NEW ZEALAND COLLEGE OF MIDWIVES
P O BOX 21-106
CHRISTCHURCH

New Zealand
College of Midwives [Inc]

NEWSLETTER

Volume 2, Number 8 : August 1990

NZCOM Dunedin Conference - ***Remits***

Nurses Amendment Bill - Parliamentary Update

BOARD OF MANAGEMENT

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CELIA GRIGG SOWMAN 102 Sommerfield Street Christchurch	MATERNITY ACTION ALLIANCE

New Zealand College of Midwives
Membership Form

Regional Information

Name _____

Address _____

Telephone _____ Home _____ Work

Place of Work _____

Type of Membership

Full Member (Registered Midwife Full or Part Time)	$52.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	$26.00
Associate Member (Other interested individual)	$52.00
Associate Member (Unwaged interested individual)	$26.00
Affiliated Member (Other Groups e.g. Parent Centre, La Leche League, etc)	$26.00

Method of Payment

Please tick your choice of payment method.

- ☐ Subscription payable to College Treasurer (Please enclose cheque or money order)
- ☐ Deduction from Salary (Please arrange with your pay office)

National Information

Name _____

Address _____

Telephone _____ Home _____ Work

Date of Birth _____ NZNA Member YES/NO

Type of Membership

Full — Waged ☐ / Unwaged ☐

Associate — Waged ☐ / Unwaged ☐

Affiliate ☐

Place of Work _____

Please return completed form (together with money if applicable) to
Local Regional Treasurer
New Zealand College of Midwives
Address:

Notes

FROM THE BOARD OF MANAGEMENT

Dear Members.

This is the "on again, off again" newsletter. Due to the sad state of our National funds, we thought we may have had to sacrifice this issue, but of course as there is so much information that you all need to be aware of, the newsletter has been produced but in a reduced form.

There are a number of interesting seminars and workshops on over the next few months and of course our August Conference. Have you registered yet? The programme looks superb! We also acknowledge the disappointment of those members who would like to attend but are unable to do so for varying reasons.

Karen Guilliland, Sally Pairman and Joan Donley represented the NZCOM at a meeting with the Social Services Select Committee on 18th July to present further submissions to the Supplementary Order papers (Nurses Amendment Bill). Read on for more information on this.

Don't forget - SUBSCRIPTIONS ARE NOW DUE - and can be paid to your local treasurer. Although, presently as per the Constitution, membership is not terminated until a year following failure to pay a subscription, it is anticipated that this will change to three months at the August AGM. Therefore, if your subs are not paid by then, you will cease to be a member.

As of the AGM in Dunedin, the Board of Management moves to Wellington. Being the BOM over the past two years as the College has evolved has been an exhausting but amazing experience. We can all say that our political awareness, knowledge and skills have increased and diversified beyond our expectations, as has the NZCOM. Special thanks all those members and regions that gave us the support we needed as our workload snowballed, particularly as the College's role expanded.

We'd like to welcome the new Board of Management - Christie Griffiths, Jennifer Sage, Beryl Davies, Chris Hannah, Lynley Davidson and Jeannie Douche, and wish them loads of energy, but also many rewarding times.

As the production of the newsletter is part of the BOM's role, this is our last issue. The articles and information sent for inclusion in the newsletter have been very much appreciated, therefore keep up the good work and send on your exciting snippets to the Wellington BOM, P O Box 7063, Wellington.

See you at the Conference.

BOARD OF MANAGEMENT

Karen Guilliland Kathay Anderson Julie Hasson

Del Lewis Lynda Bailey Jacqui Anderson

[1] ARTICLES FOR NZCOM CONFERENCE 1990

The Conference Committee in Dunedin are requesting articles that you consider both interesting and relevant to be photocopied and distributed to people attending the National Conference in August.

Everyone will no doubt have at least one informative article that has been of immense value to them. The articles will be gratefully received and should be sent to the following address as soon as possible.

CONTACT : 1990 Conference Committee
New Zealand College of Midwives - Otago
P O Box 6243
Dunedin North

[2] NZCOMI BREASTFEEDING HANDBOOK
- Lynda Bailey -

At the May 1990 National Committee Meeting, a Breastfeeding Workshop was held. It was agreed that it is timely for the College to produce its own Breastfeeding Handbook. One of the main aims of the handbook is so that health professionals can give consistent help and advice to breastfeeding mothers.

There are many breastfeeding protocols produced by Area Health Boards around New Zealand. Many of these were perused at the workshop, members present felt that for expediency of time and effect that an already existing protocol be used as a basis for the College's handbook. A unanimous decision was made to adopt the Taranaki Area Health Board Breastfeeding protocol draft 1990.

A sub-committee has been formed to work on the protocol and to adopt it for the College's purpose. The sub-committee is based in Christchurch and the members are:-

Marcia Annandale - National Committee La Leche League Rep.
Kay Faulls - Canterbury/West Coast Committee
Gail Warwick - Canterbury/West Coast Committee
Del Lewis - Board of Management
Lynda Bailey - Board of Management

The first draft is planned for November 1990. The plan is to have the handbook on an IBM compatible computer floppy disk which will be sent to all regions who can then print as many copies as is required. This will enable members to discuss, comment and forward all ideas to the sub-committee for the final draft.

New Zealand College of Midwives

Consumerism Feminism Midwifery

National Conference — Women in Partnership
August 17 to 20, 1990, Knox College, Dunedin

Keynote Speaker
Dr. Marsden Wagner
Regional Officer for Maternal and Child Health, WHO

Programme

Friday 17		Annual General Meeting (evening)
Saturday 18	*Consumerism*	Opening Ceremony, Cocktail Party (evening)
Sunday 19	*Midwifery*	Conference Dinner (evening)
Monday 20	*Feminism*	Closing Ceremony

Those wishing to present papers or workshops should inform the Conference Committee before February 28, 1990.

Conference proceedings will be published after the Conference and be available for purchase from the College in November 1990.

New Zealand College of Midwives — National Conference
August 17 to 20, 1990, Knox College, Dunedin

☐ I will be attending the Conference, please send me a registration form.
☐ I would like information on accommodation / creche facilities.
☐ I would like to present a paper / workshop (please see reverse).

