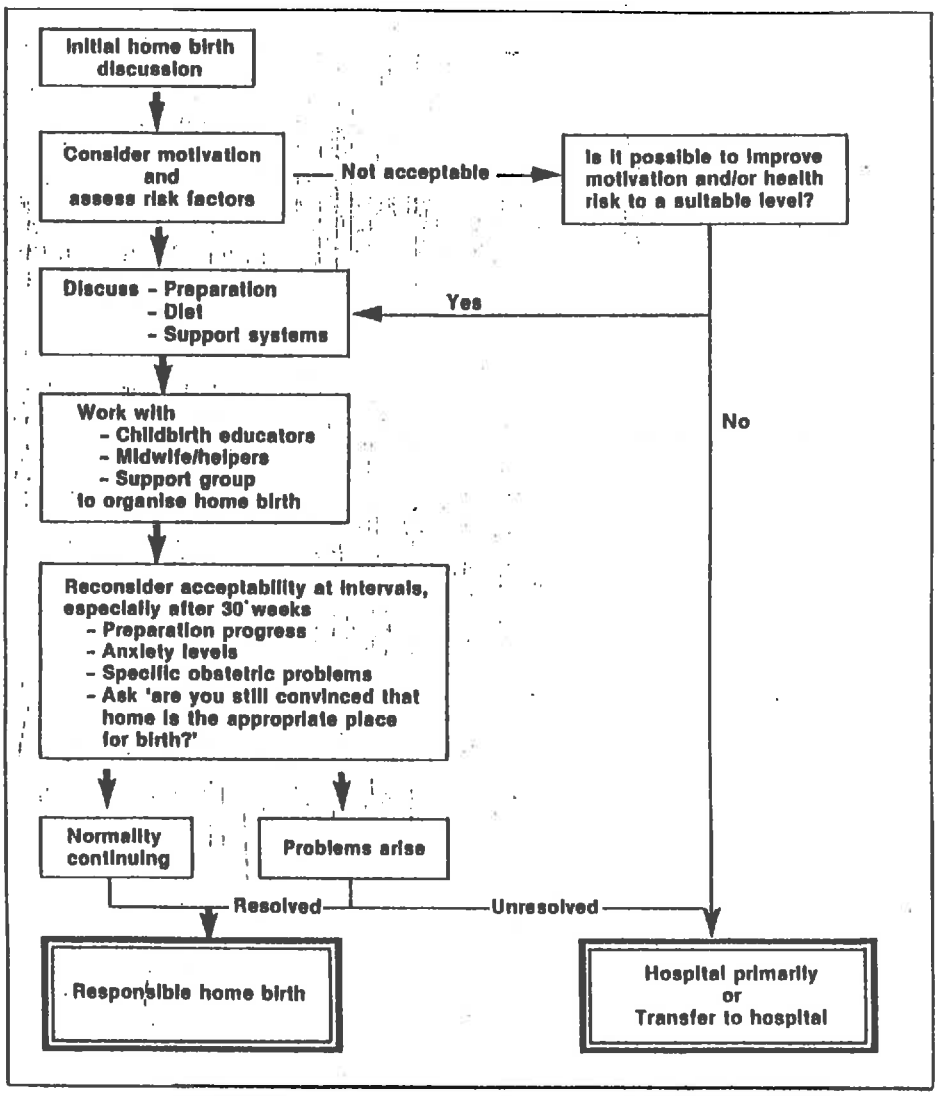

Figure 3. Assessment of parent suitability for a home birth.[3]

Table 3
Comparison of 100 home births with 100 hospital births[1]

	Home (%)	Hospital (%)
Primiparae	24	50
Inductions (all types)	0	12
Artificial rupture of membrane in labour	8	14
Augmentation	0	6
Forceps	6	6
Caesarean sections	1	6
Episiotomies	1	24
Tears	37	36
Pain relief (all types)	6	42
Fetal distress	1	1
Pre eclamptic toxaemia	0	2
Postpartum haemorrhage	0	2
Breast fed	100	90

Table 4
Patient screen for responsible home birth

- Parental commitment
- Competent supportive obstetrician
- Attending midwife
- Clean, warm, well plumbed, convenient home
- Satisfactory maternal medical history
- One or two normal pregnancies and confinements
- Healthy present antenatal course
- No predictable problems for mother or baby
- Ambulance available within 30 minutes

Table 5
Home and hospital births — comparative costs

		$	$
Home births:			
Antenatal care			
Confinement			
Postnatal care:	obstetrician	240.00	
	midwife	400.00	
			640.00
Hospital			
Antenatal care			
Confinement			
Postnatal care:	obstetrician	295.00	
	labour ward & lying-in (7 days)	850.00	
	*Intervention factor	504.00	
			1,659.00
		Difference (per birth, say,	1,019.00 1,000.00)

* Intervention factor: the average additional cost, per birth, or the sum of current costs for induction (12%), forceps (40%), spinal anaesthetic (36%), caesarian section (5%). Percentages reduced to allow for home birth intervention.

