from:

New Zealand College
of Midwives
P O Box 7063
Wellington

TO:

New Zealand College of Midwives [Inc]

NEWSLETTER

Volume 3, Number 4 : April 1991

Vision 2000 Project 1991

Maternity Benefits

NEW ZEALAND COLLEGE OF MIDWIVES INC.

President

KAREN GUILLILAND

136 Springfield Road
Christchurch 1
Ph: (03) 3559-579

Board of Management

LYNLEY DAVIDSON Ph: (04) 836-201
BERYL DAVIES Ph: (04) 887-403
JEANIE DOUCHÉ Ph: (04) 735-129
CHRISTINE GRIFFITHS
MARJORIE MORGAN
JENNIFER SAGE

Address for correspondence:

P.O. Box 7063
Wellington South

National Committee

Northland
LYNLEY McFARLAND
16 Russel Road
Whangarei

Waikato/Bay of Plenty
KITTY FLANNERY
12 East Street
Hamilton

Wanganui/Taranaki
KATHY GLASS
P.O. Box 5074
West Town, New Plymouth

Nelson
ANGELA KENNEDY
P.O. Box 672
Nelson

Otago
SUZANNE JOHNSTON
P.O. Box 6243
Dunedin North

Parents Centre
WENDY BROWNE
31 Chester Road
Tawa, Wellington

Homebirth
MADELIENE GOODA
92 Ellice Street
Mount Victoria, Wellington

Auckland
GLENDA STIMPSON
P.O. Box 24-403
Royal Oak, Auckland

Eastern/Central Districts
JULIE KINLOCH
76 Charles Street
Westshore, Napier

Wellington
MARION LOVELL
P.O. Box 9600
Wellington

Canterbury/West Coast
ANNE O'CONNOR
P.O. Box 21-106
Christchurch

Southland
LESLEY WATSON
390 Dee Street
Invercargill

La Leche League
MARCIA ANNANDALE
16 Shannon Place
Christchurch 5

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)	$84.00
Full member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	$42.00
Associate Member (Other Interested Individual)	$84.00
Associate Member (Unwaged Interested Individual)	$42.00
Affiliated Member (Other Groups, e.g. Parent Centre, La Leche League etc.)	$42.00

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 ☐ Associate : Waged ☐ Affiliate ☐
: Unwaged ☐ : Unwaged ☐

Place of Work _____

Please return completed form (together with money, if applicable) to your local Treasurer.

POSTNATAL

B14: Infections

Note number (i)perineal
(ii)breast
(iii)other
Outline treatment and outcome.

B15: Postnatal Depression

Note number, treatment etc and outcome.

B16: Postnatal Psychoses

Number, treatment and outcome if known.

B17: Breastfeeding

Number of women totally breastfeeding on discharge .....
Document any cases where mother not totally breastfeeding on discharge.

B18: Other

C POSTNATAL CARE OF LABOUR SUPPORT CLIENTS AND POSTNATAL ONLY CLIENTS

C1:Infections

Note number (i)perineal ...
(ii)breast ....
(iii)other ....
Outline treatment and outcome.

C2: Postnatal Depression

Note number, treatment etc and outcome.

C3: Postnatal Psychoses

Number, treatment and outcome if known.

C4:Breastfeeding

Number of women totally breastfeeding on discharge ....
Document any cases where mother not totally breastfeeding on discharge.

D BABY (Home Birth Babies Only)

D1: Neonatal Transfers

Document any neonatal transfers — reason and outcome, feelings of parent(s) and midwife regarding transfer, care and outcome.

D2: Meconium Stained Liquor

Note number .....
Number transferred .....
Outline any treatment given those not transferred and outcome.

FROM THE BOM

It was with regret we accepted the resignation of Chris Hannah at the beginning of March. Chris is now very busy with her midwifery practice and her husband is studying overseas. We wish to express our sincere thanks for the work Chris did over the last six months. We wish her well.

The Wellington Region promptly nominated Marjory Morgan to the BOM.

Welcome Marjorie. (Hopefully a profile will be available soon.)

Marjorie is a Charge Nurse in the Gynaecological ward at Wellington Womens Hospital.

Jeanie Douché will take over the role as Secretary and Marjorie will be the Coordinator.

Newsletter Deadlines for Material and Inserts

1991	1992
2nd June	2nd February
4th August	5th April
6th October	7th June
1st December	2nd August

We would expect to have the Newsletter
out within two weeks

NEWS & VIEWS

Maternity Benefits

Stories abound, some practitioners have heard they will not be getting paid, the Department of Health claims they have not given any directives to cease payment. Please keep us informed. Then we can present a united and accurate case to the Department.

Negotiations

It is planned that there will be a meeting on 5th April with the Department. The Regional Chairpersons supported Karen Guilliland as the negotiator with support from Trish Mulluns (NZNU lawyer), Bronwyn Pelvin (Domiciliary Midwife), and others according to their availability and commitments. (The previous planned meeting was cancelled by the Department of Health.)

Vision 2000

The Vision 2000 Conference in Auckland was a really affirming event for midwives.

We know what we want for midwifery education.
We know how we will achieve it (see Sally's report).

It was exciting to be part of a group with so much concensus and common vision.

Notice

The AGM will be 2nd and 3rd August. Do try and get to Wellington. A billetting service will be available through the Wellington Region members.

D3: Apgar Scores
Document any below 6 at 1 minute.

D4: Vitamin K
Number of oral administrations .....
Number of IM administrations .....
Briefly give reasons for administrations eg parental request, doctor's advice.

D5: Jaundice
Number of babies with significant jaundice .....
Number transferred .....
Outline any treatment given those not transferred.

D6: Hepatitis B
Number of administrations .....
Outline reason for administration.

D7: Outline any problems eg infections, weight gain irregularities etc not requiring transfer to hospital.

D8: Outline any problems with babies born in hospital and discharged into your care.

D9: Sudden Infant Death Syndrome — Cot Death
Note number and any significant details.

E Practice Issues

E1. Alternative Health Care Practices
Briefly describe your use of alternative health care practices eg homeopathics, acupuncture etc

E2. Peer Relations
Briefly outline any problems you may have had in dealings with, or assistance/support you would like from colleagues, hospital staff or administration, Home Birth Association.(Good comments welcome too.)