Name _____
Address _____
_____
_____

No need for flying squad backups says researcher

NZ DOCTOR
JULY 1990

BY OUR CHRISTCHURCH CORRESPONDENT

The NZMA's call for specialist flying squads to back up midwives delivering babies has been described as "scaremongering".

Celia Grigg Sowman, this year awarded a Winston Churchill fellowship to study the public childbirthing practices of three northern European countries, is highly critical of the NZMA stance over the Nurses Amendment Bill.

Ms Sowman says in the Netherlands, Denmark and Sweden the primary professional involved in prenatal care, education and attending the birth is the midwife.

In these countries they practice independently, as proposed in the new bill, with no compromise to the safety of mother and child in childbirth.

The medical association sees the new autonomy for midwives bringing an increased number of home births, requiring, it claims, flying squad of specialists, a paediatrician, an anaesthetist and a nurse as 24-hour on-call back-up.

But Ms Sowman says flying squads are a British idea, which are now going out of fashion there because they are not necessary.

A recent workshop of Christchurch midwives to discuss the bill stated that midwives territory does not extend beyond the normal birth.

In the Netherlands 37 per cent of women give birth at home attended by a midwife and a maternity aid nurse and there are no flying squads for back-up, says Ms Sowman.

Legislative changes are unlikely to results in an immediate or dramatic increase in homebirths said Ms Sowman because New Zealand women believe they need a hospital, a doctor and equipment to help them deliver.

Her seven-week case study of Dutch, Danish and Swedish public childbirth systems was conducted from a consumer viewpoint with her contacts in those countries extending to government agencies, hospitals, specialist medical staff, midwives, nurses and consumer groups.

Dutch figures for morbidity and mortality in childbirth match other European countries which have fewer homebirths. This shows that homebirth with home supports for mother and child is not an unsafe practice, said Ms Sowman.

Another third of Dutch women give birth in hospital under the care and supervision of a midwife known to them from the prenatal period. Within six to 12 hours of delivery woman and baby return home and are visited for the first 10 days after birth by the midwife looking after the medical care of mother and child and by a maternity aid nurse helping in the home and with the baby.

Impressive care

She was impressed with the continuity of care in the Netherlands, with a midwife following her patient through from pregnancy to the postnatal period.

Ms Sowman said it is the extensive home support system in the Netherlands for new mothers, in addition to a complex system of state and private health insurance, which enables such a large proportion of homebirths and early discharge.

The remaining one-third of Dutch women are referred by their midwife to a specialist and deliver in hospital under the specialist's supervision.

In New Zealand about 2 per cent of all births take place at home, she says, with 98 per cent in low-tech maternity units or hospitals.

Swedish birthing practices formed a great contrast to those in the Netherlands with more than 99 per cent of women giving birth in hospital.

Ms Sowman describes delivery in Sweden as medicalised with up to 60 per cent of women receiving pethidine for pain relief during delivery.

After the delivery women stay in hospital about five days with no state-provided home help system.

Celia Grigg Sowman... a flying squad is a British idea which is now going out of fashion

As with all, seemingly at first, simple tasks, this has turned into a major task e.g checking references, ensuring up to date information that is research based, etc, also additional sections to be written as required by the National Committee.

We are a keen committee and we're making steady progress. We look forward to your comments when the first draft is completed.

[3] CARING FOR YOURSELF DURING PREGNANCY AND PREPARING FOR CHILDBIRTH - AN HOLISTIC APPROACH

The New Zealand College of Complementary Medicine now offers a short course as an option paper towards a Naturopathy Certificate and Diploma titled "Caring for Yourself During Pregnancy and Preparing for Childbirth - An Holistic Approach" written by Jo Wallis and Danielle Cameron.

The paper include three sections:-

1. Caring for yourself in pregnancy and preparing for childbirth
2. Labour
3. Post-Natal

Excellent notes on nutrition in pregnancy written by Joan Donley are also included.

The paper offers valuable knowledge for both the woman/mother and anyone else involved during pregnancy, birth and the early period of mothering. It is centered on the woman - encouraging the taking of responsibility. Giving information, understanding and awareness so the woman maintains choice and control.

To Naturopathy students, the paper costs $36 which includes tutorial fees, assignment and accreditation. However as a booklet alone it is available at $18.00 a single copy, decreasing with bulk orders to a lower limited of $12.00. These prices include postage. Contact:-

NZ College of Complementary Medicine
226 High Street
Dunedin
Phone (024) 790-760
(03) 4790-760 (after October 05, 1990)

[4] GENTIAN VIOLET - Are You Aware of its Carcinogenic Potential?

Earlier in the year, Marcia Annandale brought to our attention that Gentian Violet, also known as Crystal Violet, continues to be recommended to breastfeeding women for use on nipples as a treatment for thrush. The rationale for this is Gentian Violet's antiseptic effect particularly against Candida.

The major concern is that Gentian Violet is now known to have carcinogenic potential. The Department of Health provided two references in relation to this. Martindale - The Extra Pharmacopeoia 1989 (pp 959-960) states

> "Crystal Violet has been applied topically for the treatment of bacterial and fungal infections, but its use is now restricted to application to unbroken skin because of concern of animal carcinogenicity."

Martindale also cites research where patients develop necrotic skin reactions after topical application of a 1% aqueous solution of Gentian Violet and Neonates treated with aqueous Gentian Violet 0.5-1% for oral Candidiasis developed oral ulceration not attritubable to the Candidiasis.

Consumer Food and Health February 1990 (pp 20-23) lists Gentian Violet as an antiseptic compound best avoided, primarily due to its carcinogenic potential but also states that it is effective on only a narrow range of bacterial strains and has only slight anti fungal activity.

Therefore, if you're aware of the continued recommendation and use of Gentian Violet, it is important these people are informed of its potential dire side effects.

