From: NEW ZEALAND COLLEGE OF MIDWIVES (INC)
P O Box 21-106
Christchurch New Zealand

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NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

APRIL / MAY 1993

Risk Assessment in Childbirth

Tribunal Costs

Claiming the Maternity Benefit

Computers in Midwifery

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

National Midwifery Centre

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

MEMBERSHIP APPLICATION FORM

NATIONAL INFORMATION **REGION** _____

Name

Address

Telephone Home Work

Workplace

Date of Birth

ARE YOU CLAIMING FROM MATERNITY BENEFIT SCHEDULE? YES/NO

ARE YOU A MEMBER OF NZNA? YES/NO

ARE YOU A MEMBER OF NZNU? YES/NO

TYPE OF MEMBERSHIP

☐ Full Membership (Waged)	$155.00	} Includes
☐ Full Membership (Unwaged)	$ 50.00	} Indemnity
☐ Associate with Indemnity	$155.00	} Insurance
☐ Associate & Affiliate	$ 30.00	}

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RENEWAL	
CHANGE	

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☐ Subscription payable to College Treasurer (cheque enclosed)

☐ Subscription from salary (please arrange with your pay office)

☐ Automatic Payment (contact Treasurer)

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PLEASE RETURN COMPLETED FORM TOGETHER WITH MONEY (IF APPLICABLE) TO YOUR LOCAL REGIONAL TREASURER

Baby deaths scrutiny by coroner

By KAREN HOLDOM
health reporter

A quarter of newborn babies who die at National Women's Hospital are now undergoing an autopsy in a move by the Auckland coroner to audit the work of medical staff.

The strict new reporting procedures follow the death of a baby at the hospital neo-natal unit because of an accidental drug overdose.

Two to three newborn autopsies now take place each month compared with no more than one a year previously.

Doctors are being diplomatic about the change but it is understood they believe some post-mortem examinations are being done unnecessarily, causing extra stress to families and medical staff.

And the stance of the coroner, Mr Stephen Osborne, is considered by some to be out of line with other coroners' interpretation of the law.

Mr Osborne is defending his decision on the grounds that highly skilled doctors need auditing and, while not giving details, he says the inquests have proved to be justified.

The matter blew up seven months ago when Mr Osborne held an inquest into the death of a three-week-old infant at National Women's Hospital.

The baby had died in late 1990 but it had not been reported to the coroner at the time because the accidental overdose was not discovered until the medical notes were reviewed for an accident compensation report.

Mr Osborne ruled that the overdose had contributed to the infant's death and the death should have been reported because he was undergoing a medical procedure at the time — in this case a drug infusion through a drip.

The head paediatrician at National Women's neo-natal unit, Dr David Knight, said this was the first time the words "medical procedure" in the Coroners Act had been interpreted to include a drug infusion.

Until the ruling, paediatricians had reported only the rare cases where they were unsure of the cause of death.

The cases where the cause of death was clear — such as when extremely premature babies died of respiratory failure — were not reported.

However, now the coroner was being called in all these cases to ask whether he wanted an inquest.

"What we have taken is that if the coroner has interpreted a drug infusion as a medical procedure, then being on a ventillator is also a medical procedure," said Dr Knight.

Half of neo-natal deaths now involved consulting the coroner and about half of those resulted in an inquiry which meant police being called to the unit to interview medical staff, and the baby undergoing an autopsy at the city morgue.

Dr Knight said he had taken a neutral stand on the issue because it was not up to him to interpret the law.

"My view of it is that the coroner is an officer of the court and the court interprets the law. It might change in the future with different coroners."

He said there was a time when 80 per cent of neo-natal deaths underwent post-mortems but the number had dropped significantly in recent years.

"People are a little more resistant. They just do not seem quite so keen for their baby to have a post-mortem."

Doctors also knew a lot more about the babies because of better technology such as ultra-sound and CT scans.

He said the forensic pathologists had been doing the autopsies extremely quickly, which was important particularly for many Maori families who wanted to take the baby home with them.

A neo-natal paediatrician at Waikato Hospital, Dr Phil Weston, said yesterday that the Hamilton coroner, Mr Chris Harding, did not take the same stance as Mr Osborne.

"I am aware of that case. We could extend that [interpretation] to every hospital death. I am sure that would be an awful lot of work for the coroner's officers if that was the case."

Dr Weston said he had had some informal discussions with one or two of his Auckland colleagues about the "difficulties" they were having.