Table 6
Cost saving by home births

Actual home births, 1977-1982, Australia:	3,036 total
Approximate cost saving:	3,036 x $1,000 = $3,036,000
Potential annual saving	
Total births, per annum, Australia	250,000 approx.
30 per cent could be responsible home births	80,000 approx.
Approximate annual cost saving	80,000 x $1,000 - $80,000,000

Acknowledgements

Dr Bob Brown, MHA, Mrs Henny Ligtermoet, Mrs Joan Barrington (of the Natural Childbirth Association) and Mrs Jane Jones are acknowledged for their willing co-operation in the preparation of this article.

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Australian Family Physician Vol. 14, No. 3, March, 1985

Working Party on Low Risk Pregnancies

The Women Child and Family Health Division of the Department of Health has set up a working party on safe options for low risk pregnancy.

Members are:

Ms P. Barnett, Chairperson, Scientist in Charge, Health Planning and Research Unit, Christchurch Health Development Unit
Dr T. Birch, Rawene, Northland
Ms J. Donley, Auckland
Dr R. Naden, Dept. O&G, University of Auckland, National Women's Hospital, Auckland
Prof. Seddon, Professor of O&G, University of Otago, Dunedin
Dr M. Kerr, St Albans Medical Centre, Christchurch
Dr H. Sill, RCOG nominee, Christchurch
Ms K. Guilliland, NZ College of Midwives, Christchurch
Ms Paula McIvor, Advisory Officer, Women Child & Family Health, Wellington

BIRTH CONTROL INFORMATION

Another move by the Department of Health has been the publication of a pamphlet for young people on birth control. The booklet is a response to concern at the number of adolescent pregnancies.

Called "Choice, Not Chance", the pamphlet was jointly produced by the Department and the Family Planning Association. Its aim is to help young people make informed decisions about contraception.

The First International

Home Birth Movement

Newsletter

The first issue of the International Home Birth Movement Newsletter is out now. Edited by Hilda Bastian of Australia, this new and fascinating journal has homebirth news from the Americas, Asia and the Pacific, Africa and Europe.

There are feature articles on the 1st International Conference on Home Birth, the Healing Traditions of India, Birth in Malaysia, and an extensive review of the work of the World Health Organization around the world - health promotion, breast-feeding, the role of midwives, appropriate technology during and after birth, and the safe motherhood initiative to reduce maternal mortality by 50% within 10 years.

Contributions by Janet Balaskas, Rahima Baldwin, Beverley Beech and many other childbirth activists from around the world.

Get your copy of this 52-page issue and support the International Home Birth Movement by sending £10 to:

The International
Home Birth Movement
22 Anson Road
London N7 ORD
UNITED KINGDOM

IMPRESSIONS FROM THE AUSTRALIAN 10TH HOMEBIRTH CONFERENCE

From Birthplace Newsletter Winter'89

Keynote Speaker - Marsden Wagner (WHO) was supportive of women and their need to regain their power and control of birth. He questioned the medical professions response to homebirth as unsafe, and in fact reversed the question by asking the medical profession to prove that hospital birth is safer than a well planned homebirth. The World Health Organisation does not recognise any studies that prove hospital to be safer than birth at home. He criticised the high levels of intervention in Australia - especially for c-section, induction and forceps delivery - as all these practices in Australia are above the WHO recommended level.
He emphasised that ALL hospitals should be able to provide intervention statistics to all clients upon request.

1989 NZ HOME BIRTH CONFERENCE - NEW PLYMOUTH

This was the first bi-cultural homebirth conference commencing with the full maori welcome and ongoing contact with the maori perspective of childbirth throughout the weekend. The importance of the sharing and networking was evident as usual, as was the need to provide support to the ever increasing numbers of midwives moving into the rather isolated sphere of domiciliary practice. Homebirth conferences are important gatherings for affirmations and the recognition of progress and achievements, but also for reminders of the work still to be done in the area of midwifery practice and choice of birthplace.

Hui Kāinga Whānautanga O Aotearoa

REMITS:

- to lobby the Government for funds to employ a full time National Home Birth Resource Worker.

- this conference calls for the immediate establishment of a direct entry midwifery course.

- this conference urgently calls for the re-establishment of midwives as independent practitioners.

- call for properly funded, trained homehelp service for homebirth and early discharge families for a minimum of 10 days.

- demand for unbleached products to be available as a choice for all consumers.

- to urge all Homebirth groups to undertake bicultural training before the 1990 Conference either with Project Waitangi or another appropriate group to assess the needs of Maori women in their area.

- the 1990 Homebirth Conference in Whangarei make available a session on racism.

HOME BIRTH STATISTICS 1988

The figures for 1988 represent both an achievement and a challenge. The achievement is a solid increase in home births. The challenge is to make the home birth option more widely available - to people outside the towns and to people of all ethnic backgrounds. Maori people are under represented in the home birth movement. The 1989 National conference is the first bicultural conference and accordingly I have compared the births of Maori mothers with those of others. The percentages are of all Maori births, all other births, and total births, to enable easy comparison.