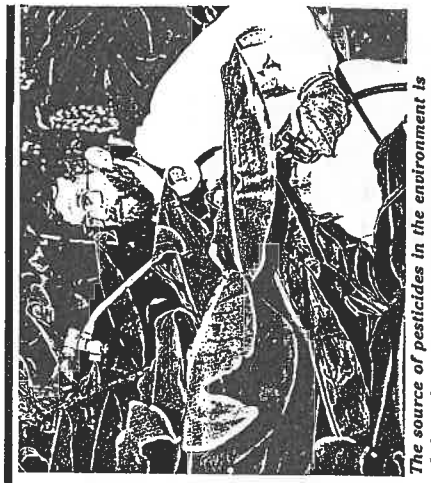
-Julie Hasson-

[5] GENITAL HERPES IN PREGNANCY
-from Lyttle H "Genital Herpes: What's New?: Parent Management, August 1988-

Over the past few years the management of pregnant women with a history of genital herpes has been debated. In the past it was thought that prevention of transmission to the infant during birth was dependent on repeated clinical examination and virological screening in the final trimester, with caesarian section recommended if lesions were present at delivery.

Infants delivered vaginally to women with primary HSV have a high risk of clinical infection - greater than 50%. However, infants delivered to mothers with recurrent secondary infection have a much lower risk - less than 5% [11]. This is due to less cervical involvement and to the fact that genital secondary lesions shed less virus than primary lesions. HSV antibodies in the neonate, acquired transplacentally, may offer some protection also.

Despite the contamination breastmilk remains best



The source of pesticides in the environment is obvious, but since 1989 all organochlorine pesticides have been prohibited

BY PROFESSOR JOHN BIRKBECK

The sensational reporting in the lay press of the Department of Health's report on organochlorine contaminants in human milk is a sad replay of the similar episode in Europe some time ago: it hardly encourages women to breastfeed.

The reports picked out the highest levels of contaminants and dramatised them. In fact, the levels of most of the chemicals measured were substantially below those reported in other countries.

The milk from only 38 women from four regions was analysed: urban areas in Auckland and Christchurch and rural areas in Northland and North Canterbury. Conclusions must be qualified in view of the small sample and restricted geographical distribution.

The levels of the pesticide components hexachlorobenzene, dieldrin and DDT were below values found in Norway, Canada or the UK, but the level of DDE, the principal breakdown product of DDT, was higher.

However, there was considerable individual variation in the levels of DDE, with average values in Christchurch and North Canterbury nearly three times those from the North Island. Even in those areas, there was a wide variation in results. DDE in the three North Canterbury samples ranged from 1500ppb to 7800ppb.

The study found levels of polychlorinated biphenyls (PCBs) which were much lower than those reported in the breastmilk of women in Los Angeles, Finland, and particularly Belgium, where breastmilk contained up to six times the levels of PCBs found here.

Our dioxin values are similar to those in Finland, Los Angeles, and Ontario, which are at the low end of the range, and much lower than Birmingham (England) or Northern Germany.

Cleaning up the environment

The source of the pesticides is obvious. DDT was widely used in the past, but has been progressively restricted and since 1989 all organochlorine pesticides have been prohibited.

Although the toxins are persistent in the environment we must presume that levels will progressively fall away to nil over the next 40 years. There are biotechnical organisms now available which actually break down DDT in pasture and consideration should be given to using these in contaminated areas.

Although PCBs are not considered very toxic, they are very persistent. Their use in "open" situations has already been banned and only sealed (electrical insulation) use remains. Both the use and the storage of these agents will be totally banned from the end of 1993.

Evidence about the toxicity of dioxins in humans is lacking although some dioxins have been shown to be toxic in experimental animals.

Although there are many sources, some of them natural, dioxin is introduced into the environment mainly through chlorine bleaches on organic compounds and as a byproduct in the herbicide 2,4,5-T. Incineration of PVC plastic can also generate dioxin as can car exhausts using leaded fuel (because ethylene dichloride is used) and some timber treatment chemicals.

The manufacture of 2,4,5-T was progressively cleaned up and has not been made in New Zealand since 1987. There is good reason to stop the use of this agent.

For most purposes there is no need to use bleached paper at all. Unbleached toilet paper is now available which is every bit as functional as bleached. Even newsprint could be unbleached if the public could be educated (in fact it should be recycled paper anyway). For best quality paper, it is likely that peroxide will be used in the future.

We need to reassess the value of PVC. While it has some useful attributes, the difficulty of its disposal, plus the ever-present danger of liver cancer from the vinyl chloride monomer in manufacture, means that perhaps it should be abandoned.

Despite concerns about milk cartons (low-dioxin board is now used), our levels are among the lowest reported from western countries and again we may assume that levels will fall in the future.

This report highlights the problems of environmental contamination. However, scaremongering is not productive and to date there is no evidence of a measurable toxic effect from the levels of the substances found in breastmilk in New Zealand.

The department's effort in bringing together such a comprehensive report which includes the results of individual samples is commendable.

Despite concerns about

Professor John Birkbeck is the director of the Nutrition Foun-

During the hearings of evidence on the bill it became clear to the committee that, for registered midwives to provide comprehensive services and to ensure the safety of mother and child, it would be necessary to permit midwives to perform the range of related services referred to in submissions. This includes: administration of medicines commonly used in low risk pregnancy and childbirth; the ability for midwives to call for routine diagnostic laboratory tests and to claim for the associated social security benefits; and ability to transfer patients to an obstetrician or to a hospital if necessary.

Summary of recommendations

The committee has carefully considered the bill and has resolved to recommend that it be reported to the House without amendment.

In recommending that the bill be reported without amendment the committee is aware that the amendments that it wishes to see incorporated are not within the scope of the bill as introduced. **The committee therefore recommends that amendments to the following Acts be drawn up by means of a supplementary order paper for consideration by the Committee of the whole House:**

Nurses Act 1977—to provide for complaints against registered midwives or allegations of professional misconduct in relation to the Social Security Act 1964 to be investigated by the Nursing Council.

Social Security Act 1964—to Part II of this Act to allow registered midwives to claim maternity benefits, pharmaceutical benefits, other benefits relating to buildings and equipment, allowances and expenses, and grants in relation to services provided; to claim payments and refunds normally claimed by medical practitioners in respect of maternity care.

Misuse of Drugs Act 1975—to allow registered midwives to prescribe the controlled drug pethidine, and to amend the disciplinary provisions for contravention of the Act to include registered midwives.