E3: Education
Give a brief outline of any courses, seminars etc you have attended during the year.
Give a brief summary of any groups you have talked to about your work during the year

E4: Special Cases
Document any interesting or difficult cases which you would like to discuss at this review. (These do not necessarily need to have occurred during the year under review.)

E5: Personal Assessment
Written statement of evaluation of your work during the year.

Cultural
Birth as well as physical
is sexual, social & spiritual.

Document transfers starting with primips. Summarise the circumstances surrounding each transfer and the outcome. Note feelings of mother /parents/ yourself regarding the transfer care and outcome.

B2: Ultrasound
Number of women having scans .....
Note reasons.
Maternal satisfaction with procedure.
Informed consent obtained?

B3: Amniocentesis
Number of women having amnios .....
Reasons.
Maternal satisfaction with proceedure.

B4: Antepartum Haemorrhage
Note number, treatments and outcome.

B5: PROM (Spontaneous rupture of membranes prior to the onset of labour.)
Note number, duration, treatment and outcome.

B6: Hypertension
Note number,treatment and outcome.

B7: Pain Relief
Note number, reason for administration, outcome.

B8: IV Fluids
Note number, reason for administration, amount type and outcome.

B9: Episiotomy
Note number, reason for, outcome — any problems?

B10: Sutured Lacerations
Number of 1st ° ....
2nd °....
3rd ° .....
Any problems with these?

B11: Ecbollcs
Note number, reason for administration and outcome.

B12: Postpartum Haemorrhage
Note number, amount, treatment given and outcome

B13: Cord Cutting
Note any requests to delay cord cutting beyond approx 5 mins.

NOTICE

AGM
2nd August, 6.00 pm

Wellington Polytechnic

School of Nursing & Health Education,

Staff Resource Room

If you wish to have billetted accommodation

please contact Beryl Davies (04) 887-403

Call for Nominations

At the AGM on 2nd August we will have the election of the President.

? Remits.

Contracts

Wellington Area Health Board has added a change into their contract suggesting an access charge may be made. Quite a shock to **ALL** practitioners.

Will keep you posted.

Any other creative Board ideas? - Let us know.

One midwife's way of ensuring open and clear communication:

Independent Midwifery Service

DOCTOR:

MIDWIFE:
Tricia Thompson
103 Cutfield Road
New Plymouth.
Phone: 89207
Telepage: 0261 07301

RE:
D.O.B.

has engaged my services as an Independent Midwife for her Domino birth at Taranaki Base Hospital.

As she wishes to have both of us care for her, I would be grateful if you would consider a shared care arrangement.

I am happy to alternate visits or to discuss an arrangement that suits you.

I have given her a shared care card.

At the time of birth, I will notify you of her admission to hospital, progress, and second stage.

Kind regards
Tricia Thompson

Well done! Congratulations!

A 1: Smokers
Number of smokers planning homebirth .....
Number of smokers who gave birth at home .....
Note any significant differences eg labour coping, transfer rate, length of gestation, weight of baby etc.

A 2: Vaginal Birth After Cesarean
Number .....
Document cases giving reason for previous caesarean, number of vaginal deliveries since (if any) and a brief summary of this labour and delivery.

A3: Waterbirths
Number of planned waterbirths .....
Number actually giving birth in water .....
Was a special pool/tub organised?
—number .....
— describe
How long did babies stay in water ?
— number lifted out immediately .....
— document any cases where baby held under the water once born giving reasons (eg parental request).

A4: Alcohol
Number of women regularly drinking alcohol during pregnancy .....
Note any significant differences eg labour coping, condition of baby at birth and during the postnatal period.

A5: Drugs
Number of women on prescribed medication .....
Note type, reason and any significant diffferences in labour, delivery and condition of baby at birth and during post-natal period
Number of women regularly using "social drugs" .....
Note type, assessment of usage ie light/ moderate/heavy.
Note any significant differences in labour, delivery and condition of baby at birth and during postnatal period.

A6:Babies Caught by Father/Other
Number caught by other than midwife by request .....
Number caught by other than midwife because midwife not present .....
Add any comments necessary eg how did parents(s) cope with this?

B Maternal Conditions
B1: Maternal Transfers (includes antenatal, labour and delivery and postnatal of any women who had planned to give birth at home)
Number of primips .....
Number of multips .....
Total transfers .....

REPORT TO THE DOMICILIARY MIDWIVES STANDARDS REVIEW COMMITTEE

MIDWIFE:

YEAR:January 1 19.... — December 31 19....

Total number of planned homebirths .....
Transfers — antenatal .....
during labour .....
postnatal .....
Total number of transfers .....

Number of postnatal care following early discharge from hospital .....
Number of Birth Centre births and postnatal care .....
Number of labour support — hospital delivery — postnatal care .....
(Number of Domino bookings) .....

Total Number of Women Cared For .....

A Planned Homebirths

	Age	Under 15	15-17	18 -19	20 - 25	26 -30	31-35	36-40	over 40
Primagravidas	No.								
Multigravidas:	No.								

Length of Gestation: — Primips
— Multips

Racial Groups: Number of — Caucasian
— NZ Maori
— Pacific Islander
— Asian
— Other

A Framework for Midwifery Education

Report collated by Sally Pairman

The Nursing and Midwifery forum called Vision 2000 : Project 1991 took place in Auckland on March 14 and 15, 1991.

The intent of day one was to identify the issues facing education, and day two was for developing strategies and a framework for nursing and midwifery education towards the year 2000.

Despite the title of the forum and the obvious intent to decide on the future of midwifery education as well as nursing, only three midwives were invited to speak during the forum. Karen was also part of the small working group whose task on Saturday 16th was to collate all the discussion from the forum and develop the framework and mechanisms.

Midwives did not go unnoticed, however, and it became increasingly clear that nursing was looking to midwifery for some guidance as to the direction they should take. Whilst there is clearly some individual resistance to the idea of nursing and midwifery being separate professions, this resistance is not active, and opportunities to challenge were never picked up by nurses.

Over the two days it became obvious to midwives that the issues we face are different to those facing nursing. We are much further down the track of developing a framework for midwifery education because we have worked on and identified our basic premises. We know what midwifery is and we have a clear philosophy; we already have a College of Midwifery and a high public profile which presents a positive image; we have effective communication systems; we do not operate in a hierarchical structure, and we believe that 'a midwife is a midwife is a midwife'.

Nursing is realising that it needs to address these fundamental issues before it can move much further.