"I do not see that they have got much to complain about. Each coroner has the right to interpret the coronial act in the way he thinks appropriate."

However, he said post-mortems were very stressful for parents.

"It is a very difficult situation and we tend to not require post-mortems on our babies very often."

Mr Osborne confirmed yesterday that there had been a significant increase in the number of neo-natal deaths being reported to him.

"This is good because it means that there is a more efficient audit."

He understood the argument that the doctors had the expertise to determine the cause of death.

Asked whether he was taking a different stance from other coroners he replied: "I try to interpret the law as best I may and I do not know what other coroners do. I have enough to worry about in my own daily work."

CONTENTS

NZCOMI
NATIONAL
NEWSLETTER

REGULAR FEATURES

SPECIAL FEATURES

PUBLISHING DETAILS

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NATIONAL COMMITTEE MEETING

Friday 25th
(6pm)
& Saturday 26th June
(9am)

Midwifery Resource Centre
1st Floor
183 Manchester Street
Christchurch

Any contributions to the National Newsletter should be addressed to
Karen Barnes
328 Blenheim Road
Christchurch

DEADLINE

for the next Newsletter

21 June

Next Newsletter due

early July

EDITORIAL

Dear Members,

Welcome to the April/May issue of our National Newsletter. Again, we have so much information to pass on to you all, some of which requires your comments and response. Do put pen to paper and add your point of view.

At our last National meeting, the Newsletter came up again for discussion. It was generally decided that the present format and production times were acceptable. If you have any comments about the newsletter, please let me know.

On another vein - if your region produces a newsletter of any sort, it would be good if I could receive a copy as regional news could then be circulated to encourage other areas.

We have a plea to continue your selling of the Breastfeeding Handbook - it's a great source of information and should be sold far afield. Just send in your requests to the Midwifery Resource Centre.

Discussion continues on the Maternity Benefits Tribunal and we finally have the Report released from the Minister for Health. However we still await monetory input towards the extreme cost of having our voice heard in those proceedings. We publish a list of regional givings as a prompt to those who may have not got around to sending their gift yet - it will still be appreciated!

Nominations were called for a representative to replace Karen Guilliland on the Nursing Council. We are pleased to announce that **Jacqui Gunn** was elected to this position. However it seems that Karen must now continue in her role until August 1993 when other new members to the Nursing Council will be appointed. We wish Jacqui well as she takes up this position of responsibility in August.

Happy reading everyone!

Karen Barnes

Television is called a "medium" because it's neither rare nor well done.

Ernie Kovacs

Marae based maternity service proves popular

Papakura Marae, in South Auckland, has set up New Zealand's first marae based birthing unit.

The unit is part of a Health Reforms Directorate pilot scheme on integrated marae based maternity and neonatal services.

According to midwife and project manager Jilleen Cole, the service is already being used by those who normally do not avail themselves of existing services.

Funding from the HRD covered set up costs, some secretarial support, a computer system and fittings for the birthing room.

The Auckland Area Health Board has contributed a lot of support and material help such as linen supplies.

Any health professionals giving their service are paid in the usual ways, either by GMS, maternity benefit or salary (in the case of Plunket nurses).

Ms Cole is practising as an independent midwife.

Mothers giving birth have three options; to have their babies at home, in the birthing room on the marae, or in hospital.

Midwife Jilleen Cole (second from left) with clients at New Zealand's first marae based birthing unit

Which ever option they choose, the same midwife attends throughout the antenatal, labour, birth and postnatal periods.

An enthusiastic approach to follow up from the midwife ensures that as many mothers as possible have all the appropriate perinatal checks.

"They may not come because they have problems with transport, care of other children or because they forget. I do a lot of the checks at home, which helps them a lot, and I also follow them up quite closely," said Ms Cole.

Middlemore Hospital, as the local hospital and focus for at-risk mothers and babies has been very supportive of the scheme but there has been a largely indifferent response from most of the local GP's, even for the antenatal classes.

Ms Cole said the personal care and the continuity of service are the main reasons women choose the service.

Most new clients are being referred to the service by family or friends.

Mother and baby clinics, and Plunket checks are held on the marae, and cervical screening, immunisation and support groups are available.

"The marae committee has been very supportive and it's a lovely place for the women to come – I believe more and more women will want to have their babies there.

"We have been holding antenatal classes in the main meeting house which is wonderful," she said.