Medicines Act 1981—to refer to a registered midwife as a prescriber of medicines; to allow registered midwives to have possession of prescription medicines; to enable the Minister to prohibit prescribing, as in the case of medical practitioners; to enable the Medical Officer of Health to prohibit a registered midwife from supplying a prescription or restricted medicine to an addict, and to include registered midwives in regulations made under this Act.

Area Health Boards Act 1983—to allow area health boards to enter into agreements with registered midwives as to the conditions on which patients in a hospital maternity ward or maternity annex are treated. This access would be on the same terms as medical practitioners are currently accorded.

The committee further recommends the amendment of a number of regulations, to come into force on the same day as the commencement date of the bill. These are as follows:

Social Security (Laboratory Diagnostic Services) Regulations 1981—to permit registered midwives to order a range of laboratory diagnostic tests as specified in the regulations, and for the Department of Health to make payments of fees for the services ordered.

Social Security (Pharmaceutical Benefits) Regulations 1965—to allow registered midwives to sign for their own pharmaceutical supply order, and to include registered midwives in the penalty provisions where medicines have been prescribed excessively.

Misuse of Drugs Regulations 1977—to allow registered midwives to prescribe the controlled drug pethidine to patients under their care, for maternity use only.

Obstetric Regulations 1986—to provide for a registered midwife to be able to notify septic conditions to the Medical Officer of Health and to notify births and maintain records.

Medicines Regulations 1984—to provide for conditions under which a registered midwife may prescribe medicines.

Recently, asymptomatic shedding of *Herpes simplex* in late pregnancy has been studied, finding that shedding during the antepartum period did not predict shedding at delivery. Antepartum culture for asymptomatic reactivation of HSV occurred in 2 to 4% but none of these women had positive cultures at delivery. Of 414 pregnancy women with a history of recurrent herpes, 1.4% were positive at delivery [12,13].

It would appear that regular virological screening in the last weeks of pregnancy is not helpful. However the obstetrician must be alerted to the past history, and at the onset of labour should carefully examine for signs of genital ulceration and take cultures. Although results will not be available for delivery, they may be helpful in the management of the neonate. Caesarian section in mothers with primary herpes infection at term would still appear to be recommended with subsequent acyclovir therapy for mother and infant if required.

Altered bill gives extra powers to midwives

CH CH PRESS
JUNE 1990

By PETER LUKE
In Wellington

An expansion in the role of midwives means that they must be given access to a range of specific powers now held by doctors, a parliamentary select committee said yesterday.

Last November, the Government introduceed a two-clause bill to enable registered midwives to take sole responsibility for patients through pregnancy, childbirth and the postnatal period.

At present it is an offence for midwives to provide a service unless a medical practitioner has taken responsibility for the patient. To get around this problem a select committee yesterday reported back with a list of recommendations that would see the bill grow to 24 clauses.

The original two clauses were not touched, but the committee argued that if midwives were to provide comprehensive services and ensure the safety of mother and child a range of related services must also be permitted.

These included prescribing medicines commonly used in low-risk pregnancy and childbirth, calling for routine diagnostic laboratory tests, and claiming for the associated social security benefits, and transferring patients to an obstetrician or hospital.

The Opposition failed in a move to return the bill to the select committee to enable submissions to be heard on these specific points.

Its health spokesman, Mr Don McKinnon, said the Opposition had supported the thrust of the original bill, but that if was a "debacle" to have these additional changes treated in this way.

The Government intends to hold further talks with doctors, nurses and midwives before amendments are later introduced in the form of a Supplementary Order Paper.

During her first reading speech last November, the Minister of Health, Ms Clark, said that midwives would not prescribe drugs. That point was reached when complications occurred, and such complications ought to be handled by doctors, she said.

But the select committee heard in submissions that de facto prescribing by midwives already occurred.

It recommended changing the Medicines Act to allow midwives to prescribe medicines and have possession of prescription medicines.

Midwives should also be able to prescribe the controlled drug pethidine, for maternity use, with any restrictions being decided by the Nursing Council.

The committee also believed that midwives should have the same access to patients whom they had referred to hospital, as doctors had to their patients.

Ms Clark said the bill would open up birth choices for women.

"If unexpected problems do arise, a midwife is competent either to deal with the problem or determine that the woman should be referred for more specialist care," she said.

Ms Karen Guilliland, president of the New Zealand College of Midwives, yesterday described the support given to the Nurses Amendment Bill in Parliament as a big step towards achieving autonomy for midwives.

"We are delighted with the unanimous support and confidence in midwives from both sides of the House," she said.

Ms Guilliland said there was some comment from the Opposition that there had been a lack of consultation about the amendment with women's health groups.

"We would like to reassure people there was wide consultation and discussion with women's health groups about the bill," she said.

FORTHCOMING EVENTS

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[1] FERTILITY ACTION : COURSE ON WOMEN'S HEALTH ISSUES

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19 July - 23 August 1990

Auckland College of Education
Epsom Cost : $100

Six (6) Thursday evening sessions. May attend individual sessions. Designed for all women with an interest in the politics of women's health.

Contact : Fertility Action
P O Box 46-148
Herne Bay
Auckland

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[2] INTRODUCTION TO FAMILY PLANNING

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31 July - 03 August 1990

Auckland Education Unit
NZ Family Planning Association
214 Karangahape Road
Auckland Phone : (09) 796-182 Cost : $220

A four day programme introductory course covering all contraceptive methods and aspects of fertility and sexuality.

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[3] INTERNATIONAL CHILDBIRTH EDUCATORS ASSOCIATION - 1990 INTERNATIONAL CONVENTION

03-05 August 1990 Chicago, USA

Theme : Midwifery Keynote Speaker : Marsden Wagner

Contact : ICEA International Convention
P O Box 20048
Minneapolis
Minnesota 55420 USA

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[4] AUCKLAND WOMEN'S HEALTH COUNCIL CONFERENCE

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05 August 1990

Auckland Technical Institute
North Shore Campus Cost : $ 25 (Unwaged)
$ 40 (Waged)

Theme : Cartwright and Beyond - The Shape of Women's Health in the 90s.