The suggestion from the NZCOM presented at the forum, that a vehicle for collaboration and communication between midwifery and nursing would be to establish a Federation of Midwifery and Nursing, was greeted positively. However, as the intent of this federation would be to bring the professions together for discussion, nursing has first to decide what shape its professional organisation will actually take. There appeared to be marked discontent amongst nurses of the NZNA and its increased industrial role in recent years.

The forum provided a unique opportunity for midwives to discuss issues. On Thursday night we met and discovered that we came from all areas of New Zealand, from all areas of practice, including the midwifery tutors responsible for all our present midwifery courses, the BOM, our president and educator, and two consumer representatives.

It was heartening at that meeting to discuss the degree/diploma debate and to recognise how similar our thinking was.

By the end of the forum it was obvious that the task of the Saturday working group was mammoth and was not going to be appropriate for midwifery. We agreed to meet on Saturday ourselves to develop a framework for midwifery education and discuss our issues. Karen still attended the meeting of the working group.

A group of 20 women gave up their Saturday to do this work. An open invitation had been extended to all midwives and again the group was very representative.

We worked extremely well together and efficiently came up with the following framework for midwifery education. There are still issues which need to be discussed and these are outlined later.

The official forum working group invited us to present what we had achieved. They were impressed and agreed that it was inappropriate for them to address any midwifery issues. They would adopt our framework and expend their energies on developing one for nursing. This is no small victory.

5) As preparation for domiciliary practice the registered midwife should undertake an apprenticeship with a practising domiciliary midwife. The exact duration would depend upon the previous experience of the midwife and the bookings of the domiciliary midwife. An alternative would be employment in a level 0 or level 1 maternity hospital. Experience in an obstetric unit where labour is sedated rather than supported is counter-productive. Continued peer support is essential.

6) We strongly discourage the use of analgesics or tranquillisers during labour at home. Necessity for sedation should be cause for transfer to hospital;

7) It is the domiciliary midwife's responsibility to make safe and adequate arrangements for transfer to hospital when this is necessary, and the midwife should accompany the woman to hospital;

8) In complying with the necessary Department of Health requirements to register in the health district in which she has a client, the geographical area and range is left to the domiciliary midwife's professional judgement;

9) The domiciliary midwife should carry all the necessary equipment, including resuscitative equipment. This should be provided by the Department of Health and returned to the Department upon cancellation of contract;

10) The domiciliary midwife must remain at least one hour - and usually two - after the completion of labour, and be avaiable on call for a further 48 hours thereafter, visiting twice within the first 36 hours.

DOMICILIARY MIDWIFE STANDARDS

We, the Domiciliary Midwives Society Inc (DMS) consider that the Standards of Midwifery Practice prepared by the Midwives Section (N.Z.N.A.) to be comprehensive. However, because of the 'relative independence' of domiciliary practice which has developed on an ad hoc basis in response to consumer demand for an alternative to the medical/technological model, we would add some specific guidelines for domiciliary midwifery practice.

Keeping in mind that it is the consumer who has the ultimate power to set and enforce standards, we suggest that:

1) The domiciliary midwife should provide her clients with accurate information as to her training, experience and methods of practice and be prepared to discuss the latter as well as the pros and cons of home birth, honestly and in detail;
2) Conversely, the responsibilities of the pregnant women and her family should be honestly stated - her responsibility to maintain good nutrition, to refrain from the use of alcohol, tobacco, marijuana and social or medical drugs, and her responsibility to accept medical intervention if this becomes necessary;
3) Domiciliary midwives should keep accurate, detailed and up-dated records starting with a thorough history - medical, obstetrical and family, - in the interests of screening for risk factors and the application of preventive/alternative measures as opposed to the practice of crisis obstetrics;
4) Although working in the community is, of itself, a form of on-going education, domiciliary midwives should have the opportunity to participate in in-service continuing education specifically related to domiciliary practice. (At the moment there are no such courses but these could be organised between Continuing Education and the Department of Health).

The information which follows is initially the framework we have developed. This is followed by the issues we think still need debate. We wish each Chairperson to call an urgent meeting to discuss these issues and to bring the regional responses to the next National Committee Meeting. Individual members who wish are invited to comment in writing to the BOM before the meeting.

The time frame is short. All curricula for the three-year midwifery courses must be with the New Zealand Qualifications Authority (NZQA) by 1st June and the polytechnics need clear guidance from the College on the issue of degrees as soon as possible.

Midwifery Education - A National Framework

- The New Zealand College of Midwives, as the recognised professional body for midwives, has a legitimate role in shaping midwifery education and practice in New Zealand.

- The midwifery profession will honour the Principles of Partnership inherent in the Treaty of Waitangi in all aspects of midwifery.

  - Action - The NZCOM, nationally and regionally, will begin dialogue with the New Zealand Council of Maori Nurses, the Maori Women's Welfare League, and the Tangata Whenua.

- Midwifery is a profession in its own right.

  - Implications - Midwives regulate their own education.
    - Midwives regulate their own disciplinary procedures.
    - Midwives evaluate and assess practice.
    - Midwives speak for the profession nationally and internationally.
    - Midwives define their own body of knowledge.
    - Midwives set their own Standards of Practice.

- The long term aim of the New Zealand College of Midwives is the establishment of a separate Midwifery Council.

- In the interim, the NZCOM requires:

  a) equal representation on the Nursing Council of New Zealand, including equal representation on all associated committees;
  b) the appointment of midwifery advisors to the Department of Health and Area Health Boards.

- In relation to disciplinary matters, the NZCOM supports a mechanism which involves significant consumer representation in all disciplinary processes, with recognition of midwives as the appropriate persons to make professional comment. It is recommended that the structure of the Independent/Domiciliary Midwives Standards Review Committees could serve as a model.

- The New Zealand College of Midwives recognises midwifery as an independent profession and all educational programmes must reflect this belief.

- The New Zealand College of Midwives recognises a three-year broad-based midwifery education as the most appropriate form of preparation for entry into midwifery practice.

  - Implications - Entry into these courses will be by individual assessment with recognition of prior experience and learning.
  - Until the Midwifery Council of New Zealand is established, the midwifery advisors to the Nursing Council of New Zealand will be the Council's representatives to the New Zealand Qualifications Authority on midwifery education.

- The New Zealand College of Midwives believes that it is an unreasonable interpretation of the Nurses Amendment Act 1990 to restrict the number of courses and prohibit the ongoing intake of students.

