24 October 1990 202/4/11

DOMICILIARY MIDWIVES MEETING

AGENDA

Date: **Wednesday 31 October 1990**

Time: **10.30 am**

1 Welcome

2 Apologies

3 Confirmation of the minutes of the previous meeting held Wednesday 25 July

4 Business arising out of the minutes of the previous meeting - nil

5 Notification of General Business

6 Notified Business

1 Item for discussion - Ms J Donley

11 Approval for services out of area

111 Central Office designated to provide controlled drugs forms (H570)

1V 11.00am Senior Advisory Pharmacists - Ms N Miller and Ms Fullwood to speak to domiciliary midwives

7 General Business of which notice has been given

8 Closing

9 Date of next meeting

REGIONAL DOMICILIARY MIDWIVES MEETING

MINUTES OF MEETING HELD AT 10.30 AM ON 31 OCTOBER 1990 AT
AUCKLAND DISTRICT OFFICE, CONFERENCE ROOM, FLOOR 1
2 OWENS ROAD, EPSOM, AUCKLAND 3

PRESENT:

Mrs A Bannister	Midwife, North Harbour District
Mrs M Boyd	Hobson/Eastern Bays Community Health Services (Minute Secretary)
Ms S Bree	Domiciliary Midwife, Northland District
Ms S Burgess	Domiciliary Midwife, Central Auckland Dist.
Ms F Clement	Domiciliary Midwife, South Auckland District
Mrs K Connolly	Domiciliary Midwife, Health West District
Ms M Cropper	Domiciliary/Hospital Midwife, Health West/ North Shore Hospital
Mrs J Cowan	Domiciliary Midwife, South Auckland District
Mrs S Denny	Maternity Services Manager, North Harbour Health District
Ms J Donley	Domiciliary Midwife, Central Auckland Dist.
Mrs M Falconer	Domiciliary Midwife, North Harbour Health District
Mrs T Grant	Charge Midwife, National Women's Hospital
Ms A Greenwood	Domciliary Midwife, North Harbour Health Dist
Ms S Haig	Maternity Unit Manager, Waitakere Hospital
Ms M Hammonds	Domiciliary Midwife, Central Auckland Dist.
Ms L Hinson	Domiciliary/Hospital Midwife, South Auckland District
Ms G Hitchcock	Acting Supervising Public Health Nurse South Auckland District
Ms B Horney	Domiciliary Midwife, Health West District
Ms R Jackson	Domiciliary Midwife, Central Auckland Dist.
Ms J McDonald	Domiciliary Midwife, Waiheke Island
Ms L McFarland	Domiciliary Midwife, Northland District
Ms J Miller	Domiciliary Midwife, Health West District
Mrs N Miller	Senior Advisory Pharmacist, Auckland District
Ms V Muller	Domiciliary Midwife, Health West District
Miss A Nightingale	Manager, Maternity Services, National Women's Hospital
Ms J Payen	Student Nurse, Carrington Polytechnic
Ms C Petersen	Dist. Director of Nursing, Central Auckland District (Chairperson)
Mrs L Rhodes	Domiciliary Midwife, Waiheke Island
Ms S Rooney	Management Trainee, North Shore Hospital
Ms G Sawers	Domiciliary/Hospital Midwife Central Auckland District
Ms J Thomas	Domiciliary Midwife, Central Auckland Dist.
Mrs J Thompson	Domiciliary Midwife, North Harbour Health District
Ms H Waugh	Domiciliary Midwife, Central Auckland Dist.
Mrs D Whitlow	Senior Executive Officer, Central Auckland District Office
Ms J Woodley	Domiciliary Midwife, South Auckland District
Ms C Young	Domiciliary Midwife, Health West District

OPENING:

Ms Petersen opened the meeting, welcoming new members

APOLOGIES:

Mrs B Armstrong, Mrs D Bridge, Ms R Cairns, Ms L Groom, Ms S Hodgetts, Ms M Makgiel

MINUTES OF THE PREVIOUS MEETING:

These were taken as read and confirmed as a true and accurate record.

MATTERS ARISING OUT OF THE MINUTES:

Nil

NOTIFICATION OF GENERAL BUSINESS:

1. Your Pregnancy - To Haputanga
   Health Department publication

NOTIFIED BUSINESS - AGENDA ITEMS:

1. ITEM FOR DISCUSSION - Ms J Donley

   Ms Donley advised that since writing the item for discussion the domiciliary midwives had held a meeting, on 26 October 1990, to discuss proposed contracts with the Auckland Area Health Board. As a result, in addition to proposals 1, 2 and 3 included in Ms Donley's item, the domiciliary midwives also suggested that the District Director of Nursing, Ms C Petersen be the supervisor for domiciliary midwives providing services to the community of the Central Auckland District.

   Ms Petersen replied that she had discussed this matter with Miss Nightingale (Manager, National Women's Hospital) and it was decided that she continue her current supervisory role in the meantime.

   Ms Donley then commented on the working party meeting held on 29 October 1990, to negotiate contracts for the domiciliary midwives with Auckland Area Health Board, at which it was recommended that the Obstetric Standards Review Committee be replaced by a Maternity Services Review Committee.

   Ms Donley submitted relevant papers to be attached to the Minutes.

2. APPROVAL FOR SERVICES OUT OF AREA

   There was a lengthy discussion concerning the relevance of applications for approvals for services out of area. Ms Petersen advised that she would like applications as a matter of courtesy.

2. Approval for services out of area, continued....

Ms Denny expressed concern that there were no clear directions included in the Health Department document "Nurses Amendment Act 1990" as to services to be provided by domiciliary midwives or whether contracts with The Minister of Health are still necessary.

Mrs Whitlow advised that she had repeatedly contacted the Health Department Head Office to obtain guidelines with specific details of services to be provided by domiciliary midwives. As yet no reply has been received.

Miss Nightingale asked if domiciliary midwives would still require sterile supplies from National Women's Hospital.

As a result of the various queries, the meeting decided it was necessary to set up uniform guidelines for the Auckland region and that:-

(a) Meetings should be held with domiciliary midwives in each Health District within the Auckland region.

(b) A regional working party should be formed. Nominations for members of the working party were as follows:-

Auckland Area Health Board representatives

Ms C Petersen, Miss A Nightingale,
Miss Heather Thompson, Mrs S Denny, Ms S Haig.

Domiciliary Midwives representatives

Ms J Donley, Ms H Waugh, Ms A Greenwood,
Ms S Skinner, Ms C Young, Ms J Miller,
Ms J Woodley, Mrs J Cowan.

A meeting for Central Auckland domiciliary midwives to be held **9 am Tuesday 20 November 1990, Room 704, 7th floor Staff Residence, Block 3, Green Lane Hospital**

A meeting of the Regional Working Party to be held **10 am Tuesday 20 November 1990, Room 704, 7th floor, Staff Residence, Block 3, Green Lane Hospital**

3. CENTRAL OFFICE DESIGNATED TO PROVIDE CONTROLLED DRUGS FORMS H571

Ms Petersen informed the domiciliary midwives in the Central Auckland District that their controlled drugs forms H571 are to be obtained from the Hobson/Eastern Bays locality office at 24 Mountain Road, Epsom, Auckland 3.

For the purpose of identification, current annual practising certificate would need to be sighted.

4. SENIOR ADVISORY PHARMACISTS - N MILLER AND M FULLFORD TO SPEAK TO DOMICILIARY MIDWIVES

Ms N Miller advised the domiciliary midwives about the prescribing of controlled drugs (H571s) and the Practitioners supply orders (H570s)

Ms Miller submitted the following papers for the assistance of the domiciliary midwives:-

i) List of legal requirements
ii) Copy of the relevant Medicines Regulations
iii) List of medicines for midwives precribing for a normal pregnancy.