Contact : Auckland Women's Health Council
10 Carlton Gore Road, Auckland

Misuse of Drugs Act 1975—to allow registered midwives to prescribe the controlled drug pethidine, and to amend the disciplinary provisions for contravention of the Act to include registered midwives.

Social Security (Laboratory Diagnostic Services) Regulations 1981—to permit registered midwives to order a range of laboratory diagnostic tests as specified in the regulations, and for the Department of Health to make payments of fees for the services ordered.

Social Security (Pharmaceutical Benefits) Regulations 1965—to allow registered midwives to sign for their own pharmaceutical supply order, and to include registered midwives in the penalty provisions where medicines have been prescribed excessively.

Misuse of Drugs Regulations 1977—to allow registered midwives to prescribe the controlled drug pethidine to patients under their care, for maternity use only.

Medicines Regulations 1984—to provide for conditions under which a registered midwife may prescribe medicines.

(i) Access to hospital services.

A number of submissions focused on the importance of appropriate back-up services and the need for midwives to have access to hospitals and referral services on the same basis as medical practitioners. This was supported in oral submissions by the New Zealand College of Midwives, the New Zealand Medical Association, the Nelson Area Health Board and the National Council of Women. The submission of the New Zealand Medical Association sought the availability of these services in the context of a team approach to maternity care, whereas the emphasis of other submissions was that referrals should be able to take place without the requirement to use a medical practitioner as a "gate-keeper".

The need for midwives to keep records and be able to notify births was also raised in this context.

The committee agrees that, in order to ensure the safety of mother and child, it is necessary for midwives to be able to refer women to hospital or to specialist advice should a pregnancy deviate from the norm. The committee is also aware that midwives would require access to patients referred to hospital on the same basis as doctors referring maternity patients. This would require amendment to the Area Health Boards Act 1983 In order for a midwife to be able to maintain records and register births, amendment to the Obstetric Regulations 1986 is required.

The committee therefore recommends the following amendments to:

Area Health Boards Act 1983—to allow area health boards to enter into agreements with registered midwives as to the conditions on which patients in a hospital maternity ward or maternity annex are treated. This access would be on the same terms as medical practitioners are currently accorded.

Obstetric Regulations 1986—to provide for a registered midwife to be able to notify septic conditions to the Medical Officer of Health and to notify births and maintain records.

Conclusions

In making its recommendations the committee recognises the need for training to be appropriate to retain existing standards of safety and care and so that any deviation from the norm can be detected. The committee is also aware of the need for adequate monitoring and review systems to be set in place. These issues received the unanimous support of the witnesses appearing before the committee.

c. Access to medicines, laboratory tests and benefits.

The written submissions of the New Zealand Nurses' Association, the Auckland Domiciliary Midwives, the New Zealand College of Midwives (Auckland and Canterbury—West Coast branches), Waikato Area Health Board, Nelson Area Health Board, Canterbury Area Health Board, and National Council of Women all drew the committee's attention to the need for midwives to be able to prescribe the range of medicines commonly used in pregnancy and childbirth, within certain parameters. Submissions also requested that midwives be able to call for a range of routine diagnostic laboratory tests such as blood and urine tests, cervical smears and swabs. To make this possible, midwives would require access to the same range of benefits as is currently available to medical practitioners carrying out maternity work.

During the hearing of oral evidence these points were reinforced by the New Zealand College of Midwives, the Domiciliary Midwives' Society and the Royal New Zealand College of Obstetricians and Gynaecologists (subject to adequate training). The committee was informed that in practice, de facto prescribing by midwives already occurs. This varies in manner, from signed prescription forms being left in maternity units and ante-natal clinics to midwives having an annual supply of medicines supplied through a general practitioner or a local hospital. Midwives informed the committee that no matter how medicines are supplied at present, they do carry medicines and are happy to assume responsibility for their use.

The committee recognises that for midwives to provide comprehensive services and to ensure the safety of mother and child, midwives would need access to the range of routine diagnostic laboratory tests and medicines commonly used in pregnancy and childbirth, and to be able to claim for the associated social security benefits. Following the hearing of evidence correspondence and discussions occurred between the committee's departmental advisers and representatives of the Royal New Zealand College of Obstetricians and Gynaecologists, the Royal New Zealand College of General Practitioners, the Domiciliary Midwives' Society and the New Zealand College of Midwives on the medicines and laboratory tests thought necessary for low risk childbirth.

Consideration was given to whether there should be any restriction on the amount of pethidine that a midwife should be permitted to administer. However, the committee was satisfied that statutory regulation is impracticable, and that adequate controls can be best left in the hands of the Nursing Council of New Zealand.

The committee therefore recommends that the following Acts and regulations be amended:

Nurses Act 1977—to provide for complaints against registered midwives or allegations of professional misconduct in relation to the Social Security Act 1964 to be investigated by the Nursing Council.

Social Security Act 1964—to Part II of this Act to allow registered midwives to claim maternity benefits, pharmaceutical benefits, other benefits relating to buildings and equipment, allowances and expenses, and grants in relation to services provided; to claim payments and refunds normally claimed by medical practitioners in respect of maternity care.

Medicines Act 1981—to refer to a registered midwife as a prescriber of medicines; to allow registered midwives to have possession of prescription medicines; to enable the Minister to prohibit prescribing, as in the case of medical practitioners; to enable the Medical Officer of Health to prohibit a registered midwife from supplying a prescription or restricted medicine to an addict, and to include registered midwives in regulations made under this Act.

19

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[5] NEW DIRECTIONS TOWARDS AUTONOMY

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10 August 1990 Time : 09.30am - 4.00pm

Hawkes Bay Polytechnic
Taradale Cost : $25

A seminar for midwives and consumers to discuss issues related to pregnancy and midwifery.

Guest Speakers: Helen Clark, Minister of Health
Joan Donley, Auckland Domiciliary Midwife

Contact : Gillian Peterson
School of Nursing and Health Studies
Hawkes Bay Polytechnic
Taradale Phone: 448-710

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[6] HEALTH CHOICES FOR WOMEN IN THE 1990s
- NZCOM Eastern and Central Region

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11 August 1990

Hawkes Bay Polytechnic
Taradale Cost : $20 (Waged)
$10 (Unwaged)

A day of workshop for all women interested in health choices. Includes: Herbs, Massage, Goal Setting, Achieving Optimum Health, Self Defence.