Standards
The basis for standards are a combination of the:

- **Domiciliary Midwives Society Standards**
- **Nursing Council Standards and Criteria for Midwifery Practice, 1983**
- **Standards for Midwifery Practise (WHO)**

A general discussion ensued about levels of support for domiciliary midwives only doing postnatal care (not much!), dual employment by AHB's as well as domiciliary practise, and new graduate midwives orientating to domiciliary practise by buddying with DMs for a period of time after graduation.

Arising from this discussion, it was agreed to prepare a remit regarding practise after midwifery education. It was generally thought that "a midwife is a midwife is a midwife" and that once registered a midwife can practise in any setting.

A little P.S. - this was written some weeks after the Conference. It is largely pieced together from an unreliable memory and a very sketchy set of notes. As such I apologise for any errors of information or misrepresentations!

Nursing Council Standards & Criteria for Midwifery Practice 1983

Registered midwives are able to practice in any setting. They provide individualised, family centred and health oriented nursing care, for individuals and groups during pregnancy, labour and the puerperium, neonatal and early infancy periods. They use knowledge from the biological, behavioural, physical and social sciences in assessing, planning, implementing and evaluating nursing care, and in providing health education.

The applicant for registration as a midwife:

1. Takes responsibility for the nursing care of mother & child during pregnancy, labour and puerperium;
2. Observes, interprets, makes decisions and uses technical skills fundamental to midwifery practice;
3. Recognises the need for, and gives appropriate care when the health status of the mother/fetus/neonate is threatened;
4. Councils and teaches individuals and groups to become self sufficient in meeting the health needs of the family unit;
5. Takes professional responsibility for midwifery practice.

Joan replied that the statistical information would go to the consumers on the Committee, i.e. the local Home Birth Association who would report on it in their annual report. She said there was a policy of confidentiality, but that also midwives are generally very open about discussing their own practise. The amendment to the Nurses' Act could well create a climate of vulnerability to prosecution - and Joan said she believes that midwives *are* responsible and have to accept their responsibility, otherwise who are we being judged by? She suggested not falling into the trap of the medical model whereby if consumers wanted financial assistance (in the form of compensation) they would have to prove medical misadventure.

Discussion followed regarding what would happen in the event of a midwife being reported to the Nursing Council. It was felt that the midwife should first be seen by the Standards Review Committee and that their opinion on the matter should carry some weight at any subsequent Nursing Council meeting. Making a recommendation to the Council was not seen as "assisting" the Council and it was stressed that any investigation be done by the Council itself.]

3) That the Committee should bring such matters in 2) to the attention of the appropriate bodies.

4) That the Committee provide a forum in which midwives and consumers share their knowledge and resources.

5) That the Committee provide free access to all resources.

6) To facilitate consumer input and participation.

Each Committee writes its own constitution. The Home Birth Association will notify the Area Health Board of the Committee's composition. Every practising midwife has the right to attend any meeting of the Committee. In case of complaint, the complainant would be present to ensure that all parties are heard, and all have the right to include support people.

Discussion about the appropriateness of this followed. Some women felt that it could be very intimidating for some consumers to have to confront the person against whom they had laid the complaint.

Midwives have the right to have the meeting adjourned in order to seek legal advice.

Celia (Christchurch Consumer Rep on BOM) asked whether it would be possible for complainants to meet the Committee's Consumer members prior to the review because she felt that consumes don't enjoy the same level of peer support as do the midwives.

The purpose of evaluation of courses should be to refine the programme, not to decide the necessity for the course.

- Implication - The NZCOM will initiate discussion with the Ministries of Education and Health on midwifery education.

- All midwifery curricula will be presented to the NZCOM for endorsement.

  - Implication - The NZCOM will establish an Education Committee to facilitate this process and to undertake an education advisory role. It is recognised that the role of the committee may change with the establishment of the Midwifery Council of New Zealand.

- The New Zealand College of Midwives recognises that the understanding and mutual need between women and midwives is the strength and base of the profession.

  - Implications - Midwives will continue to work with consumers at every level of decision-making about midwifery matters.
    - The NZCOM has a commitment to maintaining a high public profile and promoting a positive image.
    - The NZCOM recruitment policy will reflect the changing needs of the community within a cultural context.

- The New Zealand College of Midwives believes that the clinical experience available to midwifery students must encompass continuity of care and independent midwifery practice.

- The New Zealand College of Midwives believes that women have the right to decide where they will birth and have the right to continuity of care from the midwife of their choice.

- As midwives are the only primary health care givers who can provide continuity of care during the childbearing cycle, midwifery students must have priority of access to clinical experience.

  - Implications - There is an urgent need for collaboration and review of clinical experience of all students currently placed in maternity settings.
  - The NZCOM will convene such meetings, initially at a national level.

- The Nurses Amendment Act 1990 demands a re-evaluation of the role of nurses in maternity care. Education offered to nursing students must reflect the independent role of midwives. The NZCOM acknowledges that nurses must have an understanding of childbirth within the family/social model. However, the traditional placement of nursing students in maternity areas is no longer appropriate.

  - Implications - The comprehensive and enrolled nursing programmes need to be restructured to reflect the place of childbirth within this family/social model rather than the traditional obstetric nurse model.
  - The NZCOM will begin dialogue with nursing and nurse educators on this issue.

- The New Zealand College of Midwives values the contribution midwives make to students gaining clinical experience and will explore ways to acknowledge this.

- In order for communication and collaboration between nurses and midwives to be effective and to enhance the Principles of Partnership, the New Zealand College of Midwives recommends the establishment of the New Zealand Federation of Midwives and Nurses.

Report from the session on:

Domiciliary Midwives Standards Review Committee

held at the New Zealand College of Midwives' First National Conference, August 1990

by Suzanne Miller, Student Midwife, Otago

The main input in this session came from Joan Donnelly (Auckland) and Bronwen Pelvin (Nelson), both of whom are involved in these committees, which have been set up to act as a peer review system for midwives in domiciliary practise and a forum with consumer input in which to hear complaints.

Joan began by explaining something of the structure of the Auckland Committee. She explained that usually two midwives are reviewed at each sitting, but that meetings tended to be structured on the basis of when the homebirth doctors were available. The Committee consists of consumers, midwives, and doctors. Under the Area Health Board Act there was provision for payments of committee members, and that they are currently investigating the organisation of payment in Auckland.