The service is not restricted to Maori – two Pakeha women have already booked to have their babies at the marae.

Ms Cole said she would like to see more Maori midwives available for such services.

If the Papakura pilot is successful, others modelled on it will be set up around the country.

Ms Cole said while it is feasible to run such a service as a profitable business, it involves a much broader perspective.

"If money was the prime consideration this would not have been set up.

"You have to believe in the philosophy of what you are doing, devote a lot of time and effort to it, and you have to have the support of the marae," she said.

So far about 70 women have used the service, and over 45 have either given birth or booked in to give birth.

Risks of miscarriage rise on night shift

Pregnant women who work the night shift may increase their risk of miscarrying, suggests a Canadian study.

Researchers at Montreal's McGill University compare the experiences of 331 women who miscarried between May 1987 and November 1989 with 993 pregnant women who did not miscarry.

"We found women who worked an evening or night shift were four times more likely to miscarry than women who worked a day shift or did not work at all," said Claire Infante-Rivard.

However, in a paper published in the January issue of *Epidemiology*, Dr Infante-Rivard says the findings are not definitive enough to start advising pregnant women, or women who want to get pregnant, to avoid night work.

She says that while the study does not look into the causes of the high miscarriage frequency among night workers, interruption of the diurnal cycle could produce hormonal imbalances.

"Daylight affects the pattern of hormonal excretions and we don't know what happens when that pattern is provoked or changed," she says.

Dr Infante-Rivard suggests that the sleep difficulties and stomach problems associated with night shifts are not ideal for women who want to get pregnant.

Some Canadian companies offer pregnant workers "preventive allocation" allowing them to switch shift and job function during pregnancy.

In New Zealand, health and safety in employment legislation is currently being changed under the Act of that name, which comes into effect on 1 April.

Department of Labour Occupational Safety and Health Service chief advisor Lyall Mortimer said an employee concerned about reproductive hazards should approach the employer.

The employer is under an obligation to assess the hazard (usually with advice from the service) and decide on a course of action, he said.

The Canadian researchers say that women who miscarry are more likely to be older, have less schooling, have more abnormalities of the uterus and to drink more coffee than women who do not miscarry.

Research has shown that certain chemicals including lead, mercury and anaesthetic gases (specifically nitrous oxide) are pregnancy hazards.

MTNS and Sanya Baker

National Co-ordinator's Forum

During the Area Health Boards writing of contracts for Independent Midwives access to hospital facilities "risk lists" again became an issue for midwifery practice.

The RHAs have also indicated interest in defining risk, a concept the College is very cautious about because of the potential for reducing individual women to a standardised expectation.

The National Committee has discussed guidelines for referral and will provide regions with a discussion paper for debate.

Meanwhile the recently published Midwives Handbook for Practice is considered to be the appropriate vehicle for measuring Midwifery practice. You may buy a copy ($5) from your local chairperson.

The College is more inclined towards directing accountability to the health professional rather than the woman. This means the midwife or doctor (and others) having a clear understanding of their own and others role in the maternity service. This is in contrast to a risk list which concentrates on labelling the woman.

The following article, by J Rosser, discusses some of the issues which surround risk identification in Maternity Services.

The risks and benefits of "risk assessment" in childbirth.
Forum on Maternity and the Newborn, London, 18 April '90.

In view of how often one hears stories of how pregnant women have been cared for inappropriately because they have been labelled "at risk", it was surprising that the lecture theatre at the Royal Society of Medicine had many empty seats. I would have thought the level of interest would have been higher.

It rapidly emerged that almost all the audience - who were a very healthy mix of midwives, GPs, consumer groups, obstetricians, statisticians, etc - already took the view that risk scoring was an ill-conceived and unhelpful technology. Some of the papers which followed were therefore limited in their relevance, particularly the two presentations explaining the statistical intricacies of risk assessment.

Gordon Stirrat, co-author of one of the seminal books on risk assessment in pregnancy, began the day with an overview of the subject. He took as his definition of an at risk pregnancy "the likelihood of an adverse outcome for mother and baby greater than that of the general population", (and the nature of that outcome must be named). The questions which need to be asked about at risk pregnancies, eg. at risk of what?, and what is the statistical likelihood of an adverse outcome?, are too rarely asked and the thinking on the subject tends to be generally sloppy. He argued that a knowledge of the risks of pregnancy is vital in order (a) to be able to counsel the pregnant woman, (b) to deliver an appropriate level of care, (c) to allow data collection and audit, and (d) to assist in appropriate resource allocation.