Year	1984	1985	1986	1987	1988
Home births	369	387	542	596	680

The figures for 1986 and 1987 births are larger than prevously published since late forms have come in. The 1987 and 1988 figures exclude planned hospital deliveries, some of which were included in earlier years.

variable	percentages			variable	percentages		
	Maori	Other	Total		Maori	Other	Total
Mothers' data							
Age: 0-14	0.0	0.2	0.2	married/de facto	85.7	92.3	91.1
15-19	2.9	0.9	1.0	tertiary education	25.3	58.4	56.6
20-24	34.3	9.2	10.5	smoker (mostly under 5 per day)	36.4	7.2	8.6
25-29	42.8	36.6	36.9				
30-34	14.3	38.7	37.4				
35-39	5.7	13.3	12.9				
40-44	0.0	1.1	1.1				

In common with Maori people as a whole, Maori mothers can be seen to have higher risk factors although a more favourable age structure is an exception. It should be noted however that only 35 mothers are involved. So each mother makes a difference of 2.9 percent compared to 0.1 percent for others. Therefore variations due to chance are much more important.

	Maori	Other	Total		Maori	Other	Total
Pregnancy data							
hospital transfers	8.6	12.3	12.7	spontaneous onset	100.0	97.8	97.9
procedures in labour-				type of delivery-			
no procedures	45.7	46.6	46.5	cephalic	91.4	93.4	93.3
pain relief(drugs)	5.7	5.3	5.3	breech	0.0	0.8	0.7
membrane rupture	20.0	14.7	15.0	forceps	5.7	2.5	2.7
acupuncture	0.0	7.5	7.1	ventouse	2.9	0.8	0.9
homeopathic remedy	28.6	34.8	34.5	caesarian	0.0	2.5	2.4
episiotomy	5.7	3.3	3.4				
sutured laceration	25.7	22.2	22.4				
complications of labour-				complications of puerperium-			
none	85.7	82.2	82.4	none	91.2	88.6	88.7
foetal distress	8.6	4.6	4.8	infection-			
prolonged labour	5.7	7.3	7.2	urinary tract	2.9	0.3	0.5
retained placenta	0.0	0.8	0.7	genital tract	0.0	1.1	1.1
haemorrhage-				breast infection	0.0	5.1	4.9
antepartum	0.0	0.6	0.6	venous thrombosis	0.0	0.2	0.2
postpartum	2.9	3.6	3.6	secondary pph	0.0	0.2	0.2
cord prolapse	0.0	0.0	0.0	p.n. depression	0.0	1.0	0.9
other	0.0	4.6	4.3	other	0.0	0.5	0.5
Babies' data							
males	42.9	53.7	53.1	morbidity-			
females	57.1	46.3	46.9	none	91.2	94.0	93.8
still born (1 baby)	0.0	0.2	0.1	premature (extreme)	0.0	0.5	0.4
feeding at 2 weeks-				jaundice (therapy)	0.0	1.4	1.3
breast only	97.1	98.7	98.6	infection	8.8	3.0	3.3
supplement	2.9	1.1	1.2	birth injury	0.0	0.6	0.6
bottle	0.0	0.2	0.2	other	2.9	1.6	1.6

In addition to the still birth noted above, one baby died within a week after birth.

Two observations are worth making. First, that the generally trouble free record of home births continues. Second, Maori births appear comparably trouble free, but the numbers are too small to draw general conclusions.

For further information contact me (Alex Gillanders) at 104 Seddon Street, Naenae, Lower Hutt or phone Wellington 673747.

$ costs

Cost Effectiveness Study

This study was carried out by the Wellington Home Birth Association and compares the cost of a hospital delivery to that of a home birth. It relates to the period between August 1987 and July 1988.

Hospital		
Includes: Antenatal clinic, laboratory tests, appropriate specialist assessment, delivery and post natal care in hospital for an average five days		$1600.00
G.P. Care (figure cover both categories)		
Booking in fee		35.50
11 Antenatal visits @ 17.75 each	195.50	
Delivery (up to two hours)	245.00	
Puerperium visits @ 17.75 each	106.50	
Post Natal check (6 week check up)	35.50	
Total		617.75
Misc: Prolonged attendance fee (after two hours labour) $60.00 per hour. Mileage $1.50/Km		
Domiciliary Midwives		
3 Antenatal Visits @ $16.00 each	48.00	
Labour and Delivery	150.00	
12 Postnatal visits @ $16.00 each	192.00	
Total		390.00
Misc: Mileage 72c/Km		
Laboratory Costs (routine)		
2 AN Groups @ 13.70 each	27.70	
1 Neonatal Group (cord blood)	7.40	
Total		34.80
Grand Totals		
Hospital/GP/Lab	=	**2252.55**
Home/GP/Lab	=	**1042.55**
Difference	=	**1210.00**

NATIONAL WOMEN'S
305 beds.
Annual operating costs $32.2 million.

Opened 1963.

The full level-three high-tech obstetric unit includes 95 gynaecological beds. 156 post-natal and ante-natal beds and 54 neo- natal cots.

It has 15,000 admissions a year, 5000 births, 800 day patients and 55,000 outpatients.

The hospital employs 650 staff.

NORTH SHORE HOSPITAL

340 beds (four empty wards never commissioned). The main tower block was designed to have 600 beds but never has. Annual budget about $28 million.

Opened as an obstetric unit in 1957, with the geriatric unit in 1975, and general hospital in 1984.

The hospital has general medical beds, also general surgery, coronary care unit, geriatric unit and obstetrics (48 bed) unit. Its emergency department operates within limited hours.

The hospital sees 40,000 patients a year, with about 10,000 inpatient admissions, 90,000 outpatients and 5000 day patients.

The hospital employs about 700 staff.