Bronwen told us of how consumers and midwives set up the Standards Review Committee in Nelson, reminding us that we don't need to seek any kind of approval to do so, especially in the light of the move to midwife autonomy. The Committee runs under the umbrella of the Area Health Board. She sent on to explain about the DMSRC Terms of Reference:

1) To annually review the practise of each midwife; a summary of her year's work and a written evaluation of her own practise.

   [Joan showed us an example of a Report to the Committee in use in Auckland (enclosed). She explained that prior to the meeting a photocopy of the completed report was sent to each committee member for perusal. A separate form is also sent to parents at six weeks and six months following delivery for appraisal of the care they received.]

2) That the review gave the opportunity to evaluate any difficulties experienced with regard to Area Health Boards.

   [Some midwives have experienced great problems with other health professionals. It was generally felt that consumer input was essential here, especially in a supportive role.

   The question arose as to who owned the information which was reported to the Committee.

21-25 May: *4th International Congress for Maternal and Neonatal Health.* Port-au-Prince, Haiti.
Contact: President, Professor Jean Boisrond, Mères et Enfants d'Haiti, Angle de Rues St Honoré et Monseigneur Guilloux, Port-au-Prince, Haiti.
Tel: 50 91 22 760. Fax: 50 91 56 857.

15-17 July: Centre for Nursing Research Inc. (in collaboration with the Royal College of Nursing, Australia)

First International Conference - Nursing Research : Pro-active vs Reactive
St Peter's College, Adelaide, South Australia.

Enquiries to: Ms Helen Smyth, Executive Officer, Centre for Nursing Research Inc, Bedford Park, South Australia 5042, Australia. Tel: 08-275 9911 Ext 5032. Fax: 618 275 9450.

28 July - 1 August: *XIV Soroptomist International Convention*
The health workshop will be devoted to Safe Motherhood.
Contact: The Programme Liaison, c/- Soroptomist International Headquarters Office, 87 Glisson Road, Cambridge CB1 2HG. Tel: 44 223 311833. Fax: 44 223 467951.

15-20 September: *Symposium on Professional Training for Safe Motherhood at 13th World Congress of Gynaecology and Obstetrics (FIGO).*
Contact: Congress Secretariat, c/- Department of Obstetrics and Gynaecology, National University Hospital, Lower Kent Ridge Road, Singapore 0511, Republic of Singapore. Tel: 65 777 0313 or 65 775 4420. Fax: 65777 3121.

Areas for Discussion

1. ***Degree/Diploma***

The Education Amendment Act 1990 makes it possible for polytechnics to apply to NZQA for approval to run courses which will award degrees.

In at least three polytechnics, nursing is moving to the provision of three-year, broad-based courses leading to registration where students will be awarded a degree in nursing.

The previous concept of completing a three-year diploma in nursing and then going on to do a basic degree in nursing is no longer the only means of achieving degree status.

Those nurses who graduate from the degree course will have a degree at the end of three years. Because these courses must recognise prior learning and experience and give credit for these to meet NZQA requirements (the new accreditation body for **ALL** courses in New Zealand), some people may achieve registration and degree status in less time than this.

Nurses currently in practice will have the opportunity to seek credit for their knowledge and experience and complete a specified number of papers to also gain a degree in nursing. This will be individually assessed.

Nurses with degrees will have the opportunity to go on to do an Honours degree, a Masters degree, or a PhD.

Nursing intends to have three-year diploma courses in nursing continuing at the same time but believes that the graduate from a degree course is different and will have greater ability to think critically and creatively, to undertake research and to generate nursing's body of knowledge. They do not think that all nurses want or need a degree. It has been suggested that the clinical career pathway needs to change to reflect the new environmemt.

What about Midwifery? Should the three-year broad-based midwifery courses currently being developed around the country award the graduate a degree or a diploma? All graduates will be registered midwives if they meet the Nursing Council requirements for registration.

The Pros

- The present graduates from the separate midwifery courses are largely operating at a degree level already. (Three-year course graduates will be at least as skilled and educated.)
- The practice of midwifery has changed since 1990 amendment and midwives in independent practice are operating at a high level.
- Other health professionals of equal status have degrees, e.g. doctors, physiotherapists. May improve equity.
- Midwives may disadvantage selves in long term if nursing goes to degree and midwifery doesn't.
- Public credibility may increase with degree status (already high but may influence women's choice of independent midwife).
- More cost effective to develop courses which can share some teaching with nursing.
- More equitable with nurses also doing a three-year course.
- Mature applicants (over 20) will be entitled to open entry, therefore not disadvantaged.
- May be more appropriate education for future midwifery leaders and midwives who will do research and generate and develop midwifery's body of knowledge.

The Cons

- May distance midwifery from consumer.
- Could be detrimental to public perception of a midwife (e.g. too academic).
- May deter mature women and those from other cultures from applying.
- Resistance from midwives in practice.

FUTURE EVENTS

13 & 14 April: *Midwifery Workshop; Manuatu Workshop*
Palmerston North

April/May: *Sheila Kitzinger*
The world's most renowned author and speaker on childbirth issues will be touring Australia in April/May 1991. Plan now to attend events featuring this exciting and charismatic woman.

Itinerary:

	Public Lectures	Workshops
Perth	Friday 26 April	Saturday/Sunday 27/28 April
Adelaide	Monday 29 April	Tuesday 30 April
Melbourne	Friday 3 May	Wednesday/ Thursday 1/2 May

(A 3-day conference will be held 3/4/5 May in Melbourne.)

Brisbane	Monday 6 May	Tuesday 7 May
Sydney	Friday 10 May	Wednesday 8 May Saturday 11 May

Full details will be mailed in February 1991. If you wish to be on the mailing list please send a .43¢ postage stamp (not a stamped addressed envelope) with your name and address to: Capers, 177 Buckland Road (PO Box 567), Nundah, Qld 4012, Australia. Tel: 07-266 9573. Fax: 07-260 5009.

17, 18, 19 May: *1991 National Homebirth Meeting* (in Nelson)
Thursday pm Domiciliary Midwives Meeting.

NZCOM Stocktake - 30/1/91

Available from Board of Management, PO Box 7063, Wellington South, Wellington.