He gave an interesting example of two women's different perceptions of risk: he had recently counselled a 40 year old woman that she was at a one in 50 chance of having a Down's syndrome baby; the woman felt that as she was, therefore, 98% sure of having a normal baby she declined an amniocentesis. Soon afterward he had a request from a 24 year old woman (who stood a one in 2000 risk of having a Down's syndrome child) for an amniocentesis. Despite being told that the risk of miscarriage from the amniocentesis was considerably higher than that of having an affected baby the woman, who worked in a school for children with special needs, opted for an amniocentesis. This anecdote set the theme for the day, which was, broadly, that each individual woman requires individual assessment and her needs, fears and perceptions will be unique to her. Allocating her a number to define her risk status is not helpful in planning and delivering appropriate care.

There followed a presentation by Marjorie Tew, well known for her work in the home vs hospital debate. Much of the material presented was new and it was all revolutionary: the implications of her findings turn the most fundamental assumptions about safe maternity care upside down. Broadly, these assumptions are that intranatal interventions increase the safety of all births, but especially those at higher risk. The setting for this care should be a specialist hospital, where the necessary sophisticated technology is available.

If this assumption is true then perinatal mortality rates from births at comparable risk should be lower in hospital than at home. In fact, all the available evidence, from 1958 onwards, and from sources in Britain and Holland, shows consistently that the PNM rate is invariably lower at home for all risk categories.

Breast-feeding rule divides town

Press 8/3/93

NZPA Sydney

The tiny New South Wales township of Burren Junction, population 150, is reportedly on the brink of "civil war" after a local club drew up a by-law to stop a mother breast-feeding her baby in the clubrooms.

The Burren Junction RSL and Sporting Club Ltd has enacted the special by-law to stop Mrs Sandra Knox feeding four-month-old Keegan in the club's lounge.

She has been told that babies may be bottle-fed in the lounge but if she wants to breast-feed at the club she can do it only in the restroom.

Mrs Knox, aged 31, said the restroom had a stained carpet, dirty walls, a view of the toilet, and an unreliable light bulb.

"Its unclean, unhygienic, and totally unsuitable for the act of breast-feeding," she said. "I want to know if any of the other members are prepared to sit in there and eat their meals."

The club president, Mr John Simshauser, told the "Sunday Telegraph" newspaper that the ban had been imposed because Mrs Knox "well and truly exposed too much breast".

"I think breast-feeding is probably a very good thing but if my wife did it in public she would not be sitting down for a day or two... I'd kick her in the backside," he was quoted as saying.

Mrs Knox said there was "no way" anyone had seen her breasts and that she fed her baby discreetly.

She did not want to be seen as a "militant feminist", just a normal mother who believed breast-feeding is best for babies.

She said the club only a few years ago had held wet T-shirt and lovely legs competitions.

"The (club's) board of directors' perception of women's breasts is distorted; they clearly see them as sex objects when their purpose is to feed babies."

The newspaper said the dispute had soured relations in the town where "civil war has effectively been declared" with everyone taking sides.

Mrs Knox has now lodged a complaint with the NSW Anti-Discrimination Board.

Dutch agree home birth is best

Press 8/3/93

From CAROLINE SMITH, of Reuters, in Amsterdam

As President Bill Clinton prepares to tackle one of the United States' most pressing domestic problems — the cost of health care — Dutch women are setting an example which could save him billions of dollars.

Every year a third of Dutch women who give birth do so at home, in the presence of an independent, professional midwife.

It is not only cheaper than going to hospital, but the medical profession and most Dutch women believe natural childbirth at home is the best way to have a baby. Home births are often easier and quicker for the mothers and are no riskier than hospital deliveries, they argue.

The figures seem to bear them out. Out of 20 European countries, the Dutch infant mortality rate is fourth — below Finland, Sweden and Switzerland.

Maternal mortality is 13th out of 20, but the Netherlands still has a better record than Germany and France.

Much of the Dutch public's faith in home births stems from the special status enjoyed by the midwives.

In contrast to colleagues in other countries, they work independently of doctors and hospitals, having sole care of pregnant women from conception to a few weeks after the birth.

While much of the world has seen a decline in home births as hospital-based medics insist on using ever more sophisticated equipment, the Dutch total has remained stable since 1980.