NB The list is intended only as a guide

Ms Miller recommended that midwives get a copy of the British National Formulary which can be obtained from The Pharmaceutical Society of New Zealand, P O Box 11640 Wellington (copies of extractions are attached)

GENERAL BUSINESS:

Your Pregnancy - To Haputanga, Health Department Publication

Ms Hammonds and Ms Donley are concerned about certain comments included in the publication in relation to choices and homebirths.

Ms Petersen agreed to draw the specific sections to the attention of the Health Education Section at Health Department Head Office.

OTHER BUSINESS:

1. There was general discussion which included several topics, as follows:-

H554 Maternity claim forms, Obstetric Notes, starter packs for domiciliary midwives, computerisation of maternity services, prescription forms etc.

It was decided that these matters should be discussed at the regional working party meeting.

2. Ms Petersen advised that the Discussion Paper for Pregnancy and Childbirth is available for comments from:-

Ms S Dahl
Manager
Womens Policy Unit
Department of Health
P O Box 5013, Wellington

Ms Petersen would like there to be an informed discussion on this paper at the next domiciliary midwives meeting

3. Ms Donley submitted a copy of the report on the International Confederation of Midwives 22nd International Congress, a copy of which is attached.

THERE WAS NO FURTHER BUSINESS AND THE MEETING CLOSED AT 12.25 p.m.

NEXT MEETING: **FRIDAY 14 DECEMBER 1990**

VENUE: **HOBSON/EASTERN BAYS COMMUNITY HEALTH OFFICE, SEMINAR ROOM, 24 MOUNTAIN ROAD, EPSOM, AUCKLAND 3**

TIME: **11 am**

It was proposed as this would be the final meeting for the year, that a luncheon be held at the close of the meeting.

Midwives are invited to bring a plate and a small Christmas gift costing no more than $2.00

Enclosures:

MB : JP

Dated 14 November 1990

AAHB CONTRACT FOR DOMICILIARY MIDWIVES (DMs)

1.

Access to Area Health Board Facilities

Area health board services provided to mothers under the care of a midwife are free. Section 49(1) of the Area Health Boards Act 1983 has been amended to enable midwives to have access to area health board facilities.

Each midwife must, however, negotiate an agreement to do so with area health boards. Requirements for the agreement would be the same as those for medical practitioners.

Under such agreements midwives can arrange to admit women to public hospitals for maternity care.

Area health boards will, therefore, need to develop policy on agreements for midwives to access their facilities.

Department of Health
TE TARI ORA

Wellington
October 1990

ISBN 0-477-07520-7

2. The contract which doctors currently hold with AAHB (Appendix A) is based on a contract recommended by the Department of Health in Circular Letter (Hospital) No 1981/209 signed by T. Lawrence, Director, Division of Hospitals. The Annex to this Letter (Appendix B) explains the establishment of local Obstetric Standards Review Committees (OSRC) was "to advise hospital boards as to which medical personnel should be permitted to enter into contracts with the board to provide services in an 'open' maternity unit".

   The recommended guidelines which are to be administered 'informally' are:
   - Holder of Diploma of Obstetrics
   - Minimum of 20 deliveries p.a.
   - Readiness to seek advice & guidance and adherence to criteria
   - Standards of antenatal & postnatal practice
   - On-going education (for which OSRC should accept some responsibility)
   - Age & health.

   The Annex also says that "it is the department's view that once the local organisation is functioning the OSRC can probably be disbanded".

3. The AAHB Task Force on Maternity Services, Working Party on Training & Education felt that "the continuing review of standards of medical practitioners and midwives should be performed jointly". Specifically it recommended

Recommendations

6.7.1 That all professional groups working in the Maternity Service define and publish their practice standards.

6.7.2 That it be a condition of appointment (or contract) for all health workers to actively participate in the quality assurance programme in the Maternity Service.

6.7.3 That a Maternity Service Standards Review Committee be established to monitor the practise of all professional providers in the region.

6.7.4 That systems of evaluating and developing quality of care from the the consumers perspective, be established.

These recommendations were incorporated into AAHB's Strategic Plan.

Obviously time and event have overtaken the OSRCs. They are a relic of the past.

4. The Women's Policy Divison, Department of Health in Discussion Paper on Care for Pregnancy & Childbirth (Dec 1989) recommended that "the OSRC should be disbanded" and replaced by more comprehensive service committees which would "co-ordinate pregnancy and childbirth services within each board, including the granting of access to facilities. These committees should be accountable to the board and could be a subcommittee of the board's Standing Committee on Women's Health. The committee's meetings (at least five times a year) should be open to the public and the committee should provide an annual report of their activities for public distribution. Membership should include the board's advisor on women's health, four consumers, two of whom should be Maori, general practitioners, obstetricians, midwives, and the board's manager for childbirth services. As Childbirth Services Co-ordinating Committees will be responsible for access to facilities they must receive reports from the professional bodies to ensure that standards are being met.

   It is expected that monitoring of standards should continue through the individual professional bodies. Acceptable and effective peer review and quality assurance mechanisms must be in place, and all health professionals working in the childbirth service should participate. Peer review groups may adopt a variety of strategies depending on membership and the issues under consideration.

Therefore, before domiciliary midwives can negotiate a contract with AAHB, the Maternity Services Standards Review Committee will have to be in place.

We urge immediate establishmnet of the Maternity Services Review Committee.

5. Maternity Services Standards Review Committee

Recommended membership: 1 manager of maternity services; Board's Advisor on Women's Health; 1 obstetrician, 1 paediatrician; 2 GPs actively engaged in maternity care - one covering births in hospital & one at home; 2 midwives - one hospital based nominated by N.Z. College of Midwives, Auckland Region & 1 DM nominated by Auckland domiciliary midwives; 4 consumers nominated from community groups.

Professional groups which have not already done so should define and publish their standards of practice.
Midwives have already done this nationally. Midwifery Standards of Practice, Service & Education is available from NZCOM, Auckland Region, P.O. Box 24403, Royal Oak @ $4.

Domiciliary midwives are already monitered by the Domiciliary Midwives Standards Review Committee (DMSRC) (Appendix C) and this would continue and be recognised for its valuable contribution to maintaining standards in community practice.

AAHB Maternity Service Quality Assurance guidelines should be part of the contract and applicable to all health professionals. Domiciliary midwives would expect to be graded on the basis of the current AAHB grading system.

Basic requirement for the midwife's contract would be evidence of registration as a midwife (R.M.) and current practising certificate. S/he would be subject to the relevant Acts and Regulations.

Access to facilities would be guaranteed in line with the changing concepts of normalcy of pregnancy and birth, continuity of (wholistic) care and informed consent.

In particular access to community antenatal clinics and well women centres supported by AAHB, as well as access to hospital antenatal and labour facilities.

As core providers (Roles & Responsibilities, Appendix D) DMs would be entitled to visit women in hospital, either antenatally or postnatally and be involved in the woman's care with provision of a primary care plan and would be available if needed.

6. The establishment of a Maternity Services Standards Review Committee and development of a contract in line with these principles fit neatly into the Board's Principles of the Auckland Maternity Services.

Prepared following meeting 26.10.90 with: Yvette Watson, Karen Connolly, Jenny Woodley, Mary Hammonds, Heather Waugh, Rhonda Jackson, Barbara Harvey, Joan Miller, Joyce Cowan, Joan Donley.

This is a draft, feel free to amend.