Contact : Julie Kinlock
NZCOM - Eastern & Central Region
76 Charles Street
Napier Phone : 357-170

or Joan Barton Phone : 355-541

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[7] HOMEOPATHY IN PREGNANCY AND CHILDBIRTH

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15 August 1990 Time : 7.30pm

College of Natural Medicine
80 Park Terrace
Christchurch Cost : $4

Speaker : Mary Glaisyer

Contact : Canterbury Homeopathic Society
Barbara Thompson Phone : (03) 389-801

[8] NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE

17-20 August 1990

Knox College
Dunedin

Theme : Women in Partnership

Speaker : Marsden Wagner

Contact : Conference Committee
Otago Region of NZCOM
P O Box 6243
Dunedin North

[9] LA LECHE LEAGUE NEW ZEALAND - SOUTH ISLAND CONFERENCE

22-24 August 1990

University of Canterbury
Christchurch

Theme : Breastfeeding - Passport to Life

Information and support for all those interested in Breastfeeding and Parenting.

Contact : Isobel Fanshawe
243 Port Hills Road
Christchurch Phone : (03) 842-583

[10] A BREASTFEEDING SEMINAR FOR HEALTH PROFESSIONALS

23 August 1990 Time : 08.30am - 12.30pm

Study Centre 3rd Floor
Rochester & Rutherford Halls
Canterbury University
Christchurch Cost : $20

Contact : Marcia Annandale
16 Shannon Place
Christchurch

The committee addressed the issue of who is competent to be a registered midwife for the purposes of this bill. The committee was advised that the term "registered midwife" covers those registered midwives currently practising in New Zealand whose training is sufficient to meet the criteria for registration by the Nursing Council of New Zealand and would include:

a registered general and obstetric nurse or a registered comprehensive nurse with a post-graduate midwifery course;

or an overseas trained midwife who has been granted registration by the Council and who is likely to have a broad based midwifery education.

The committee also recognises that these standards are more appropriately incorporated in guidelines than in legislation.

The committee recommends no amendment in relation to knowledge and safety in practice.

b. Accountability.

A number of submissions stressed the need for enhanced accountability should the bill proceed. This issue was addressed by the Royal New Zealand College of Obstetricians and Gynaecologists, the New Zealand Medical Association, the New Zealand College of Midwives, the New Zealand Nurses' Association, and the Domiciliary Midwives' Society in oral evidence.

The principal focus of the submission of the Royal New Zealand College of Obstetricians and Gynaecologists was the maintenance of standards and the necessity for appropriate training and peer review.

The committee was interested to hear that this issue is being addressed in the development of a peer review concept by the New Zealand College of Midwives and the Domiciliary Midwives' Society. Standards for Midwifery Practice, Service and Education are being used by individual midwives and midwifery tutors as well as area health boards as a basis for the specific standards of their maternity services. Ongoing midwifery training is being promoted, and the Domiciliary Midwives' Society has set up a pilot scheme to monitor midwifery standards in domiciliary care. The New Zealand College of Midwives is working to extend this monitoring system into area health board services.

A number of other submissions addressed the issue of monitoring and review, linking annual review to a licence to practise. Monitoring and review were also addressed by the Nelson and Northland Area Health Boards which saw a need for an amalgamated system of monitoring in the obstetric field. The New Zealand Medical Association suggested that any review team should include patient representation to ensure accountability to the consumer.

The New Zealand Nurses' Association informed the committee that the Labour Relations Act defines employer responsibility where a midwife is employed by an area health board. An external monitoring mechanism is provided by the Nursing Council which is the disciplinary body for nurses and midwives where the safety of the general public is concerned.

As with training issues, the committee agreed with the suggestion of the New Zealand College of Midwives that monitoring issues are a professional matter, more appropriately incorporated in guidelines than in statute. However, the committee indicated its interest in the development of these standards for accountability, and their incorporation in guidelines.

The committee has no amendments to recommend in relation to accountability.

Board argued that the current training of midwives is not sufficient to permit the proposed change to legislation and maintain standards of safety, even if that training is preceded by a 4 year general nursing course. The concept of autonomy for midwives in itself was not opposed by the College, providing these concerns are met. The question of whether claims against the Accident Compensation Corporation are possible in the case of medical misadventure involving the practice of midwives was also raised.

The manner in which the Royal New Zealand College of Obstetricians and Gynaecologists saw existing standards of care and autonomy for midwives being best applied was within the context of a team approach. This would involve an initial assessment being made by a medical practitioner, with subsequent modification of future management if the assessment proves normal. This view was supported by the New Zealand Medical Association, the Nelson and Wanganui Area Health Boards and the National Council of Women. The Nelson Area Health Board and the New Zealand Medical Association cited the United Kingdom practice of "flying squads" as an example of the team concept.

The National Council of Women, although supporting the principle of greater autonomy for midwives, was anxious that the amendment not be seen as a cost cutting measure that would eventually limit rather than expand choices for women, and might lead to a decrease in standards of care.

The view that midwives lack sufficient training to recognise possible complications was refuted by the New Zealand College of Midwives, the Domiciliary Midwives' Society and the New Zealand Nurses' Association.

The committee was informed that the reality is that maternity care in New Zealand is almost exclusively undertaken by midwives to the extent that they are often in the position of instructing house-surgeons in aspects of care. Where unexpected problems do arise, a midwife is competent either to deal with the problem or refer the woman to a general practitioner or an obstetrician.

The New Zealand College of Midwives further stated that assessment constitutes a major part of midwifery education and that the relationship built up between midwife and client often enables an assessment more accurate than would be made by a general practitioner. Assessment is enhanced by the ability of a midwife to spend time with a client and gain a thorough understanding of socio-cultural and other influences on underlying health. The New Zealand College of Midwives stressed that midwives have no wish to take on the role of doctors, and that it is quite appropriate to refer a woman to a general practitioner, or to an obstetrician as do many general practitioners, should problems arise.