Beatrijs Smulders has been a midwife for 15 years. She has travelled to Britain and the United States trying to persuade the medical profession that home births are best and cheapest.

"The pride of the midwife is to give women as much care as possible and as much pride in their own achievement, of giving birth under their own steam," Smulders said.

The Dutch example is slowly gaining support elsewhere.

A group of parliamentarians from Britain — where home births make up less than 2 per cent of the total — recently visited the Netherlands before publishing a report advocating the benefits of natural and home-based deliveries.

Midwives supported

PA Wellington

Two reports released yesterday advise the Government to continue its official recognition of midwives as child-birth alternatives.

Since the Nurses' Amendment Act was passed in August 1990, midwives have been allowed to work independently of doctors.

The midwives have been allowed most of the same Government maternity subsidies as doctors, a situation which has upset the Medical Association. The dispute led to a Maternity Benefits Tribunal being set up to consider the fees scale.

The tribunal's report was released yesterday by the Minister of Health, Mr Birch, together with a report from the Health Department on the tribunal's recommendations.

Both tribunal and department advise that doctors and midwives be paid the same, except when specialist consultants are needed.

ChCh Press 20/3/93

More British caesarean births

Reuter London

More British babies are being born by caesarean section because medical teams are worried about being sued if normal births go wrong, according to a report from the Royal College of Midwives.

More technology was being used to monitor births and the number of caesarean operations had doubled in the past 15 years, the report said, and the number of court cases brought against hospitals in connection with troubled births had also increased.

"I believe that fear of litigation is a major factor in maternity services staff seeking refuge in defensive practice," said Mr Rory Murphy, director of industrial relations for the Royal College of Midwives.

This development was worrying, said Mr Murphy. "Not only does it reduce choice over birth, but it may also bring increased risk to the mother."

In many instances the PNM among the high risk who deliver at home is lower than among the low risk who deliver in hospital. Marjorie also looked at PNM in relation to the carer; midwife or doctor. In all settings, and in all risk groups, PNM was lower among women cared for by a midwife, in some instances by a factor of 10. Even for a woman at highest risk it is statistically safer for her to deliver at home with a midwife (though Marjories is sure that there must be some serious conditions when the woman and baby would be safer in hospital). Of the many figures she used, the following are typical.

All births The Netherlands 1986

Care given	*Setting*	*PNM rate*
Obstetrician	hospital	18.9
GP	hospital	4.5
Midwife	hospital	2.1
Midwife	home	1.0

At the end of her stunning presentation a colleague on my right (a senior labour ward midwife) shook her head and asked in anguish *"What are we all doing?"* The colleague to my left (president of a major consumer organisation) said bitterly *"This makes me so angry; that this knowledge is available and yet it is not acted upon!"*

For me at least, the rest of the day was overshadowed, but there were more interesting papers to come. Speaking under the title "Ethnicity as a risk factor for birth" Dr Parsons presented the available data on this subject. As ethnicity is not recorded on records, country of origin is used as a proxy. The perinatal mortality rate among women born in Pakistan is 16.9 - about twice the national average. There is a marked difference in the mean birth weight between different groups, and the mean gestational age is 5 days shorter among women born in Pakistan, India and the Carribean as compared to those born in the UK.

Induction is more common among UK born women than those of the New Commonwealth. The CS rate varies. Small babies do better if their mother was born in Pakistan. Congenital malformations among this group are 4.3 compared to 1.9 from UK born women. The general message was: the risk factors are all different and, anyway, although associated with an adverse outcome, are not necessarily casual. Our understanding is still very incomplete. Again the only sensible conclusion is an individual response to each case.

The proceedings were nicely balanced by including among the afternoon speakers a woman who had been labelled "at risk" in her first pregnancy. It is an approach that all of us running study days and conferences could well bear in mind.

Jilly Rosser, Midwife

Maternity Benefit Tribunal Expenses and Donations as at 26th March 1993

Estimated Total Expenses		$30,000.00
Breakdown of Donations received to date:-		
Northland	28 Members	$ 100.00
Auckland	339 Members	$ 2,100.00
Waikato/BOP	233 Members	$ 3,795.00
Eastern/Central	78 Members	$ 910.00
Wanganui/Taranaki	67 Members	$ 650.00
Wellington	132 members	$ 1,785.00
Nelson	43 Members	$ 1,250.00
Canterbury/WC	158 Members	$ 9,783.00
Otago	65 Members	$ 3,130.00
Southland	19 Members	$ 115.00
TOTAL	1,162 Members	$23,718.00

This leaves us with a deficit of $7,000.00 approximately, so please work hard at encouraging your members to send in their donations as we urgently need to get this money paid out. Thank you

Media Watch

PRESS CHRISTCHURCH 24/4/93

Midwives claim victory

PA Wellington

MIDWIVES have welcomed two reports on maternity services as the only case of pay equity won in New Zealand and as a success for women.