The issue of a Supervisor should be dealt with separately at meeting 31.10.90.

APPENDIX A

AN AGREEMENT made this day of
19 BETWEEN THE AUCKLAND HOSPITAL BOARD ("the Board") of the one part AND
of
Medical Practitioner ("the Practitioner") of the other part.

WHEREAS (1) the Practitioner has applied to the Board for permission to treat his/her maternity patients in private beds in the Board's Maternity Hospitals ("the hospitals")

(2) the Board has decided to grant such permission.

NOW THEREFORE IT IS AGREED BY AND BETWEEN THE PARTIES HERETO AS FOLLOWS:

(1) Maternity patients who nominate the practitioner may be admitted to private maternity beds in the hospitals and the practitioner may attend them.

(2) The Board and the Practitioner shall comply with the provisions of the Hospitals Act 1957, its amendments and any regulations made thereunder including the current Obstetric Regulations, a copy of which shall be kept in each hospital

(3) The Practitioner shall comply with:

(a) the provisons of Section 62 of the Hospitals Act 1957 (which relates to non-disclosure of information) as if he were a member of the Board's Medical Staff.

(b) the instructions or directions of

(i) the Superintendent-in-Chief of the Board's institutions.

(ii) his deputy

(iii) the Superintendent of any hospital where he/she may be attending patients.

(c) the Board's special instructions relating to the private maternity beds in National Women's Hospital and Obstetric Hospitals under the control of the Auckland Hospital Board (a copy of which is annexed hereto)

(4) The Practitioner shall have the right to appeal to the Board over any matter arising out of Clause 3 (b) above but this right shall in no way affect the Practitioner's obligations under clause 3 (b) pending the decision of the Board.

(5) The Board may terminate this agreement forthwith if the Practitioner's conduct or obstetrical technique or methods are deemed by the Superintendent-in-Chief or his deputy to be detrimental to the welfare of patients or to the safety or efficiency of any hospital.

(6) Either party may terminate this agreement by giving the other one month's notice in writing of his/her or its intention so to do.

(7) The Board may review this agreement after it has been in effect for five years unless earlier terminated pursuant to clause (6) above.

IN WITNESS WHEREOF these presents have been executed the day and year hereinbefore written

SIGNED BY THE SAID)
in the presence of:)
) ____________________
Signature

WITNESS ____________________
OCCUPATION ____________________
ADDRESS ____________________
____

SIGNED by the said) Per pro
THE AUCKLAND HOSPITAL BOARD) THE AUCKLAND HOSPITAL
in the presence of:) BOARD:
Witness ....
Occupation .... (Executive Manager-
Address .... Administration)

ANNEX

APPENDIX B

STANDARDS OF OBSTETRIC PRACTICE

It is the responsibility of each hospital board area to ensure maintenance of standards of practitioners in its own area based on guidelines formulated in this paper. It is not the intention of the department to impose central control on standards of obstetric practice, rather it is the department's view that once the local organisation is functioning the Obstetric Standards Review Committee can probably be disbanded. In the meantime the committee still exists and can be recalled should it be necessary. The Maternity Services Advisory Committee of the Board of Health does of course represent authoritative opinion on the broader aspects of obstetrics.

Each hospital board should establish a local obstetric committee comprising the board's obstetric adviser, the board's paediatric adviser, two general practitioners in active obstetric practice, the medical superintendent-in-chief or a medical administrator. The department believes that there should be a representative of the nursing staff on the committee but is prepared to leave this to the obstetric committee itself and also the decision as to whether, if such an appointment is made, it should be a member of the nursing administration or a practising midwife since local circumstances vary so considerably. The obstetric committee should have the power to co-opt extra members as and when deemed necessary.

In order to ensure continuity it is suggested that boards should arrange for the term of office of members of local obstetric committees to expire on a staggered basis.

In the case of some smaller boards it may be found desirable to combine with a neighbouring board in the formation of the committee and it will almost certainly be necessary to arrange for an obstetrician and paediatrician from a larger neighbouring board to sit on the committee.

It will be the duty of the committee to advise hospital boards as to which medical personnel should be permitted to enter into contracts with the board to provide services in an "open" maternity unit. After a date, to be determined by the board, there should be no new contracts signed unless recommended by the committee and these should be only for medical practitioners who have had satisfactory experience in obstetrics.

The standard of obstetric qualifications and experience required of practitioners to whom contracts are granted should as far as possible be uniform. The Obstetric Standards Review Committee among other factors took two main points into consideratio

1 The position of those practitioners who already have contracts with hospital boards.

2 The obstacles to young doctors and others in gaining a diploma in obstetrics because of the diploma requirement that recognised training be for 6 consecutive months whereas there is a tendency of many hospitals to require a training period of only 3 months.

It was accepted that a 6 month period of postgraduate training at an institute recognised by the University of Auckland or the University of Otago for the granting of a D.Obst. in which a satisfactory standard is achieved equivalent to the standard required for a D.Obst. (irrespective of whether that examination was taken), would be generally accepted as an adequate standard.

The review committee noted however that other special factors should also be taken into account when considering applicants for contracts eg the number of deliveries conducted per applicant annually (it is noted that whilst twenty deliveries may be recorded as a minimum to retain proficiency some rural areas may not have a sufficiently high birthrate to permit a practitioner to conduct this number of deliveries).

When a practitioner with limited experience seeks a contract, the local obstetric committee should grant an initial contract for 1 year. The committee may take into account the number of practitioners already having contracts with the board in relation to the needs of the community and the nature of the applicant's practice.

The review committee recommended that those practitioners who have contracts on the date on which this scheme is implemented (and which will be determined by each board), should be permitted to continue working in terms of the contract or until the practitioner seeks a new contract. The committee believed that it would be preferable for those existing contracts still in effect 3 years after the commencement of the scheme to be terminated and new contracts substituted. Boards will be required to examine their contracts and possibly consult their legal advisers as to whether this is desirable.

It is recommended that contracts should be reviewed, and if appropriate, renewed at 5 yearly intervals unless circumstances require review at a shorter interval.

The review committee recommended that the following points should be considered by a local obstetric committee when reviewing contracts:

(1) The number of deliveries conducted taking into account any sr ial circumstances.

(2) An assessment of the practitioner's conduct with regard to:

(a) the practitioner's record of compliance with the local committee's criteria;

(b) the practitioner's readiness to seek advice and guidance from senior colleagues;

(c) the standard of the practitioner's antenatal and postnatal practice.

(3) The postgraduate education relating to obstetrics undertaken by the practitioner during the term of the contract.

(4) The age and health of the practitioner.

The obstetric committee should encourage practitioners to take part regularly in postgraduate education and, when necessary, indicate to the practitioner the consequences of omitting to do so. It is noted that members of the local committee should accept some responsibility for ensuring that postgraduate education is available and should also take part in such activities themselves.

In general the approach of the obstetric committee should be as informal as possible. It should determine its own procedures as for example whether it wishes to interview practitioner applicants for contracts as a general rule, or only in cases where the applicant's ability is not known to the committee. The committee's precise terms of reference may vary from board to board and it is not proposed to be dogmatic about these but that they should be sufficient to enable the committee to act as a general overseer of the standards of obstetric practice and, certainly in the smaller units, the standards of neonatal care. It should also have sufficient authority to review contracts and make appropriate recommendations to the hospital board.

A sample of a recommended contract is appended.

APPENDIX D

1.0 INTRODUCTION

The Working Party accepted the Draft Principles of the Auckland Maternity Service as a basis for their discussions and for writing this report.