PUKEKOHE HOSPITAL

48 beds (18 obstetric) 30 geriatric long stay. Annual budget $2.4 million.

The geriatric unit was established in 1979; obstetrics unit 1950.

There are about 300 births a year, 600 admissions and 2000 outpatients.

The hospital employs 40 staff.

HELENSVILLE HOSPITAL

6 obstetric beds. Annual budget $400,000.

Built 1956.

There are about 100 births a year.

The hospital employs six staff.

HOWICK HOSPITAL

Eight obstetric beds. Annual budget $500,000.

Built 1916.

There are about 170 births a year.

The hospital employs 10 staff.

PAPAKURA

17 obstetric beds. Annual operating costs $700,000.

Opened 1920.

The hospital has about 420 births a year. It employs about 13 staff.

WARKWORTH HOSPITAL

12 obstetric beds. Annual operating costs $380,000.

Opened 1920.

The hospital has about 110 births a year. It employs 10 staff.

WAITAKERE HOSPITAL

180 beds (140 geriatric, 40 obstetric). Total budget $9.4 million.

Obstetric unit opened 1968; geriatric unit 1974.

The hospital has about 650 births a year. There are about 1600 (total) admissions and 13,000 outpatients.

ST HELENS

Level-two obstetric and neo-natal unit with 103 beds (20 ante-natal, 45 post-natal, 26 neo-natal cots and 12 delivery unit beds).

Annual operating costs, $8.6 million.

Opened 1968.

The hospital has about 3600 births a year. The neo-natal unit admits 1000 cases a year. There are about 18,000 outpatients.

The hospital employs about 200 staff.

MEDIA RELEASE - 19 JUNE 1989 MATERNITY SERVICES TASKFORCE

A Maternity Services Taskforce consisting of seven people has recently been formed at the direction of the Commissioner, Mr Harold Titter. They have been charged with -

> "The design and implementation of a new maternity service for the Auckland region within the general structure outlined by Mr Titter in the document 'Corporate Strategy for financial Control' (16 May 1989)".

The Taskforce is headed by Dr Ray Naden. Its members are:

Dr Graeme Cable	Miss Shirley Hutchinson
Mrs Sam Denny	Miss Anne Nightingale
Ms Kim Hastwell	Ms Yvonne Underhill-Sem

All members have been selected for their knowledge and abilities rather than as representatives of particular hospitals or departments. They bring together skills and experience in obstetric and midwifery practice and management, workforce planning and budgetary control, community consultation, demography, service and facilities planning. Other people with particular skills will be co-opted from time to time.

There is a strong commitment by the Taskforce to consultation and liaison with staff, other health workers, users of maternity services and community groups. There will also be a close working relationship with hospital management who are responsible for implementing changes and operating services.

The Taskforce is confident that with staff support it can meet the challenge of designing a high quality maternity service which is responsive to the needs and preference of individuals.

UPDATE ON CARTWRIGHT TASK FORCE

The Commissioner is pleased to announce that the Cartwright Taskforce, which was set up in April of this year, considers that substantial progress has been made towards implementing the recommendations of the Cervical Cancer Inquiry.

Patient Advocate(s)

Recent activities include advertisement of the position of Patient Advocate(s) to be based at National Women's Hospital.

It is hoped to make an appointment as soon as possible after applications close at the end of this month. All applications will be considered by a panel independent of the Auckland Area Health Board, and the appointee(s) will report initially to the Director General of Health and subsequently to the Health Commissioner.

Ethics Committees

A working party has been set up recently to develop a proposal for the establishment of Ethics Committees for the Board. The working party plans to develop a draft proposal which will then be distributed widely for comment. This is the first stage in the establishment of Ethics Committees which conform with the national standard, a process expected to take six to nine months.

The Taskforce is working on several other projects and an update on progress with these will be provided at the end of the month.

Account of one speaker from 1989 NZ Obstetric & Cynaecological Society Conference - 17-19 March by Pauline Scott (Childbirth Education Network)

FETAL ADAPTION FOR EXTRAUTERINE LIFE

Speaker: Peter Dunn, Professor of Perinatal Medicine and Child Health. Bristol, England.

This lecture dealt with the benefits of non-intervention of the third stage - as far as the baby was concerned.

Dunn strongly believes that a baby who is not separated early from the umbilical cord has a more healthy outcome, than a baby whose cord is clamped and cut immediately after birth.

If the latter is done - the baby could be deprived of its full complement of placental blood. In turn, the increased volume of blood required by the pulmonary circulation must be drawn from the baby's own bloodstream. Low blood volume may cause failure of lung expansion, leading to IRDS (idiopathic respiratory distress). Dunn believes this is even more important when dealing with premature babies, (see his latest paper on the subject at the end of this review.)

He went on to say that intervention of the third stage - that is the routine application of an ecobolic (synotometrine) - can lead to further infection problems. Because early clamping of the cord is desirable after synotometrine, blood trapped within the placenta, makes it bulky and rigid. This in turn makes the delivery of the placenta more difficult as it tries to pass through the closing, contracting cervix. Cord traction and fundal pressure can further complicate matters.

Dunn goes even further and suggested that if the placenta (with cord intact) is delivered by the mother naturally - it then could be placed beside the baby to enhance the best possible normal blood level. The cord can be clamped and cut once it has stopped pulsating.