However, the Medical Association's chairman, Dr Alister Scott, claimed the Health Department had hijacked a report by the Maternity Benefits Tribunal.

The office of the Minister of Health, Mr Birch, yesterday denied that he favoured the department's recommendations, saying he had not made a decision.

Since the Nurses Amendment Act was passed in August 1990, midwives have been allowed to work independently of doctors in helping women during normal pregnancies and childbirth.

This has meant midwives are allowed most of the same maternity subsidies as doctors, upsetting the Medical Association.

The association recommended a separate schedule of fees for midwives, saying midwife claims were contributing to a blow-out in maternity costs.

The tribunal's report, dated January 19, 1993, was released yesterday by Mr Birch along with a Health Department report on the tribunal's recommendations.

Both the tribunal and the department advise Mr Birch that doctors and midwives should be paid the same, except when specialists are needed.

The reports also suggest changes to the payments, including increasing the ante-natal consultation fee from $20.65 to $26.

The national co-ordinator of the College of Midwives, Ms Karen Guilliland, said that funding decisions should be made by regional health authorities.

"For us, the fact that both documents have accepted the need to keep doctors and midwives on the same payment schedule, that's affirmation of midwives' integration into maternity services with acceptance that the services provided by both is the same," Ms Guilliland said.

That was a major success and the only case of pay equity won in New Zealand.

Dr Scott said the association had no quarrel with the tribunal report, but the department's report revived arguments rejected by the tribunal.

Both sides will make further submissions.

Occupational risks - be warned!

Hazards of N_2O exposure

MIDIRS Midwifery Digest (Mar 1993) 3:1

Editor's Note. A past article on this subject printed in our newsletter received no response from midwives. This seems a potential and possibly serious risk to our health. Any comments?

Nitrous oxide is a potentially dangerous gas. Prolonged exposure is problematic, and the gas may even be teratogenic[1,2]. Dentists have been investigated following occupational exposure to N_2O and have reported an increased incidence of neurological complaints, including numbness, tingling and/or muscle weakness[3].

Midwives have been found to be exposed to levels of the gas well above the recommended safety limit, apparently owing to lack of ventilation or scavenging equipment[4]. At present we have no legally enforceable limit, but a level of 200–250 ppm has been mentioned by the Health and Safety Executive. This study investigated the levels of nitrous oxide to which midwives working in a labour suite were exposed.

Personal diffuser samplers were used by 14 midwives who were asked to give verbal consent. As N_2O must be inhaled to be absorbed, the samplers were worn as near the mouth as possible (in the uniform breast pocket). The day-to-day workload in the labour suite and the amount of N_2O analgesia used by individuals varied a great deal. It was therefore impossible to ascertain a 'typical exposure'; samples ranged from 7.5-hour shifts to 37.5-hour weeks. The results are shown in Table 1.

This small study demonstrates that midwives working in our labour suite are exposed, at times, to unacceptable levels of N_2O, which exceed all the recommended or legally enforceable limits (USA: 25ppm, Sweden: 100 ppm, UK and Europe: suggested 200–250 ppm). Even if the level was to be set at 200 ppm, this was exceeded in half the samplers. In one case the level was over seven times the limit.

To prevent harm occurring, labour wards need good ventilation and adequate air changes. Scavenging equipment would also minimise waste gas levels. Midwives must also take personal responsibility to ensure they do not suffer 'prolonged' exposure to nitrous oxide in early pregnancy. This poorly researched area must be examined more closely and standards must be set.