Childbirth is a normal life process. The Maternity Service is accountable for facilitating the optimum health and well-being of mother, baby and family. There must be a partnership between women and the service which enables choice, informed decision making and input into improvement of Service delivery.

Continuity of care is a priority, and the Working Party advocates the concept of core providers to facilitate this.

Providers and women must be made aware of their responsibilities and acknowledge the necessity for actioning them.

2.0 CRITICAL ISSUES IDENTIFIED IN THE PRESENT SYSTEM

During its discussions, the Working Party identified the following as some of the critical issues that appear to impede the provision of maternity care at the present time:-

- The absence of a clearly stated common purpose in philosophies and values produces an organisation without recognised styles or standards of service delivery. Consequently the structure is dependent on individuals taking on leadership/management roles that are poorly defined and lack the necessary authority and financial responsibility to demand accountability.
- The present systems that impact service delivery are slow to respond to the community's demand for partnership, continuity of care, informed choice, cultural relevance and access.
- Childbirth has become inappropriately institutionalised.
- The full development of roles has been constrained by legislation. This has resulted in providers pursuing professional rather than organisational identities. Gatekeeping behaviour has denied consumers access to or knowledge of the full range of services.
- Education needs are frequently superceded by the organisation's demand for task performance.

3.0 ROLES AND RESPONSIBILITIES

The Working Party has put forward the concept of core providers. This is expanded in this section of the report, but is visually summarised in Figure 1.

3.1 Core Provider Role

The health professionals able to fulfill the core provider role are midwives and doctors who have th[illegible] Diploma in Obstetrics or equivalent qualification.

The essence of the core provider is to provide continuity of care throughout the childbirth process as much as possible, including clarifying responsibility at all stages, and that care is evaluated.

The focus of the service is to provide health care to the woman, baby and her family through pregnancy, labour and in the puerperium. While the pregnancy is the reason for being within maternity services, once there, a holistic approach is taken which includes the physical, emotional, social, spiritual and cultural dimensions. This is in accordance with the Maori perspective of health, which identifies te taha tinana (the body), te taha hinegaro (the mind), te taha whanau (the family) and te taha wairua (the spirit). Thus the core provider seeks to address the interweaving dimensions of health within their role.

3.2 Description of Role

The core provider must be able to give the necessary information to facilitate choice and to provide care for women, the unborn infant and their families prior to, and during pregnancy, labour and the post partum period, to conduct deliveries in their own responsibility and to care for the newborn infant.

This care includes preventative measures, the recognition of abnormal conditions in mother and child, the procurement of expert assistance from a support provider, and the provision of emergency measures in the absence of help. They have an important task in health counselling and education, not only for the women, but also within the family and the community. The work should include pre-conception and ante-natal education, preparation for parenthood and extending to relevant areas of women's health, family planning and child care. They may practice in any setting including the home, hospital and community.

The core provider may be an individual who is able to provide such a scope of practice. It may be two people working together in a complementary manner. It may be a small team of people working in collaboration. The core provider should be known by name to the patient who can be contacted all through their pregnancy.

3.3 Responsibilities

Each core provider is responsible for:

- their own actions or lack of action in providing care (the provision of care includes informing, assessing, facilitating choice, providing service and evaluating)
- meeting standards of practice as defined by:

  National Bodies
  Regional & Local Bodies
  Management
  Professional Bodies

- identifying their own role within the larger group
- working [illegible] partnership with woman and family, and being sensitive to cultural practice

NZMA - AK Division   EDITORIAL   NEWSLETTER - June 1980

THE O.S.R.C. - MORE THAN ANOTHER SET OF INITIALS ?

Like it or not, peer review is here again.

The Obstetric Standards Review Committee (O.S.R.C.), which was formed in accordance with a resolution of the N.Z.M.A. Council in April 1979, has had two meetings and has produced a Report.

Currently the members of the Committee are :-

Dr. B.G. Jew	New Zealand Medical Association (Acting Chairman)
Professor D.G. Bonham	Professor of Obstetrics & Gynaecology, University of Auckland
Professor R.J. Seddon	Professor of Obstetrics & Gynaecology, University of Otago
Dr. B.J.H. Insull	Royal College of Obstreticians & Gynaecologists
Dr. B.M. Williams	New Zealand Obstetrical and Gynaecological Society
Dr. M. McKerr	Royal New Zealand College of General Practitioners (Attendance at 2nd meeting only)
Mrs. Sandra J. Davies	Secretary.

The O.S.R.C. was formed "to present precise proposals for the establishment and monitoring of obstetric standards in New Zealand". To many practitioners, this statement will conjure up memories of Department of Health attempts to impose an Obstetric List upon unwilling obstetricians.

Obstetrics is vulnerable to increased control by the Department of Health because of the separate Maternity Benefit Scheme and the exceptional right to private practice in public hospitals. Departmental officials were involved in discussions with N.Z.M.A. Executive Committee of Council prior to the formation of the O.S.R.C. so perhaps we are faced again with another "increase in bureaucratic organisation" (H.V. Coop Newsletter No. 172) and a further loss of independence.

Despite the beginnings of the O.S.R.C., I believe that it is a step in the right direction. At present, it is an independent body whose report resounds with statements like "..... with the patient's interests paramount",....." criteria established by the Committee not by the Department of Health", "acceptable standards of obstetric practice", ".... the level of training .... should be determined by the Committee ... NOT by the Department of Health". (Report's emphasis). Laudably, the O.S.R.C. has divested itself of potential power by favouring the establishment of Local Obstetric Review Committees although it would retain overall responsibility for ensuring uniformity of standards.

Local committees, the O.S.R.C. recommends, should be established by Hospital Boards and would comprise the local Hospital Board's Obstetric Advisor, the paediatric Advisor and two General Practitioners who are in active obstetric practice. They would have two principal roles :

1. to ratify new contracts   and   2. to review existing contracts.

The new contracts would require six months postgraduate training in obstetrics in a recognised hospital and would normally be valid for five years. Practitioners who have contracts already "should be permitted to continue working in terms of the contract or until the practitioner seeks a new contract" but the O.S.R.C. believes that existing contracts should be terminated after three years and new contracts substituted, with review at five yearly intervals.

The recommendation that the Local Committees be established by Hospital Boards is a weak point, not only because Hospital Boards are dependent on Central Government for finance and policy but also because a lot of antenatal care and an increasing number of births are taking place outside Hospital Board institutions.

There are other objections that one might raise but the O.S.R.C. report contains much to praise. So far the Committee itself has not been defined formally nor has it been accepted by anyone as the committee responsible for adminstration of Obstetric Standards. However, its message is clear - the establishment of standards of practice and methods of peer review is underway and will be imposed upon us unless we take action ourselves.

Despite the Orwellian ring, "peer review" is an illdefined concept that can take many forms. There has always been peer review, mostly of a nebulous character but now a more formal type is required and we have the opportunity to determine our own form, free from bureaucratic control.

The Obstetric Standards Review Committee has given a lead which we should grasp and upon which we should act.

M.A.H. BAIRD.

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INTERNATIONAL CONFEDERATION OF MIDWIVES

22nd INTERNATIONAL CONGRESS October 7-12, 1990

KOBE, JAPAN

A Midwife's Gift-Love, Skill and Knowledge.

Twelve New Zealand midwives attended this 22nd ICM Congress - four from Auckland, thanks to financial assistance from the Margaret Millar Memorial Fund & the Maurice & Phyllis Paykel Trust.

Some 6000 people attended this first Asian congress, 5000 of these were Japanese; one each from China & India both of whom were medical doctors.

Entitled 'A Midwife's Gift - Love, Skill and Knowledge',it was efficiently organised and run to a tight schedule. More than 200 papers were presented which made choices for concurrent sessions difficult to make.