*** All prices subject to GST being added from 30/1/91 ***

		Price (excl GST)	+ GST
1.	NZCOM Journal: Issues 1 (4 copies); 2 (191); 3 (90)	$4.00 each	+ .50
2.	594 NZCOM Badges	$5.00 each	+ .63
3.	259 Keyrings: perspex with NZCOM logo	$3.00 each	+ .38
4.	73 Notebooks with "Women need Midwives, Midwives need Women" logo. Colours: navy, red, white, royal blue.	$3.00 each	+ .38
5.	174 Keyrings: plastic, 1990 Conference. Black with yellow, red, white, green, blue	$1.00 each	+ .13
6.	Scales (one set only) **SOLD**	$30.00	+ $3.38
7.	300 Pens: 1990 Conference. (30 boxes of 10)	$5.00 box	+ .63
8.	54 Sweatshirts with "Women need Midwives, Midwives need Women" logo. Colours: black, white, pink, red, light blue, navy, lilac. Sizes: Large and Extra Large.	$34.00 each	+ $4.25
9.	31 Teeshirts with "Women need Midwives, Midwives need Women" logo. Colours: mint, royal blue, white, black, lilac, yellow. Sizes: Large and Extra Large.	$19.00 each	+ $2.38
10.	256 Standards	$3.50 each	+ .44
11.	163 Logo Stickers: "Women need Midwives, Midwives need Women". Sheets of 13, uncut.	$2.00 sheet	+ .25
12.	45 "Having a Baby in Europe"	$5.00 each	+ .63
13.	11 Proceedings from Conference	$30.00 each	+ $3.75
		TOTAL	$9976.05

- Will it improve care for women?
- Does our status come from qualification or from consumer?
- Does midwifery need research or written body of knowledge?
- Words like Bachelor, Masters, Doctorate are inappropriate for midwifery.
- New Zealanders generally are not academically qualified and perception of what degree level is may be incorrect.

Some Discussion

In Auckland we debated these issues but did not have time to reach conclusions. It was felt important for all midwives and consumers to have input into the final decision.

Whatever outcome we thought it was important to have consistency throughout New Zealand and not to develop two levels of midwife from these new courses. We recognised that 'degree' would become basic level qualification and that experience and ongoing learning comes after this and must be valued highly. Midwifery **practice** is considered more important than qualification. Midwives in practice will have the opportunity to undertake some further study to also obtain a degree if they wished. (May improve opportunities for present DE midwives.)

The Nursing Council requirements for midwifery state that clinical experience will be no less than 50% (1500 hours) and up to 60% in a three-year course. Therefore the clinical experience will be the same in both types of course.

Our main concern was that whatever the title of the course, midwives must define the product (midwife graduate) and control what is in the course. Midwifery must not distance itself from its powerbase - the consumer.

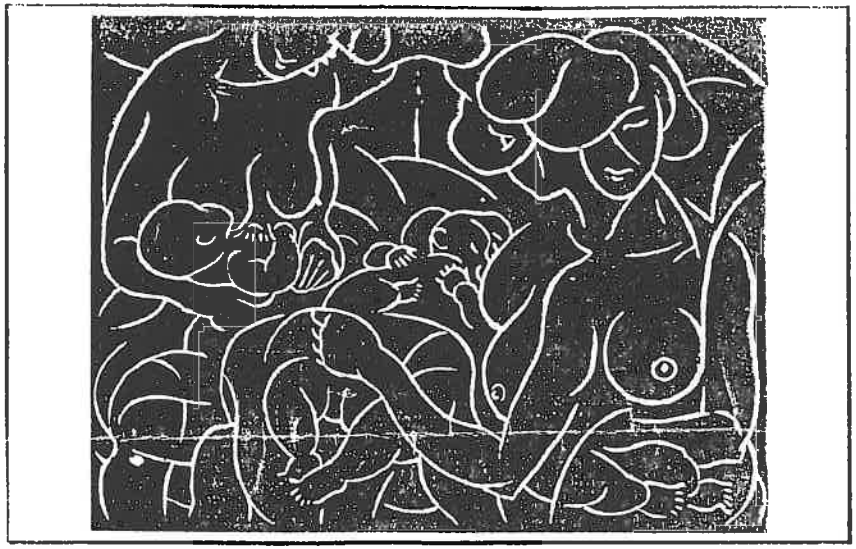
There are undoubtedly aspects we haven't covered. The question to be asked is:

Do we want the new three-year midwifery courses to award a degree or a diploma along with midwifery registration?

Please discuss this and let your regional chairperson or BOM know what you think **AS SOON AS POSSIBLE**. (Before next National Committee Meeting mid-April.)

2. One other aspect we wanted discussion on was how the midwifery profession could acknowledge to midwives the value it places on their contribution to midwifery student experience. Any ideas?

3. What kinds of post basic qualifications do midwives want available to them?



"A Nursing Mother" Etching by Harold Hawkins
Weaver

BOOK REVIEW

"Psychological Processes of Childbearing"
by Joan Raphael Leff. Chapman and Hall, 1991.

The first thing to admit is that this book is a truly horrendous price in New Zealand at $88.95. But read on anyway; it's worth it. Raphael Leff is a social psychologist and writes in detail on the psychological processes of each phase of the childbearing cycle. Normal pregnancy, labour, birth, and early parenting are located in the contemporary cultural and social nexus. She also explores in detail the universality of each woman's conscious and unconscious journey before, during, and after pregnancy. This makes this book especially useful reading for midwives entering practice of the "continuity of care" type. The book covers in great detail just the type of information that midwives need in their on-going dialogue with each pregnant woman. I would also see it as having value for midwives who haven't had a child themselves and sometimes feel at a disadvantage when counselling pregnant women.

Excellent format makes this an easy book to read and use for referencing quickly. There are no illustrations but each chapter has plenty of headings to keep the reader signposted. Each chapter also has a summary of key points [just in case you are reading in bed at night and discover you haven't taken it in].

The price is unfortunate but perhaps the local library can be approached and convinced that this book ought to be on their shelf as I am certain that many midwives would appreciate the read.

Jennifer Sage

There was a very useful session on lactation trouble shooting, with ideas and suggestions based on years of experience but including latest research findings.

The *BIRTH Conference* was much more scientific in its approach and geared more to the medical profession. The keynote address (by Dr Iain Chalmers, Perinatal Epidemiology Unit, Radcliffe Infirmary, Oxford, England) queried the priorities in perinatal research. For instance, there are many studies done comparing different forms of epidural, but very few comparing epidurals to other forms of pain relief. There are many studies done on the various medical and technological interventions, but very few on things like nausea, heartburn, leg cramps, insomnia etc. (i.e. doctor rather than woman oriented).