All of this, of course was hard for the majority of the audience to swallow! Comments later about Peter Dunn's lecture were - "of course, his studies are over ten years old" (if that makes any difference), and "he's a paedatrician, not an obstetrician" - even though he has spent over 30 years working in maternity hospitals, studying childbirth and its effect on the newborn. Speaking to Peter after the Conference, he said that he has had to align himself with consumer groups, to help get his message across, and he was not popular with O & G's in general. A similarity there with Odent. Both men, as male doctors, are standing up to the medical world on issues which concern women, even though women have been questioning childbirth matters for years and years. Says something about our society doesn't it? Peter's other lecture - "Maternal Posture and Mobility During Labour and Delivery" was excellent - although for me it was old hat! Congratulations should go to the O & G Society for bringing Peter Dunn to New Zealand for this Conference. Maybe next time - some New Zealand women could be invited to speak on childbirth issues!

First Dunedin midwifery course in 50 years opens

By Cheryl Norrie 23.5.89

It was cause for celebration at the Otago Polytechnic last night when the first midwifery course in 50 years opened in Dunedin.

The city has had no midwifery course since 1938 when St Helen's Hospital closed.

The course co-ordinator, Ms Sally Pairman, said it was coincidental that the opening occurred on the same day as that of the new polytechnic, but this made it all the more special.

The southern region midwifery course is a joint venture between the Otago and Southland polytechnics, and the 11 students will divide their time between the two centres.

The year-long course is open to registered comprehensive nurses and registered general obstetric nurses.

Ms Pairman said the students would do practical training at several small maternity units and would each attend a home birth.

Since 1979 midwifery has been a subject in the advanced diploma of nursing and Ms Pairman said midwives had been campaigning to have it recognised as a qualification in its own right.

Courses in midwifery had been set up this year as part of a trial and a nation-wide review of midwifery training would take place after three years.

▼▼▼▼▼▼▼▼▼ The Ministry of Health - *New Structure* ▼▼▼▼▼▼▼▼▼

Minister of Health - Helen Clarke

▼

Director General - George Salmond

▼

Corporate Management Group
(made up of heads from:)

▼

Personal Health Policy
- yet to be decided

* Dental
* Elderly
* Handicapped/Disabled
* Mental Health
* Hospital Specialist Services

Population Health Policy
Sally Shaw

* Health Development
* Health Promotion
* Health Protection
* Workforce Development
* Child & Family Health

Special Health Issues
Karen Poutasi

* Cartwright Report
* Primary Health Care
* Medical Benefits (policy review)
* Special Committees
  - ☞ Women
  - ☞ Maori
  - ☞ Aids

Support Services
Ian Miller

* Communications
* Corporate Services
* Economic Unit
* Health Education
* Medicine & Benefits (payments)
* National Health
* Statistics Center
* Health Services Research & Development Unit

Review
Gordon Davies

* Health Council Operations (eg. review contracts for AHBs)

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EARTH FIRST EXPO

A group of people in Auckland are working on an exciting project - EARTH FIRST EXPO - an environmental awareness event planned for October 1990.

We are inviting participation from as wide a variety of interests as possible. We hope to have input from any community groups - e.g. environmental, health, education, peace, co-operatives; schools; inventors; researchers, government departments; cottage industries; small and large business.

Regional displays from throughout NZ are welcome.

If you are interested in participating, exhibiting, performing or would just like more information please write to:

Earth First Expo
PO Box 8371
Symonds Street
Auckland

"TALKING TO YOUR DOCTOR"

Waikato Women's Health Action Centre has produced a comprehensive pamphlet for people who do not feel satisfied with visits to their doctor. "Talking to your doctor - developing a healthy partnership" clearly and concisely deals with anxieties about going to the doctor, how to make the best of an appointment both from the doctor's and the client's point of view and gives handy practical suggestions.

For copies of the pamphlet contact Waikato Women's Health Action Centre, 151 Collingwood St, PO Box 269, Hamilton, ph 80-341

OVERSEAS

Quebec doctors denounce proposed midwifery law

The Minister's announcement was made after three government advisory bodies said it was urgent midwifery be given some form of legal status. No province has legalized midwifery.

BY ANDRE PICARD
The Globe and Mail 11 May 1987

MONTREAL

Quebec doctors reacted angrily yesterday to a proposal to legalize midwifery in the province.

"You might as well make prostitution legal. More people are asking for prostitutes than midwives," Augustin Roy, president of the 16,500-member Quebec Corporation of Physicians, said in an interview.

Clement Richer, president of the 9,600-member Quebec Federation of General Practitioners was equally incredulous: "It's like letting an apprentice pilot take charge of a Boeing 747 loaded with passengers."

Helene Cornellier, president of the 60-member Quebec Alliance of Practicing Midwives, dismissed the reaction as "insipid and insulting . . . It really shows how little respect the medical establishment has for women."

She said doctors' fears of midwifery are based on financial self-interest, and said they are "determined to maintain a monopoly on what they call medicine."

On Tuesday, Health Minister Therese Lavoie-Roux said she would introduce legislation to set up six pilot projects involving midwives. She said that with the co-operation of the opposition Parti Quebecois, the law could be adopted before the June 23 summer recess.