In the case of medical misadventure, the committee was assured by its departmental advisers that patients should be able to claim compensation in case of personal injury resulting from an accident caused by a midwife. Midwives who are members of the New Zealand Nurses' Association are covered by personal indemnity insurance which is designed to meet the costs of any civil or statutory liability that a nurse/midwife may incur in the practice of his/her profession.

The committee is aware that the issues of knowledge and safety in practice are closely related to training of midwives and their accountability both to their peers and to their clients. The issue of accountability is discussed below. The committee is satisfied that the New Zealand College of Midwives has the capacity to set appropriate standards of training to permit registration as a midwife and to ensure that no diminution of standards of safety occurs.

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[11] NZ ASSOCIATION OF NATURAL FAMILY PLANNING NATIONAL CONFERENCE

24-26 August 1990

Lincoln University
Canterbury

Theme : Breastfeeding

Contact : National Secretary
NZ Association of Natural Family Planning
P O Box 38-406
Howick
Auckland

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[12] IMMUNE SYSTEM CONFERENCE

07-09 September 1990

War Memorial Hall
Napier

Theme : Gateway to Health Cost : $ 99
(Lunch Provided) $125

Contact : Immune System Conference
c/- Hawkes Bay Polytechnic
Private Bag
Taradale

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[13] PELVIC EXAMINATION COURSE FOR NURSES 1990

19-20 September 1990
21-22 November 1990

Nursing Administration
NZ Family Planning Association
214 Karangahape Road
Auckland Ph : (09) 775-049 Cost : $150

A skills based course involving a one and a half day theoretical component followed by clinical experience in the taking of cervical smears and bi-manual examinations.

[14] INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS

07-12 October 1990

Kobe
Japan

Theme : A Midwife's Gift - Love, Skill and Knowledge

Information and Enquiries : Board of Management
NZCOM
P O Box 21-106
Christchurch

[15] HEALTH PROMOTION FORUM 1ST ANNUAL CONFERENCE

24-26 October 1990

Lincoln Function Centre
West Auckland

Contact : Health Promotion Forum
Department of Community Health
Medical School
Private Bag
Auckland

[16] FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES

08-10 November 1990

Massey University
Palmerston North

Theme : Women as Health Providers Within a Context of Culture, Society and Health Policy

Contact : Fourth International Congress on Women's Health Issues
Department of Nursing Studies
Massey University
Palmerston North

[17] HOMEOPATHY FOR NEWBORN INFANTS

14 November 1990 Time : 7.30pm

College of Natural Medicine
80 Park Terrace
Christchurch Cost : $4

Contact : Canterbury Homeopathic Society
Barbara Thompson Phone : (03) 389-801

REPORT OF THE SOCIAL SERVICES COMMITTEE ON THE NURSES AMENDMENT BILL

NEW ZEALAND HOUSE OF REPRESENTATIVES 1990

COMMITTEE CONSIDERATION OF THE BILL

Background

The Nurses Amendment Bill is a two clause bill amending the Nurses Act 1977.

Clause 1 relates to the Short Title.

Clause 2 amends subsections (1) and (2) of section 54 of the principal Act which creates offences relating to obstetric nursing. The effect of the amendment is to permit a registered midwife to take sole responsibility for the care of a patient throughout pregnancy, childbirth and the post-natal period where currently that responsibility may be exercised only by a medical practitioner.

Following the introduction of the bill the committee advertised publicly for submissions, setting a closing date of 9 February 1990. 99 submissions were received, 12 of which requested a personal appearance before the committee.

Issues raised in submissions

Submissions fell into two categories: those supporting the bill and indicating brief reasons for that support, and those supporting the principle of autonomy for midwives but raising specific concerns.

General Issues

Submissions stating general support for the bill made the following points:

- The amendment will open up birth choices for women.
- Midwives have the competence to care for women both pre- and post-natally, to recognise the need for referral should the pregnancy deviate from the norm, and to deal with emergencies.
- The amendment will simplify maternal and health care. Many procedures at present carried out by medical practitioners could be performed by midwives.
- Midwives offer continuity of care and a professional, relaxed and supportive service.
- Birth is a natural process. Current law encourages over use of medical intervention and makes it too technical.
- The amendment will advantage rural women who do not have the same access to health care as other women.
- The amendment would relieve the burden on hospital resources where normal pregnancies are concerned, and help channel resources to areas of greater need, to high risk areas and to post-natal care.
- Women during pregnancy and childbirth are vulnerable. Some doctors tend to create a less than harmonious atmosphere.

Specific Issues

a. Knowledge and Safety in Practice

The issue of whether midwives are competent to recognise complications that may arise during pregnancy and childbirth was raised in a number of submissions.

The principal concern in the submission of the Royal New Zealand College of Obstetricians and Gynaecologists was that passage of the bill should not lead to a reduction in standards of care; there should be adequate provision for assessment of the underlying health of the woman, provision for laboratory tests and interpretation of their results, treatment of existing disease, and competent use of medication. The College, the New Zealand Medical Association, and the Nelson Area Health

PARLIAMENTARY UPDATE ON NURSES AMENDMENT BILL

- Karen Guilliland -

On Wednesday 18 July 1990, The College went back to the Select Committee to speak to our submission on the Supplementary Order Papers. The Medical representatives had felt they had not had the opportunity to put forward their view point on Midwife Autonomy and this return to the Select Committee gave all parties the opportunity to speak again. Contrary to the Medical opinion, we felt that there had been ample time in which to put forward submissions and of course we had done so on several occasions.

Sally Pairman (Otago) and Karen Guilliland (Canterbury) spoke to the submission and six Wellington midwives came to support. Viv McInnes (College Member) and Joy Bickley from NZNA presented their submission with us.

We concentrated our discussion on the safety of midwifery practice and explained again the depth of understanding and education midwives have which makes them safe to practice (which includes the prescribing of pregnancy specific drugs). We pointed out that the 1200 hours midwifery course is an extensive preparation of structured, comprehensive one on one teaching that provides an intensive knowledge base centred on normal pregnancy and birth. Compare 680 hours which the Department of Education considers a full time course in a tertiary institute.

We also compared the Midwifery Course to the Obstetric Diploma which further emphasised midwifery's expertise and experience in the normal birth process.