Another session posed the question "Why are we still doing routine Electronic Fetal Monitoring, when the research shows no evidence of improved fetal outcome over intermittent auscultation (which latter is performed by a person rather than a machine)?"

There were numerous new ideas such as a 'birthing cushion' that is popular and successful in Britain, and I brought back with me several simple but practical birthing aids, as well as books, posters, pamphlets and tapes. I was able to view quite a number of the latest videos and films, but found few if any that relate well to the New Zealand scene - they are also the wrong format, and expensive to convert. But they were valuable for ideas regarding what we should be looking at doing and producing in New Zealand.

One of the most valuable aspects of such conferences is the contacts made and the links forged between different countries and cultures. I found that there was a much greater awareness of New Zealand now than when I visited the States in 1984. There was strong interest in and admiration for the recent developments in midwifery (autonomy, independence). In this respect New Zealand is out in front, but in our recognition of childbirth educators per se we have a way to go. The new Parents Centre training and certification programme for childbirth educators is a very positive step in the right direction, and in line with developments overseas.

THE REAL BATTLEFRONT

I am a Midwife in a dilemma. I am a N.Z. Registered Midwife. I hold a current practising certificate. I am on the N.Z. Register of Midwives. I have had 17 years of midwifery experience. It fit into the description of the W.H.O. definition of a midwife. I do not have the same choices of practice that most other Midwives have in N.Z.

I am one of the 178 Registered Obstetric Nurse/Midwives equalling 4.8% of all Midwives practising in this country. We are a dying breed! There are 29 overseas Direct Entry Midwives making up 0.7%.

Direct Entry Midwives (N.Z. and Overseas trained) have legislative restrictions limiting our practice. We are governed by Sect 54(3) which states "only Registered General Nurse and Registered Comprehensive Nurses are able to attend women in childbirth." We are able to practise antenatal and post natal care in the community but Sect 54(3) restricts us from giving continuity of care when consumers demand. Our Midwifery care is fragmented. We are unable to take responsibility for homebirth, and at this stage there is a query over our ability to gain a contract with Area Health Boards (for Domino births). There is a demand for both in my community.

Direct Entry Midwives working in the community before 1984 were rightly protected by the Act. These Direct Entry Domiciliary Midwives have exactly the same education as all other N.Z. Direct Entry Midwives. All completed the 18 month maternity programme (terminated early 1970's) and graduated from the 6 month Midwifery programme (terminated for Obstetric Nurses around 1979). Direct Entry Midwives still practising would be more experienced and would be familiar with current Midwifery practice.

Our education is as follows:

18 month: Maternity programme (Base Hospital) approved by Nurses and Midwives Board (now Nursing Council)
12 month: (at least) Staff Nurse in a Maternity Hospital.
6 month: Midwifery programme (approved by Nursing Council) same programme as RGNS.

All of the above equate to:
3 years: Education in all aspects of ante-natal, birth, post-natal and at least 10 years or more Post Graduate Midwifery experience if continuance of practice.

Domiciliary Midwifery is care of the low risk women, being able to detect deviation from the normal and consult and refer as necessary, and be familiar with emergency procedures. I believe our training and experience did prepare us for the above.

Our status is diminished. We are N.Z. Registered Midwives on the register with all other Midwives in N.Z. New Zealand is short of Midwives.

Domiciliary Midwives are reviewed annually by the Domiciliary Midwifery Review Committee which consists of: 4 consumers (chosen by the Homebirth Association), 1 Domiciliary Midwife, 1 Hospital Midwife, 1 Area Health Board Doctor.

My history of practice is as follows:

4-65 Commenced Maternity programme
2-67 Gained Registration as an Obstetric Nurse.

4-67 Staff Nurse Taranaki Base Hospital. All aspects of normal and abnormal obstetric care.
9-67 Staff Nurse 10 bed Level One Maternity Unit Taranaki Hospital Board. Low risk maternity care.
67/68 Staff Nurse Hutt Hospital. Neo Natal Special Care Unit and Post Natal. Resigned to have family.
71/72 Staff Nurse Hutt Hospital. Neo Natal Special Care Unit and Post Natal.
72/73 Student Midwife St Helens Wellington
8-73 Gained N.Z. Registration as a Midwife

73 Staff Midwife Elderslea Hospital Wellington Area Health Board.
Elderslea was a Level One hospital in Upper Hutt. I practised there until the unit was closed in December 1989.

All staff Midwives had equal status at Elderslea (until the last 2 years of its existence). I worked afternoon and night shift mostly. My first eight years at Elderslea I worked part time night duty. Most of that time I was the only Midwife on duty and worked with an untrained Nurse Aide. On other duties I had full responsibility for clients antenatally, during labour, birth and postnatally with assistance of one or two other staff members who may have been Registered General Nurse (not Midwife) Obstetric Nurse, Enrolled Nurse or untrained Nurse Aide.

Work at Elderslea included all low risk care, recognising the abnormal and consulting with or referring to medical staff and making decisions to transfer women or babies to level two or level three hospital as required. We regularly dealt with epidural anaesthesia, intravenous therapy and general anaesthesia as required.

This clearly indicates my ability to take responsibility and take decisions as required of a Domiciliary Midwife.

In 1989 my application for a contract with the Minister of Health was approved. Two other Midwives and myself set up an independent Domiciliary Midwifery practice. We had a hiccup in 1990 for three months when the legality of my practice was questioned by the Medical Office of Health. This was resolved through legal process. Finally at the end of 1990 we resumed our domiciliary practice after three months of no work and no income.

My ambition was to become a Domiciliary Midwife including home births when family commitments allowed. Health problems prevented me from working independently until 1985. By then the law had changed.

I am the same person, with the same qualifications that I was before 1984 when the Nurses Act Sec 54(3) was amended. The only difference is that I am now more experienced, have been practising in the community, attended home births and regularly update my knowledge in all aspects of Midwifery i.e. courses, reading, seminars etc. My colleagues and myself have set up a successful, respected safe practice in our community.

Lynne Legge, D.M.W.
Upper Hutt

Report to Mr Roy McKenzie on Birth Conferences

Jenny Drew, December 1990

The following is a brief report of the *8th Annual Convention of the Midwives' Alliance of North America (MANA)* (in Kansas City, November 2-4) and the *9th BIRTH Conference on Innovations in Perinatal Care : Assessing Benefits and Risks* (in San Francisco, November 11-13, 1990).