The themes for the plenary sessions explored the areas of midwives' 'dilemmas' - bioethics, basic midwifery versus technology, midwifery education (diploma/degree) and research. There were many contradictory attitudes and opinions often loudly expressed.

The opening ceremony was patriotically colourful as the flag of each member country was paraded across the stage and members from that country identified themselves in the audience. When our turn came we vigorously waved our N.Z. flags

The Congress was opened by Her Imperial Highness (HIH) Princess Mikasanomiya dressed like Lady Di addressing us in excellent english; the Japanese hostesses dressed in traditional costume spoke japanese which was translated into english, french and spanish.

The most contradictory issue was - what is a midwife! Is she a basically trained primary health carer or is she a degree level nurse-midwife? And, what really is her function?

WHO speaker Barbara Kwast questioned if the current education of midwives is appropriate for fostering community care and to fulfill the goals for the Safe Motherhood Initiative (SMI) launched at a Conference in Nairobi in 1987 and supported at the ICM Congress in The Hague several months later.

Eighty -six percent of the world's births occur in Third World countries - Africa, South & East Asia & Latin America where only 50% of women are attended during childbirth and where maternal deaths average from 50 to more than 800 per 100,000 live births. This is approx 200 times higher than the 7 - 30/100,000 for developed countries.

Barbara said that in many countries nurse/midwives are trained and used for hospital services which could be delegated to other health workers; and in many countries midwifery training has been either restricted by this medical education or has been abolished altogether. This leaves a serious gap in the middle which cannot be filled either by TBAs or degree-level nurse midwives.

On the other hand, Sumiko Maehara, ICM President spoke about how midwives must strive towards the development of technology that supports them in their work, turn midwifery into a science... even though the pre-Congress Council meeting re-endorsed the ICM definition of a midwife, which, in effect is basic midwifery training to produce a midwife who can function in the community - a primary health carer.

At the 1986 Ottawa Conference, WHO Director-General Dr Halfdan Mahler said health promotion must not be about creating a new breed of academic and health professional. In fact, he asked if cannibals should really be allowed to speak for those they have eaten, and warned against a new breed of cannibal emerging from the Ottawa Conference on primary health care.

Margaret Peters (Australia) who has been working for UNICEF was brilliant. She spoke of the obstacles in the way of women trying to take control of childbirth which is "women's business". In the Third World one of the problems is illiteracy - 2/3 of the women and half the men are illiterate. The other major problem is the male domination of this "women's business".

Margaret blamed the debt crisis, attributable to military spending which not only appropriates the money available for health services (world-wide only $2 out of every $10 is spent on maternal-child health & FP) (1), that which is spent goes 75% to urban hospital services and importation of the latest technology and pharmacology.

She said that the process by which and by whom decisions about what is introduced need to be examined. "I have yet to read much about the way medical decision makers and providers are influenced by the multinational firms that sponsor international meetings, promote their wares at professional gatherings and support medical research activities and professional publications with advertising". (2)

This process was evident at the ICM Congress. Pharmaceutical companies pay big biccies for a stall here. In addition to the birth-related sophisticated technology there were at least five displays of disposable nappies (the environmental impact of which is being seriously questioned), and a SMA display. When I queried the SMA display because of the uproar at The Hague in 1987 over the Glaxo display in relation to the WHO Code of Marketing Breast Milk Substitutes, I learned that the Council had decided that such displays were O.K. when targeted at "professionals".

However, in her paper Margaret saw professionals to be just as vulnerable as any other person. She made reference to "this insidious selling of goods to medical practitioners who are striving to gain recognition from their colleagues in the developed world (which) is just as questionable as that which created the need for a WHO Code on Breast Milk Substitutes. It is regrettable when personal economic imperatives cloud the professional judgement of any health care provider and in this the poorly paid can be more vulnerable..."

One of the few midwives from Africa told us that enforcement of the WHO Code had meant that African midwives could not now accept funds from Glaxo to attend ICM as they had in the past.

Karyn Kaufman, midwifery coordinator, Ontario Department of Health dealt with midwifery and bioethics. When midwives are confronted with ethical issues in practice, it creates a dilemma. Today, there are an unprecedented number of issues where midwives are caught in the middle with a responsibility to be a central participant. She mentioned reproductive technology which encompassed medical, political and social issues.

Another vexed area is routine antenatal screening which is becoming progressively more sophisticated, but availability does not equate with necessity. Some tests may yield more information than the woman wants but not provide the information she needs. Short term technological fixes are self-defeating, she said and midwives must listen to women.

Karyn warned midwives that in making decisions they had to examine their own beliefs and values. Values are anchored in feelings and feelings are not a reliable indicator for a moral position.

In the brief time I had to speak to Karyn about midwifery progress in Ontario she said that with the change in government in the recent election, their midwifery bill had to go back to square one but that the new government was definitely sympathetic and it's only a matter of time before midwives become a recognised part of their health care system.

Ruth Wong, ICM Western Pacific representive spoke about ultrasound in pregnancy. She made reference to Nastad, 1988, Norway that "ultrasound examinations had not been scientifically proven" as beneficial and that its widespread use during pregnancy is being carried out without sufficient evaluation. Ruth also said that Hong Kong recognises attendance at the ICM Congress as the mandatory five-yearly refresher course required of British midwives.

In my paper I dealt with the changes in midwifery in N.Z. and the difficulties in the way of making the transition from doctors' handmaidens to independent practitioners. Mention of the legislative changes to enable direct entry midwifery got a good response from some and opposition from others- including some Aussies. Dorothea Laing (U.S.A.) is hoping to get legislative changes made in New York state so that a direct entry training can commence early or mid-1991. Following my paper I was interviewed by the Nursing Times reporter.

After the ICM Caroline Flint visited Australia where she held some seminars and apparently told her audience about the N.Z. midwives - how far ahead they are in their independence and their relationship with women.

The ICM Council, however, is not impressed with our inclusion of consumers on our professional body. For the next Congress in Vancouver, May 9 - 14, 1993 we are to have a 'position paper' on this issue!

Our accomodation was good - not as expensive as we anticipated, three of us roomed together. It was in down town Kobe and there was a half-hourly free bus to the Conference Centre. We were provided with boxed lunches - choice of traditional Japanese which was good, or American junk food. Practically all drinks were in aluminium cans - yuk! Found the throw-away wastage of plastic and paper (our trees) hard to handle.

To commemorate the Congress the Japanese government issued a special stamp.

We revised and added a couple of new verses to our song - but never got a chance to 'sing' it. We added:

We have formed ourselves a college
And we're using all our knowledge
Of strategies and tactics
To educate us all

And now we're independent
We've created history,
In partnership with women
We've lobbied to be free!

A saying quoted several times at Congress re planning for the future was:

If planning for one year - plant a seed;
If planning for ten years - plant a tree;
If planning for the future - educate the people.

In an effort towards international reciprocity for midwives a 'Preliminary Survey' questionaire was distributed at Kobe. Prepared by Dr Christine Hindle Verber EdD,RN,SCM., 49 Eastern Drive, Ardsley NY 10502, USA it asks "only what is legally needed for foreign-trained midwives to practice in your country".
I brought back a copy for N.Z. consideration - Nursing Council, NZCOM, polytechs?

The Oxford Database of Perinatal Trials contains more than 3000 published reports of randomised controlled trials in the field of perinatal medicine plus experts' interpretations. Supplied on a set of floppy disks (IBM PC, XT, AT or PS/2) accompanied by an operations manual, the price is US$1200. With six-monthly updates - the first one free to subscribers - at a cost of US$200.