Dr. Roy said the corporation was not opposed to midwives assisting doctors in some restricted circumstances, but denounced the proposed law because it appears to allow midwives to participate in "all aspects of pregnancy, from the planning stages to post-natal treatment, and including the birthing process."

Mrs. Cornellier agreed the battle was an ideological one and doctors were out-of-touch with modern thinking: "Pregnancy is not an illness and childbirth is not a medical procedure. Doctors who think so are living in the Middle Ages."

A midwive herself, she said a doctor's help is needed only when there are complications.

Mrs. Cornellier said about 2,000 Quebec women used a midwife last year at some stage in their pregnancy, but only about 350 deliveries were carried out by midwives in the home.

UK *Parliamentary Report*

REGIONAL PAY experiments for midwives in the "expensive" Home Counties are being planned by Health Secretary Kenneth Clarke. Several health authorities in London and the South East have already been cat marked as part of a bid to boost midwifery recruitment and retention. Mr Clarke wants to introduce a permanent system of geographically based pay deals for nursing and midwifery. Such arrangements, he believes, would give health managers greater flexibility to overcome local staffing problems.

Fierce opposition to the idea has already been voiced by the health unions, but the Health Secretary intends to launch pilot studies this spring. Authorities will be allowed subject to approval to supplement national rates "where deemed appropriate on recruitment and retention grounds".

Fuller details of the scheme are believed to have been passed to the Pay Review Body. Confirmation of the moves came in evidence on NHS funding presented to the Commons Social Services Committee by the Management Side of the Whitley Council. This reported that the experiment was likely to be "targetted on health regions in Southern England."

Midwives Chronicle & Nursing Notes

Too Many C-Sections

USA Today (January 27, 1989) reports that half of all cesarean sections performed in the U. S. were unnecessary, according to the Public Citizen Health Research Group in Washington, D. C. The group's study was based on all available birth and hospital discharge records for 1987 — 2,288 hospitals in 41 states.

Of 3.8 million births, 934,000 were deliver by cesarean, an average of about 24 percent. Dr. Sidney Wolfe, Public Citizen's director, believes that the rate should be about 12 percent.

The group believes that unnecessary cesarean sections are done by doctors for money, for convenience or to reduce the risk of malpractice suits.

The study found that unnecessary cesareans:

- Increased the risk of maternal death 2-4 times compared to vaginal delivery.
- Caused 25,000 infections.
- Cost $1 billion and kept women in the hospital an extra 1.1 million days.

Write to:

USA Today, *John Quinn, Executive Editor, Box 500, Washington, D. C. 20044.*

Public Citizen Health Research Group; *2000 P St., N.W., Suite 700; Washington, D.C. 20036.*

CALIFORNIA ASSOCIATION OF MIDWIVES

California midwives continue to work toward unification in order to promote autonomy. Autonomy is defined by Webster's as "self-governing, functioning independently without control by others. This applies to us as individuals, as well as to us as a professional organization.

Our interests as individuals might include client load, quality of care being provided, forming friendships with other midwives, and making a living. Our interests as an organization might include protecting and preserving all routes of entry into midwifery, making choices available and known to birthing families statewide, and promoting friendship on a statewide level.

No matter what route of entry, be it direct, CNM, PA midwife, state licensed school-trained (eg., Arizona, Washington, New Mexico, Florida), clinic-trained (Texas), or correspondence; no matter what our chosen client load; we really need to help and encourage each other and validate each other. We need to be looking at the big picture.

One of the CAM goals for 1989 is to get midwives working as midwives. To facilitate this goal I have made a personal commitment to enjoy other midwives, more trained or less trained, maintaining a larger client load or a smaller one, having a different belief system than I. I am convinced that the only way to maintain my personal autonomy, as well as the autonomy of the profession, is through unification. Alison Osborn

Marsden Wagner

Dr Marsden Wagner has been the Director for Maternal and Child Health for the European Region of the World Health Organization since 1978. He is a neonatologist and epidemiologist who formerly lectured in paediatrics and public health at the University of California, becoming the Director of Maternal and Child Health for the State of California. Marsden is based in Copenhagen, and has four children.

A key figure in the development of the WHO's recommendations on appropriate care and technology before, during and after childbirth, Marsden co-authored the two publications which arose from the WHO's review of European maternity services: Having a Baby in Europe and Searching for Better Childbirth.

Why did the World Health Organization decide to investigate childbirth practices in Europe?

In 1979, the International Year of the Child, the 32 countries in the European Region asked the WHO European Office to investigate perinatal services because they were concerned about these services in their countries. They were finding that these services were getting more and more expensive, even though they were having fewer and fewer babies born and they couldn't understand why it had to be so expensive. They were also beginning to feel that all of this high technology was perhaps somewhat out of control. But it was the Member States who came to us and asked us to do this investigation.

It was then my responsibility to carry forth this work and since I was in fact a paediatrician, neonatologist and epidemiologist but not an obstetrician nor midwife, I did feel that I needed to gather some expertise around me in doing this job. That is why I formed the Perinatal Study Group, which as you know includes what we hope were all interested parties. We worked for five years gathering all the information.

What did the Perinatal Study Group find?