We addressed the flying squad debate which has been brought up as a red herring on the autonomy issue by the NZ Medical Association. Flying Squads were a British concept set up in response to British conditions. Many British women had their babies at home with no telephone or transport. This is not the situation in New Zealand where midwives carry their own emergency equipment and have access to a reliable and competent ambulance service.

We needed to emphasise again that independence for midwives will mainly effect hospital services as the vast majority of midwives work for Area Health Boards. The debate continually seems to stick on the birth only and in the home. We talked about other options which would be more freely accessible to women once midwives are independent. e.g. domino schemes.

We believe our submissions have been credible and effective and were received well by the Select Committee. There were areas in which the College and the Medical representatives agreed and the College reiterated the importance of liaison between all the producers of maternity services.

We now await the second reading on the House in the near future.

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[18] AUSTRALIAN COLLEGE OF MIDWIVES 7TH BIENNIAL CONFERENCE

16-18 September 1991

Perth
Western Australia

Theme : Birthdays, Birthdays

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[19] 2ND INTERNATIONAL HOMEBIRTH CONFERENCE 1992

Sydney
Australia

Calling for ideas and input

Contact : Jane Thompson
12 Thornton Street
Fairlight
NSW Australia

Doctors say midwives 'need back-up'

- CHCH PRESS June 1990

PA Wellington

Doctors want a 24-hour telephone hotline and specialist flying squads to back up midwives delivering babies, according to the Medical Association's chairman, Dr Lewis King.

Midwives, however, say the doctors are unnecessarily concerned as they are quite capable of screening pregnant women to ensure that those likely to need specialist services have access to them.

The Nurses Amendment Bill which was reported back to Parliament last week allows midwives to take full responsibility for care of women and babies before, during and after birth.

Anticipated changes to other laws will also allow them to prescribe a limited range of drugs such as pethidine, to be paid the maternity benefit payable to GPs and to be allocated hospital beds for patients.

Yesterday Dr King said doctors, contrary to popular belief, were not opposed to the changes.

But he said the association was concerned about New Zealand's perinatal mortality rate — the number of babies who died immediately before and after birth — which did not show up well in a recent OECD survey.

"If we are going to have a move to more home births then we need back-up from flying squads which include a nurse, a pediatrician, specialists and an anaesthetist," Dr King said.

"There also needs to be a 24-hour phone advice bureau."

Dr King said he envisaged a service similar to that provided by the Life Support Unit which doctors could phone if unsure of how to cope with a patient having a heart attack.

The unit could respond by sending a two-person paramedic team with specialist equipment.

Dr King said the competence of midwives was not in question but the legislative changes proposed did not include any directive to area health boards about back-up.

The association also wanted the list of drugs midwives could prescribe to be strictly defined and carefully controlled.

The College of Midwives president, Ms Karen Guilliland, said research had shown quite clearly that the greatest problems arose where there was a high level of intervention in births.

Births attended by G.P.s and midwives either in homes or at small maternity units were statistically safer than those in high-technology hospitals.

"Doctors have to stop being terrified of birth, which is a natural process with a level of risk attached like anything else.

"Rather than anticipating disaster at birth the answer is in ante-natal education, training and in good ante-natal screening which midwives are absolutely competent to give," she said.

Both the association and the college have been asked to make further submissions to the select committee which considered the Nurses Amendment Bill.

MS GUILLILAND

NZCOM - REMITS 1990 AGM

4. That "Midwifery Policy Statement N.Z.N.A. 1988" be deleted.

MEMBERSHIP:

7.2 That overseas individuals' membership is to the National Committee.

7.6.2 That "except on issues concerning the midwifery profession" be deleted.

7.8.2 That the member has paid no subscription for 3 months after membership has expired.

THE NATIONAL PRESIDENT:

The National President shall be a Full Member and is elected for a term of 2 years with a right of renewal.

9.1 That regions shall submit nominations to the Board of Management 3 months prior to the AGM or SGM.

9.1.2 That the Board of Management shall forward nominations to each region.

9.1.3 That voting shall be at regional level and results sent to National Committee 14 days prior to the AGM.

FUNCTIONS OF THE PRESIDENT:

9.2.1 The President shall be the national spokesperson for the NZCOMI.

9.2.2 Attend the National Committee meetings, AGM and National SGM.

FUNCTIONS OF THE BOARD OF MANAGEMENT:

9.1.13 That BOM call for remits 3 months prior to the AGM.

ALTERATION OF RULES:

17.3 ... not less than 3 months prior to the AGM.

OBJECTIVES: (NELSON REGION)

3.13 That the NZCOMI actively promotes membership by a College representative onto relevant NZ Government committees i.e those concerning family, childbearing and/or women's health.

BYLAWS:

- Membership fees to be increased to $74.00 for waged full and associate membership and $37.00 for other membership groups.
- That membership fee includes subscription to the NZCOMI Journal.
- Overseas members subscriptions shall be retained in their entirety by the National Committee.
- The NZCOMI AGM is to be held in August of each year.
- The National Conference is to be held biennially in August in conjunction with the AGM.
- That capitation fees be divided between National Committee and region as 60% to National Committee and 40% to Regional Committee.

WELLINGTON REGION OF THE NEW ZEALAND COLLEGE OF MIDWIVES

1] That the NZCOMI establish a nationally standardised refresher course which registered midwives be encouraged to attend at least five yearly.
Footnote: The Wellington region of the NZCOMI acknowledge the impractability of making this a statutory requirement in the current economic climate. However, we feel this would be a good goal to work towards.

2] That the NZCOMI assists in the setting up of regional peer review bodies using the Domiciliary Midwives Peer Review system as a model.

3] That the NZCOMI standards of Practice, Service and Education be reviewed two to three yearly.

4] That Midwifery Education become separated from the Advanced Diploma of Nursing in all centres and that midwifery education be made more readily available by the end of 1991.

5] That the NZCOMI support the availability of a Direct Entry Midwifery Course nationwide as from 1991.

6] That all Midwifery Comprehensive and Bridging students when working in areas where midwives are the preferred care givers be supervised by tutors who are currently practicing Registered Midwives.