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? Does routine hospitalization of women with twin pregnancies reduce their risk of pre-term delivery?

? Is it worth giving oxytocics routinely in managing the third stage of labour?

? Does antenatal administration of corticosteroids reduce the risk of respiratory distress in extremely pre-term infants?

? Are there any trials currently being undertaken which compare chorion villus sampling with amniocentesis? If so, who do I contact to receive full details?

? Which perinatal trials have studied maternal satisfaction as an outcome?

The *Oxford Database of Perinatal Trials* helps to provide answers to these and many more questions by making readily available references to randomized controlled trials in perinatal medicine.

Jean Donley
30 Oct 1990

MIDWIFERY & CHILDBIRTH IN JAPAN J. Donley Oct 1990

The history of midwifery in Japan reveals a clear picture of how midwifery is undermined when nurse midwifery is introduced.

The Japanese word for midwife is 'sanba'. In earlier times there were 60,000 of these sanba who cared for women in their homes and also played important roles as promoters and counsellors in community health.

In 1868 (Meiji era) in response to contact with modern western medicine referred to as 'civilisation' midwives were brought under government control with the introduction of organised education. Licensing was established in 1874.

In 1927 the national Japanese Sanba Association (now Japanese Midwives Association) was formed when the unions of midwives from every region and prefecture united. At that time 98% of births took place in the home.

Changes began in 1947 influenced by the American occupation. As midwives were not acknowledged in U.S.A., the US Medical HQ required that every delivery was to be performed in the presence of a physician. To assist these physicians, nurses were required to take a six-month midwifery course. This increased the number of births taking place in hospitals - with doctors doing the deliveries assisted by the nurse-midwives. This "led to the abolishment of midwives" according to the male doctor, Seichi Matsumoto of Jichi Medical School of Nursing. (1)

In 1950 more than 95% of births were at home. By 1965 nearly 85% of babies were born in institutions. This deprived midwives of their autonomy and independence. Furthermore, as the nurse midwives were trained in medically based institutions rather than in the community, this undermined any "motivation to conduct community (and social) aspects of midwifery practice....Childbirth became dehumanised" and the number of midwives decreased.

The remaining midwives finally found a role in family planning following the Eugenics Protection law. Now, 1989, Japanese women have only 1.57 children each.

In 1970 the nursing curriculum was revised. After a year of "heated discussion" midwives partially reasserted their role as promoters of maternal and infant health. By 1987 (in response to the forthcoming Congress?) the Ministry of Health and Welfare requested that midwives resume their normal (?) role "in a modern team with obstetricians and related health professionals". Midwives are trained as specialists in sex and reproduction, the training varies from 6 - 12 months.

The new 1989 curriculum requires a minimum total of 720 hours. Of this, 480 hours is devoted to midwifery technology and only 60 hours each to midwifery and community practice.

In 1988 there were 24,402 midwives in Japan of whom 72.9% work in institutions where 99% of birth occur. Only 5100 are 'practising' midwives, i.e. still independently pursue their duties in the community - mainly in small hospitals or midwives' clinics or doing postnatal visiting. There are very few home births - they are considered dangerous.

The role of these independently practising midwives is precarious due to the drastic decrease in the birth rate and increasing urbanisation. Also, the "Japanese preference" to do the same as others has reinforced the medical management of childbirth. Although pain relief is rarely used for normal vaginal births, the usual position for delivery is flat or slightly elevated dorsal with feet secured in stirrups. Electronic fetal heart monitoring is routine as are ultrasound scans - two or three times during each pregnancy.

Babies are separated from their mothers from 12 hours to two days following the birth and given glucose or formula. Demand feeding is rarely encouraged, the baby being brought to the mother three-hourly during the day.

The postpartum stay in hospital is about one week for normal births, 10 days to two weeks for caesarian sections. Data on c/section rates is rarely made available to the general public, but the 1987 average is given as 10.1%, but as high as 26% at Kagoshima City Perinatal Medical Centre. Breech births are usually conducted vaginally.

Inductions are common with methods ranging from castor oil to 'pitocin' or insertion of a laminaria (seaweed) suppository.

PNMR is 6.5/1,000 live births. Maternal mortality is 9.3/100,000 live births (1988).

In his welcoming address the Mayor of Kobe, Kazutoshi Sasayama said: "the quality level of maternal and child health care in Japan is ranked high among the advanced countries". That's the male opinion of "women's business".

Childbirth in Japan, Past, Present & Future says: (1)

> Childbirth in Japan, as in any other society, is culturally influenced. In the long history of Japanese births, medical interventions were administered only when indicated by the birthing woman, or the midwife who was equipped with the practical knowledge to orchestrate the birthing scene and closely attend to the birth. Childbirth was never treated as pathology. There was a reliance on supra-natural powers and visits to shrines and temples but not hospitals or clinics.
>
> One clear problem today is that Western medicalized birth practices were brought into Japan without the necessary changes in ways of thinking and ways of life. The practices were simply imported because they were expected to be effective, convenient and modern just as high-tech electric gadgets are today. The sudden adoption of Western practices resulted in an institutionalized, impersonal, and mechanized birth for Japanese women. Traditionally obedient, Japanese women complied with the changes, putting up with any problems and coping with any bitter experiences by pushing unpleasant memories aside.
>
> The present day search in Japan for ways of treating childbirth as a natural, healthy event may find some of its answers in Japanese traditional ways.

(1) Proceedings p 371 (2) Birth International, Tokyo 1990

Midwives' Dilemma

Joan Donley Domiciliary Midwife

Founding Member, N.Z. College of Midwives
3 Hendon Ave., Auckland 1003, NEW ZEALAND

After 20 years in limbo, legally defined as 'obstetric nurses', New Zealand midwives have become independent practitioners. We may now take sole responsbility for the care of normal pregnancy and birth. Our independent status has also been reinforced in practice by amendments to several Acts and Regulations. These will permit us to order laboratory tests, to prescribe routine pharmaceuticals, to claim payments and refunds normally claimed by medical practitioners in respect of maternity care and to have access to hospitals on the same terms as doctors. It also makes us legally accountable.

Are we ready for this sudden change in status and responsibility, especially in the face of strong medical opposition?

From the beginning of midwifery training in N.Z. in 1904, midwives could and did assume responsibility for pregnancy and birth, both in the St Helens hospitals and in the community. As in other western countries with the exception of Holland, birth became both institutionalised and medicalised as birth in hospital was promoted and technology proliferated. In 1939 New Zealand became the first western country to provide free hospital care for every woman having a baby. This was followed at a later date by the right of every woman to have the doctor of her hoice, also paid by the state at the G.P. level. As a result N.Z. women have been conditioned over a period of 50 years to believe that 'safe' maternity care means birth in hospital under medical supervision. Furthermore, since 1971 when N.Z. midwives had their fragile independence revoked, every pregnant and birthing woman is legally required to be under medical supervision.

However, until the mid-70s there were numerous rural and small urban maternity units where women had relaxed and normal births with midwives who were relatively independent. The move towards 'regionalisation' i.e. the consolidation of maternity services into base hospitals bristling with technology, forced the closure of the majority of these level 0 and level 1 units. Childbirth became increasingly medicalised thus reinforcing the idea that pregnancy and birth is a medical crisis. This concept has disempowered both women and midwives.