MANA: I attended this convention in the weekend between my two ICEA events (i.e. Board Meeting and Basic Teacher Training Workshop). It was not intended as an international event and I found I was the only non-North American present.

American midwife Carolyn Steiger's keynote address on "Nurturing Unity in the Birthing Community" was a brilliant presentation which I felt had real international significance. If I had heard nothing else at the convention, this alone would have made attendance worthwhile. When it is transcribed and published I will circulate this excellent appeal for unity and cooperation as widely as possible both in New Zealand and Australia.

But there were other very worthwhile sessions too, such as the one by Dr Jim Horine on "Psychological Support in Childbirth". Dr Horine discussed the power of positive imagery and suggestion in helping women cope with labour, and demonstrated effective relaxation techniques.

A very powerful session was the workshop, where participants (mainly midwives) shared their experiences of 'abuse issues' surrounding birth, and explored ways women who have suffered abuse can be helped in the birthing situation. Birth often brings suppressed feelings and memories to the surface, and because the problem is much more prevalent than is currently recognised, caregivers need to be alert for signs and be able to respond with appropriate helping techniques. A great deal more needs to be known and done in this area.

I am hoping to hear of many more midwives who take the opportunity to attend the next Spiritual Midwifery Workshop run in New Zealand. In strengthening ourselves we will strengthen our profession.

Jennifer Sage

AUSTRALIAN COLLEGE OF MIDWIVES INCORPORATED

Birthdays, Birthways.

7th Biennial Conference
of the
Australian College
Of Midwives Incorporated

16 - 18 September 1991
Perth
Western Australia.

COPY

Department of Health
TE TARI ORA

133 Molesworth Street
Wellington
New Zealand
P.O. Box 5013, Wellington
Phone (04) 496 2000
Fax (04) 496 2340

letter to Lynne's lawyer

I refer to your letter of 30 November 1990 about section 54 of the Nurses Act.

In our view, section 54 (3) of the Nurses Act 1977 provides that a nurse must be registered as both a general and obstetric nurse and a midwife, or as a comprehensive nurse and a midwife if he or she attends a woman in childbirth in an obstetric capacity outside of an institution under the control of an area health board or licensed hospital.

Consequently a person who is a registered midwife only, or who is registered as a midwife and a obstetric nurse would be able to provide antenatal and postnatal care in all practice settings. Such a midwife would not be able to attend a woman in childbirth, other than in an institution under the control of an area health board or licensed hospital.

This view is, of course, subject to the proviso contained in subsection (5) which applies to registered midwives practising midwifery immediately before 1 April 1984 in place or places other than in an institution under the control of an area health board or hospital board or a licensed hospital within the emaning of Part V of the Hospitals Act 1957.

It follows that your clients are able to practise as domiciliary midwives providing antenatal and postnatal care

Yours sincerely

Michael Chapman

Michael Chapman
for Acting Manager
Workforce Development

Definition of the Midwife

The New Zealand midwife accepts the World Health Organization definition of a midwife, as adopted by the International Confederation of Midwives 1972, and International Federation of Gynaecologists and Obstetricians 1973 which reads:

'A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed

the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

Scope of Practice of the Midwife

The midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant.

This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve pre-conceptual and antenatal education and preparation for parenthood and extends to certain areas of women's health, family planning and child care. She may practice in any setting including the home, hospital and community.

MEDIA WATCH

Japan's baby panic

MATURE mothers are to be the new targets of what the Japanese are calling "the procreation police". A special team has been set up in the "population problem unit" of the health and welfare ministry to research high-risk pregnancies and to encourage older women to give birth.

The government has realised its strategies for economic expansion could come to nothing if the fall in the national birth rate is not stopped. Last year, Japan had the lowest fertility rate — 1.57 children per woman — of all industrialised countries.

A Japanese scholar triggered panic by predicting that if remedial action were not taken, Japan would be left with a population of 40 by the year 3000. A senior cabinet minister suggested Japanese women should be discouraged from pursuing careers to opt for labour, not labouring.

The Japanese fertility rate will fall to a new postwar low of 1.54 this year, according to health and welfare ministry estimates. The results of the most recent ministry survey, in 1983, showed that 37.4 per cent of women did not want to give birth in their thirties or forties because of fears of miscarriage and fetal abnormalities. The ministry plans to attack the problem by distributing leaflets explaining the joys of mature pregnancy, and all prefectural governments will have ambulances, which are crewed by midwives, on standby.

If older women were to become pregnant, they could boost the Japanese birth rate by 0.2 per cent. But this would still leave the nation with a severe baby shortage. — The Times

Spiritual Midwifery Workshop

One of the special times in my life started on Saturday 23rd February when I attended a 5-day workshop entitled "Spiritual Midwifery". Rachana describes herself as the seminar leader and indeed has a large repertoire of therapeutic and life experience to draw from, but the journey she invited us on was to be one of our own exploration. Rachana herself would be sorry to hear that our participation stopped at the end of the workshop and was totally dependant on her.

All participants arrived with the intention to explore differing aspects of our womanhood and our relationship with midwifery and birth [not all the participants were midwives]. It can feel really scary to expose your inner fears and needs to other women for the first time, but I am sure that most, if not all, found the all-women setting a releasing and nurturing environment. The Nelson country setting was glorious too and the food [some of which was kindly prepared by Nelson participants in the workshop] superb. There was plenty of time between the sessions to get to know other better or spend time by yourself.

At this point in midwifery herstory I believe we are reclaiming much of the knowledge that has been lost for centuries. Some of this women knowledge cannot be taught - it can only be experienced. This knowledge is emotional and intuitive [described in modern parlance as right brain] and the strength women gain from experiencing a sense of reawakening or rediscovering these parts of our feminine heritage is truly priceless. Rachana is not a midwife but I would say quite categorically that she has much that midwives need to understand and know. Somewhere I remember reading that life becomes a glorious adventure when work, play, and learning become intertwined, and this is the essence of the lesson I relearned [how often we need reminding!].

If you want to deepen your knowledge as a practitioner there is a wealth of learning. If you want to explore some of your own fear or pain in a safe and caring environment - I can attest that Rachana is a highly skilled therapist. If you want time out or you're burnt out this workshop is a wonderful change of pace and will renew and refresh you. If there are big decisions to be made in your life you will have the time and space to find the answers. Some lucky hedonists will just go for a good time and you'll get that too.