Having a Baby in Europe is the final report of that group and everything that is in that book is what we found. (See "Reviews") Very briefly summarising it, we found that there was an enormous variation in the amount of prenatal care given without any relationship to the perinatal outcome. Furthermore, there was very little or no information on what the actual content of the prenatal care was, and very little information on what parts of the care were of value, and what parts of prenatal care are not of value.

With regard to the birth we certainly found that there were all kinds of obstetric interventions going on at birth with very little or not scientific justification. In other words, we found that the birth technology seemed to really be out of control. We also found two very important facts: first of all, the midwives had been seriously suppressed and lost very much of their role in many of the European countries. The other thing was that the control of choice around birth had really been lost and that women were very much losing any possibility to have any say about their own birth.

We also found that the information that was being given to the women was biassed and inadequate, and that there was only one country in the whole Region that was really doing an adequate job of monitoring their perinatal services. We found that there were alternative perinatal services in all of these countries.

What led to the series of Conferences and recommendations on Appropriate Technology before, during and after birth, and will there be more?

What had happened is that the Perinatal Study Group in Europe had more or less wound up their work and we had gone to China for a meeting with China's perinatal authorities because we were very concerned that in China they were rush-

ing out to grab all of the new perinatal technology without realising that very much of it was unproven, if not harmful. Present at the Perinatal Conference in China was the Deputy Director of the Regional Office for the Americas, Dr David Banta, an American. He had just finished a five-year stint as the Chief of the Office of Technology Assessment for the US Congress, and he was very sensitive to the issues of appropriate technology. Now that he was working for WHO he and we felt that it might be an idea for the European Region and the Region of the Americas to combine together in a series of conferences looking at appropriate perinatal technology. This is how the three conferences were set up, and this is why the first two were in Washington and Brazil, and the third was in Trieste - all three meetings were a combination of these two Regions.

These three conferences are the subject of the book that I have just now completed in draft form and which hopefully will be out by the end of this year. This book will go into great detail about how these three conferences were run and in great detail about exactly what the final recommendations were and how they came about. They were run essentially on the "consensus conference" model in which we gathered all interested parties together, we reviewed the world's literature on each technology, and we then had an open debate at the conference until consensus was reached on each technology. (Birth recommendations reproduced from page 7.)

The final step in the consensus conference is to present the draft consensus recommendations to an open public meeting for discussion and final policy formation. Now we are doing that, not on an international basis but on a national basis and we are going country by country organising these birth conferences. In fact the meeting in Melbourne in December was hopefully the first of such birth conferences in Australia where we are to consider these recommendations. (See "Reviews".) So we will not be having any more inter-regional conferences. We have already had close to 20 national or sub-national level follow-up conferences in Europe and we will be having more.

What is the WHO's policy regarding homebirth and midwifery?

Our policy regarding homebirth is that there is no scientific evidence that hospital birth is any safer than homebirth for a woman without any complications or high risk factors. Furthermore, our policy is that there should be informed choice for the woman with regard to the conditions of her own birthing. This would mean of course that if the woman chooses a homebirth, she would be completely backed up by the official health sector and provided with whatever supportive services she needs to have that homebirth.

With regard to midwifery our policy is that midwifery is an absolutely essential primary healthcare profession providing vital primary healthcare services and therefore should be an option for all birthing women. We believe that the midwife is the preferred birth attendant at uncomplicated births and that the countries in the world that have the lowest perinatal mortality have the midwife as the only birth attendant and there is no doctor in the room. Therefore we strongly believe that for women who do not have complications the midwife should be the primary healthcare worker during the pregnancy, and the primary attendant at the time of birth.

We believe also that midwives should play an active role in the dialogue and discussion and debate in every country with regard to what the nature of perinatal services should be. There is some evidence that there is a relationship between a strong midwifery profession balancing against a strong obstetrical profession, and the quality of the perinatal services and the appropriate control of the technology. This is why it is so important for there to be a strong midwifery profession.

In Australia, only about 0.5% of women plan to give birth at home. How common is homebirth in Europe?

First of all, of course, is the Netherlands, which at the present time has a planned homebirth rate of just about exactly 40%. What happened in the Netherlands was that the homebirth rate used to be about 80%. It gradually came down until just about 1979-80 it bottomed out at around 32% and since then - in other words in the last eight years - it has been gradually going up every year until it now has reached 40%. In Denmark there has in the past

been only 1 or 2% homebirth, but in the last several years this has been on the increase and there are places in Denmark now where the homebirth rate is approaching 10% - although there are places in Denmark where it is still closer to 1 or 2%. Now for all the other countries in Europe - at least in western Europe, the homebirth rate is around 1 to 2%. The exception is the Soviet Union and Turkey where there is homebirth in the rural areas where there are not the possibilities of putting them in the hospital.

Let me make a side comment with regard to homebirth. We have been actively collaborating with a group in Canada in the northern Hudson Bay region of Quebec where the local Inuit Eskimos have requested that the women no longer be flown 1,000 miles south to give birth and we have also consulted with some Eskimo groups in Alaska who are also concerned about this business of flying women far from their homes to give birth. The Eskimos and Indians feel that this is destroying their culture because in the first place it means that the traditional midwives have lost their key role in the community. It also means that there is no one left who is in fact a real native of their own village.