Our dilemma, shared by all midwives trained and working under the present medicalised model of childbirth, is to believe that pregnancy and birth are normal and to have faith in a woman's ability to accomplish this. This is not as simple as it sounds, as both midwives and women have been led to believe that birth is only normal in retrospect and that every pregnancy and birth has the potential for disaster. This is the medical definition of childbirth! It is based on fear of birth. So long as a midwife accepts this, either consciously or subconsciously, she will be unable to trust a woman's innate ability to give birth. A labouring woman is very perceptive and soon picks up on a midwife's anxiety or apprehension. This can undermine the woman's self-confidence which may be fragile due to the same influences. Then, this woman is disempowered and will be driven back into the waiting arms of the doctors. So regardless of the legal right to practice independently, in order to succeed, both midwives and women have to believe in the normalcy of pregnancy and birth.

Another aspect of our long dependency on doctors and technology is the loss of the art of midwifery and midwifery skills. These not only have to be relearned, they have to be reclaimed. This means actively changing our style of practice. But this will threaten long established role relationships. As the supporter and advocate of the woman, the midwife is placed in the primary role rather than being the obstetrician's handmaiden. This places the obstetrician in a secondary position in a normal labour and birth and undermines the jealously guarded heirarchy upon which power and status is based. Is this possible in an environment where the medical model is considered to be the norm?

Can a midwife feel comfortable and confident supporting a woman who is labouring at her own pace? Or in monitoring a fetal heart with a pinnard rather than relying on the print-out from the electronic fetal heart monitor —if only to establish her credibility? And, what about the woman, what will she opt for in this environment of fear?

There is also the question of loyalty. As a junior member of a power structure known as the 'team', the mdiwife's loyalty is to the team, if only to consolidate her position. She would undermine her own position if she

defended the judgement or actions of another midwife; to uphold the rights of a woman could be seen as disruptive of team unity. Structured as it is, this organisation not only creates divisions among 'with women'. Furthermore, it reinforces the midwife's and the woman's dependence on the doctor.

This dependence cna be seen to have some advantages — which makes it difficult to discard. As part of the team, the midwife never has the final responsibility for decision-making i.e. she is never truly accountable. If she feels unsure of her skills or fears childbirth, then, of course the team offers a security blanket — as well as stasis. As a domiciliary midwife who has been through the process of challenging these dragons, I feel that the only place a midwife can become truly independent is in the community. Being on the woman's turf not only provides a psychological advantage, it also guarantees the support of the woman and her family. Midwives cannot stand alone! The next best option is a DOMINO contract which can be part of a process towards independent midwifery.

Outside of these fears, what other factors keep midwives within the feudal structure of a hospital? Probably the most significant is the substantial and guaranteed income which has been fought for over many eyars by the New Zealand Nurses Association which is also the midwives' negotiating body. Life styles — and mortgages —have been determined on the basis of this income, which also includes holiday pay — the ability to plan and afford holidays.

Then there are regular rosters. Independent midwifery can play havoc with one's life style. It makes parenting difficult and can put considerable stress on relationships. This can be overcome by midwives setting up group/shared practices. So, while the medical/hospital structure is oppressive it is also protective. It relieves us of the trauma associated with challenging cozy relationships and roles; of becoming politically aware of power structures and vested interests and finally of being truly accountable.

We are like the mediaeval peasants who were finding the costs of allegiance too high but were loathe to give up the plot of land on which their survival depended. It was the disintegration of the feudal system which forced the peasants to explore and develop other survival mechanisms. These gradually developed into our present economic/politcal system.

Today, this system is in a state of global crisis. We are all experiencing the effects of the instability created by 'market forces' such as inflation, unemployment, while the rich get richer and the poor get poorer. In New Zealand our health status is trailing far behind other OECD countries. However, it is in this state of chaos that midwives and women, like the peasants of old, can forge new and exciting survival mechanisms.

In fact, it is because of scarce resources and 'deregulation' which challenges the medical monopoly of childbirth, that enabled our Minister of Health to justify her legislation granting us independence. This will reduce the incidence and hence the cost of duplication of services while still maintaining free maternity care. This makes Treasury happy — but not the doctors! I have no doubt that we will experience some unpleasant repercussions from this still powerful lobby. There is no room for complacency. We must be prepared at all times by maintaining an up-to-date and realistic analysis of all social, economic and political forces and alliances. We live in dangerous if exciting times.

It is the global economic crisis which has prompted the move to primary health care, sponsored by W.H.O. as 'Health for All by the Year 2000'. National governments can no longer sustain the costs of expensive technological medical systems oriented towards illness. So health services are to be based on self-reliance with partnership and cooperation between health professionals and the users of the services. Primary health care is a revolutionary social movement which encompasses everyone involved in health care. As a strategy it cuts across community and institutional boundaries, challenging out-dated power structures and vested interests. Primary health care is care at a community level which is the level at which the midwife can function most effectively. We would be draft if we didn't utilise primary health care in the interests of midwifery!

Our Government has embraced the primary health care concept. Already one of the spin-offs from this has been an official declaration that "pregnancy and childbirth are part of the normal life experience of women. The majority of women have the ability to conceive, undergo pregnancy and give birth without problems" (1) Such a statment cannot but help to change attitudes towards childbirth in New Zealand. This is the first time since 1921 that our Department of Health has officially endorsed the concept that birth is normal.

At that time our Minister of Health and two other officials toured New Zealand, telling women from public platforms that birth was a normal function, and if they wanted to have babies without sepsis to have midwives. This was in response to three enquiries into maternal mortality from puerperal sepsis, due mainly to forceps deliveries which resulted from the growing trend towards 'twilight sleep' — the beginning of the medicalisation of childbirth.

Besides the move to primary health care we have a couple of other advantages. One of these is our recent

separate midwifery training. After a 10-year struggle we have midwifery courses at three polytechs, of one academic year in duration and based on the WHO/ICM definition of a midwife i.e. as an independent practitioner. After the hands-on St Helens training was terminated in 1979 all we had was a 'midwifery option' within the Advanced Diploma of Nursing. This was a 10-week 'obstetric component'. There is also a probability that a three-year polytech direct entry midwifery course will commence in 1991.

And, finally, we have a vigorous New Zealand College of Midwives which has united midwives. Since consumers are also active members we have formed a strong alliance with women. Our influence can only be as strong as our convictions — and we are convinced that we are a powerhouse to reclaim midwifery as an independent profession to serve the needs of women and their families. Together we will resolve our dilemmas.

1) Policy Recommendations for Care of Pregnancy and Childbirth, Sixth Draft.

Also added that last minute legislative changes to the Nurses Act removed power of the Nursing Council to prevent the pilot course in direct entry education proposed by Carrington Tech.

For those jet-setters '<u>planning for the future</u>' here is a list of forthcoming conferences advertised at Congress:

1991 - 21 - 22 March, s-Hertogenbosch (Utrecht) The Netherlands
International Conference on Primary Care Obstetrics & Perinatal Health.
Keynote speakers: Prof M Keirse & Dr I Chalmers
Address: NIVEL, P.O. Box 1568, 3500 BN Utrecht, The Netherlands.

1992 - March International Confederation of Midwives Research Group Meeting in Holland.
Enquiries to Conference Associates & Services Ltd ICM, Congress House, 55 New Cavendish St, London W1M 7RE U.K.

14 -17 June, Stockholm, Sweden, Reproductive Life, 10th International Congress of Psychosomatic Obstetrics & Gynaecology.
Enquiries to Congrex, ISPOG - 92, P.O. Box 5619, S-114 86 Stockholm.

5 - 7 October, University of Sydney, 2nd International Homebirth Conference - 'Reclaiming our Heritage, Creating our Future'
Call for papers.
Contact: Secretariate, GPO Box 2609, Sydney, NSW 2001.

1993 9 - 14 May, Vancouver Trade & Convention Centre, Vancouver, International Confederation of Midwives, 23rd International Congress.
'Midwives - Hear the Heartbeat of the Future'
Contact: The Midwives Ass'n of B.C. 244 - 810 West Broadway, Vancouver, B.C. V4Z 5C9 Canada.

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Sig:

3. DATE OF BI...

4. NAME OF MEDICINE.

5. QUANTITY.

6. DOSE & LABELLING.

7. PRESCRIBER SIGNATURE.
Please also print name if nonheaded paper is used.

8. PRESCRIBER ADDRESS.

9. PRESCRIBER REGISTERED NUMBER.

10. PRESCRIBER DATE.

11. A CONTROLLED DRUG PRESCRIPTION OR ORDER TO BE ALL IN THE PRESCRIBERS HANDWRITING, NUMBERS BOTH AS FIGURES AND WORDS.

MITTE:

Signum:

LEGAL REQUIREMENTS FOR A PRESCRIPTION,
DRAWN UP FOR AUCKLAND MIDWIVES.
AUCKLAND PRESCRIPTION PRICING OFFICE
NOVEMBER 1990.

personally (whether in the presence of the pharmacist or by speaking to him on the telephone) a prescription relating to a prescription medicine that the practitioner or veterinary surgeon requires urgently.

(3) Within 7 days after any communication made by any practitioner or veterinary surgeon to a pharmacist under subclause (2) of this regulation, the practitioner or veterinary surgeon shall forward to the pharmacist a written prescription confirming the oral communication.

41. Form of prescription—Every prescription given under these regulations shall—

(a) Be legibly and indelibly printed; and

(b) Be signed personally by the prescriber with his usual signature (not being a facsimile or other stamp), and dated; and

(c) Set out the address of the prescriber; and

(d) Set out—

(i) The title, surname, initial of each given name, and address of the person for whose use the prescription is given; and

(ii) In the case of a child under the age of 13 years, the date of birth of the child; and

(e) Indicate by name the medicine and, where appropriate, the strength that is required to be dispensed; and

(f) Indicate the total amount of the medicine that may be sold or dispensed on the one occasion, or on each of the several occasions, authorised by that prescription; and

(g) If the medicine is to be administered by injection, or by insertion into any cavity of the body, or by swallowing, indicate the dose and frequency of dose; and

(h) If the medicine is for application externally, indicate the method and frequency of use; and

(i) If it is the intention of the prescriber that the medicine should be supplied on more than one occasion, bear an indication of—

(i) The number of occasions on which it may be supplied; or

(ii) The interval to elapse between each date of supply; or

(iii) The period of treatment during which the medicine is intended to be used; and

(j) In the case of a prescription relating to the treatment of an animal,—

(i) Set out the title, surname, initial of each given name, and the address of the owner of the animal; and

(ii) Contain the following statement, or words of similar meaning:

"Not for human use".

42. Dispensing of prescription medicines—(1) Except as provided in subclause (2) of this regulation, no person other than a practitioner, a pharmacist, a veterinary surgeon, a pharmacy graduate, or a dispensary technician may dispense a prescription medicine.

(2) An agent or employee of a veterinary surgeon may, in any particular case, dispense any prescription medicine at the direction of the veterinary surgeon for use in the treatment of any animal under the care of the veterinary surgeon.

(3) Subject to regulation 43 of these regulations, every person dispensing a prescription relating to any prescription medicine shall comply with the following requirements:

SUGGESTED GUIDE LIST OF MEDICINES FOR MIDWIVES PRESCRIBING FOR A NORMAL PREGNANCY

ANTACIDS

Alginic acid with magnesium trisilicate, aluminium hydroxide gel, dried and sodium bicarbonate tablets (Gaviscon)
Aluminium hydroxide gel? Amphogel
Aluminium hydroxide gel dried Alutabs
Aluminium hydroxide gel with kadlin mixture Kaomagma
Aluminium hydroxide gel with magnesium hydroxide mixture Aludrox
Aluminium hydroxide gel with magnesium hydroxide and activated dimethicone mixture and tablets Mylanta liquid
Aluminium hydroxide gel, dried, with magnesium hydroxide tablets etc Mylanta tabs
Aluminium hydroxide gel, dried, with magnesium trisilicate, magnesium hydroxide and dimethicone tablets Gastrogel
Magnesium trisilicate with aluminium hydroxide gel, dried, tablets Gelusil
Magnesium trisilicate mixture
Sodium polyhydroxyaluminium monocarbonate hexitol complex tablets Actal
Calcium carb and aminoacetic acid tablets Titralac
Calcium carb and aminoacetic acid with dimethicone Titralac-Sil

PREGNANCY TEST - Approved type

ANTI-NAUSEA

Pyridoxine

INTRAVENOUS FLUIDS

GENERAL

Ural sachets
Citravescent granules
Dettol solution 100ml H570
Ergometrine and its salts H570
Naloxone pediatric H570
Oxytocin H570
Oxytocin with ergometrine maleate H570
Pethidine injections H571

IRON AND FOLIC ACID

Ferrous gluconate Fergon
Ferrous sulphate
Ferrous sulphate long acting tablets Ferro-Gradumet
Ferrous sulphate with folic acid long acting tablets Ferrograd Folic

ANTIFUNGALS

Clotrimazole, vaginal cream, and vaginal tablets, Canestan, Chlocreme, Gyne Lotremin
Di-iodohydroxyquinolone compound vaginal tablets Floraquin
Econazole nitrate ovules and vaginal cream Ecostatin, Pevaryl
Miconazole nitrate, pessaries, and vaginal cream Gyno Daktarin, Micreme
Nystatin vaginal preps. Mycostatin, Nilstal
Ornidazole and pessaries Tiberal
Tioconazole, vaginal ointment and pessaries Gyno-Trosyd
Triamcinolone acetonide with nystatin and lignocaine, ointment and suppositories Kenoid

LAXATIVES

Biscodyl enema, suppositories, tablet Dulcolax
Docusate sodium enema and tablets Coloxyl
Docusate sodium with biscodyl suppositories Coloxyl
Docusate sodium with senna tablets Coloxyl with senna
Lactulose syrup Duphalac, Laevoloc
Mucilaginous laxatives Isogel, Metamucil
Senna standardised tablets Senokot
Glycerine suppositories 4gm

TOPICAL PREPARATIONS

Bismuth subgallate compound ointment and suppositories Anusol
Bismuth subgallate compound suppositories with hydrocortisone
Calamine lotion, lotion oily, ointment Anusol
Chlorhexidine gluconate obstetric cream 5% 500gm Hibitaine H570
Chlorhexidine gluconate obstetric solution 100ml Hibitaine H570

TOPICAL PREPARATIONS (Contd.)

Cinchocaine hydrochloride and clemizole undecylate ointment and suppositories
Cetrimide with chlorhexidine gluconate cream
Crotamiton Eurax
Dimethicone cream Barrier cream
Lead lotion evaporating
Lead lotion
Furacin 15G on prescription only
Peanut oil 100ml H570
Soya oil 100ml H570
Toughened silver nitrate
Tolcilate cream, lotion, powder
Urea 10% proprietary cream Aquacare
Zinc ointment
Heparinoid hyaluronidase ointment Hirudoid
Dibromopropamidine cream 15G Brulidine

SUPPRESSION OF LACTATION

Dopergin - Lisuride 0.2mg times daily 7 days
Liserdol - metergoline 4mg immed. post partum
Parlodel - Bromcriptine mersylate 2.5mg. Twice daily for seven days

POST NATAL CONTRACEPTION

3 months only