They have this very interesting experiment in Quebec in this one area of the Hudson where the women are no longer being flown out and are being attended by trained midwives who are also training some of the traditional local empirical midwives. Together they are conducting the births without flying them out unless there has been a complication during the pregnancy. By the way, they are doing these births where there is no possibility for Caesarean section should there suddenly be a problem and there is no way to get these women out to a hospital for a C-section should there be a sudden emergency. So this is a very courageous and very exciting experiment. I bring this up because we feel that this issue is valid wherever in the world there are indigenous people living long distances from so-called "western perinatal services" and we believe this would be relevant to your Aboriginal people in Australia.

You have spoken and written a great deal about the importance of women retaining control over childbirth and their own bodies, and the need to control the proliferation of childbirth technologies. Do you feel these are the most critical perinatal issues facing women in developed countries today?

I guess I would first answer this question generally by saying yes, that those are probably the two most urgent issues in the developed countries. Of course, with regard to the issue of the women having control, my feeling is that the way to get that control is through informed choice - but the informed choice is basically a part of that control issue.

There are other issues which are also perhaps on my list of important issues, although I would not give them as high priority. For example, there is a really urgent need to set up perinatal epidemiology systems in the various countries to monitor the practices and the outcomes, and feed the information back to the public as well as the health practitioners. So this is another important thing that is needed, although I don't believe it is as high priority as the other things.

I also think there is a need, for example, to completely reconsider the obstetrical/gynaecological profession, since I feel that combining obstetrics with gynaecology was a disastrous mistake and that these two should be once more separated into two different professions. You need a gynaecological profession to take care of the pathological problems of women's female organs. But exactly what we need in the way of an obstetrical profession I am not certain about. There are really two possibilities here. One is that we have a separate obstetrical profession whose tasks are totally limited to the management of complications - pathological complications - of pregnancy and birth.

The other possibility - which is a more radical possibility - is that there would be no obstetrical profession, and that pregnancy and birth would be managed by midwives who would have family doctors as back-up. Then if there is a need for a surgical procedure such as a Caesarean section, you would call in the surgeon for that purpose,

because of course there are abdominal surgeons who are perfectly competent to do Caesarean sections or other surgical procedures.

The important point here is that there needs to be a re-evaluation of this whole profession. I do feel very strongly that obstetricians should never be involved with the care of pregnant and birthing women who do not have complications, and everywhere in the world where there is a too close contact between obstetricians and women without complications we find high rates of unnecessary intervention.

Another thing that is needed that is really part of the priority for appropriate technology is to have Offices of Technology Assessment in every country that have strong abilities to prohibit the use of any technology which hasn't been adequately scientifically evaluated. In other words, that we should have controls of technology similar to what we have now for the control of drug use. That of course is simply one of the methodologies for bringing perinatal technology under control.

There is another whole field that is very important, and that is the appropriate care following birth. For example, I think we do need to give the newborn back to the mother and back to the family. This means that there should be early discharge from hospital if there is a hospital birth: and I mean within 24 hours, unless there is some very real medical indication for staying in the hospital.

I also have good data showing that neonatal technology is also out of control and that there is a need to completely re-assess neonatal intensive care and the balance in the amount of resources given, for example, to tertiary neonatal intensive care versus better basic primary healthcare for infants.

I believe that we are not only medicalising birth, we are medicalising being an infant. That means that we define infancy as a medical problem, when of course it is neither medical, nor a problem. We define infants as being fragile; we define infants as needing lots of medical attention when there is in fact no good evidence for any of this, and there is a very big, very serious problem of iatrogenesis in the care of newborn infants.

I also feel that in the field of neonatology the single biggest disaster of the 20th century has been the centralised nursery for healthy newborn infants in hospitals. This should never have been allowed to happen in the first place and I feel strongly that all newborn nurseries in hospitals should be immediately dismantled and the babies given to room in with their mothers.

With regard to care following birth, I think that there is not only a problem of the medicalisation of infancy, I think there is also the problem of the professionalisation of parenthood. By this I mean that we give the strong message to parents that without the help of a lot of professionals such as doctors and nurses and midwives, and without reading a lot of books for parents, it is not possible to be good parents. We are pushing aside the wisdom of the ages in how children should be raised and use rather the so-called scientific information of about 50 years, and think that that is more valid in deciding how infants should be managed.

From HomeBirth Australia Autumn 1989

Danger To Babies Seen In Hospitals

NZPA-Reuter Jerusalem

An international health official has warned doctors that hospital births endanger the health of mothers and babies.

Dr Marsden Wagner, European regional director of the World Health Organisation, told an international medical conference in Jerusalem yesterday that hospital births risked lives because of impersonal procedures and overuse of technology and drugs.

"I am convinced the procedure of placing all newborn babies in one room was the biggest mistake of modern medicine," he told the five-day international congress on the psychology and medicine of birth.

His remarks drew applause from some of the doctors, midwives, social workers and childbirth educators at the congress, although others defended the system.

Dr Wagner said a hospital nursery was a cradle of germs, separating babies from their mothers at the most sensitive point of their relationship. He said studies linked separation at birth to later child abuse.

Dr Wagner criticised hospitals for routinely using medical procedures once reserved for only the most extreme cases.

"Ten out of every 1,000 babies in developed countries die. In an effort to save those 10 babies, we put 990 babies through procedures that profoundly disrupt the experience of birth," he said. HERALD 30-3-89

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