Table 1. Exposure to nitrous oxide

Sampler	*Warning Time (hrs)*	*Exposure Time (hrs)*	*Reading (ppm)*
1			overexposed
2	37.5	4.25	20
3	37.5	1.25	12
4	37.5	6.1	426
5	37.5	8.45	1151
6	7	0-4	1065
7	7	0-4	481
8	7	0-4	35
9	7	0-4	272
10	7	0-4	892
11	7	0-4	1558
12	7	0-4	18
13	7	0-4	8
14	7	0-4	<5

Midwives are exposed to high levels of nitrous oxide in labour suites

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Carol Newton, SRN, CTM, SCM, ADM, is a midwife, Newstead Ward, City Hospital NHS Trust, Nottingham

Janine Wiedel Photo-library

© Nursing Times, vol 88, no 39, 23 September 1992. p 54.

News & Views

CLAIMING THE MATERNITY BENEFIT

A recent prosecution against a pharmacist by the Dept of Health shows their determination to prosecute health providers who fraudulantly claim against benefit schedules.

Midwives claiming the Maternity Benefit are urged to ensure they have a copy of the Health Benefit letter which provides the latest fees for service and their interpretations.

These letters are available from the Region Benefits Payment Office, P O Box 1349, Christchurch.

POINTS TO REMEMBER WHEN CLAIMING

* mileage fees are payable for the distance from the clinic or residence from which the visit commenced. If two or more maternity clients are visited in the course of one journey, the distance common to the two or more of the visits is to be included only once in the claim.

* if working for an Area Health Board as a midwife, there is no capacity within the schedule for a midwife to also claim for clients services whilst on duty for that Board.

* If other Midwives (and doctors) are involved in a particular case, the checking and payment of claims is facilitated if all names are included on the claim form.

* The DOH is presently preparing to provide statistics of claiming patterns both personal and collective.

15 April 1993

Maternity Benefit Claimant
Chief Executive
NZMA/NZGP/NZCOMW
address

DRAFT

Dear Claimant,

HEALTH BENEFITS PAYMENTS REVIEW

Over the last few years the Department of Health has been developing improved systems for paying health benefits. The recent focus includes an assessment of the effectiveness of expenditure under the current system and the continuing development of ways to control the risks associated with making benefits payments.

As a result of work conducted to date, it is now possible to start several risk management initiatives. These are:

Claimant Attitude Review

This is designed to assist the understanding health professionals have of the policy and system for paying health benefits. It will seek to clarify the adequacy of system guidelines, and identify issues which bring claimants into conflict with the system. The research component will cover a sample of approximately 50 health professionals.

Education

This involves identifying which may assist health professionals regarding levels of service provided in relation to their peers. Overseas experiences indicate that greater awareness of the overall process has led to increased compliance with the system.

Once diagnosed as having gestational diabetes, all women would receive dietary advice and information on exercise and lifestyle changes before insulin therapy would be considered. Women are encouraged to carry out home blood glucose monitoring so that the effect of the above changes on glycaemic control can be assessed. Only if blood-glucose levels remain elevated would insulin therapy be considered.

Because of the long term risks to the mother of developing type II diabetes, lifestyle changes can be recommended during pregnancy, so that they continue after pregnancy. These include:

- Weight control
- Dietary changes
- Increased exercise

Midwives have an important role in supporting and reassuring women who are diagnosed as having gestational diabetes, as this can be a particularly anxious time for these women. It is important that as midwives we review the usefulness of routine screening tests in pregnancy, but we must balance this against our main objective of a healthy mother and baby not only at birth, but for the years ahead.

Carolyn Conroy
1993

References :

(1) Beischer N.A. Incidence and Severity of Gestational Diabetes Mellitus according to Counting of Birth in Women Living in Australia. Diabetes 1991. Dec Vol 40 Suppl 2 p 35-38

(2) Reece E., Coustan D. Diabetes Mellitus in Pregnancy Principles and Practice p 425

(3) Hod. M, Merlob P. Gestational Diabetes Mellitus A Survey of Perinatal Complications in the 1980s Diabetes 1991. Dec Vol 40 Suppl 2 p 74-78

For the vast majority of women the test will only involve a 50g polycose test being organised at 26-28 weeks gestation. The polycose load is administered as a drink, with a blood test one hour afterwards. This test does not require a period of fasting or any other special preparation.

In only about 15% of women will the result of this test be abnormal and require follow-up with the more involved 2 or 3 hour glucose tolerance test.

This test does require a 12 hour fast, but this occurs overnight at a time when most women woud not be consuming food.

Only if the results of this test are abnormal are women considered to have gestational diabetes, and the incidence of this will vary within different communities.

Though there is some difference of opinion amongst Physicians as to what constitutes "abnormal levels" within borderline results, most grossly abnormal results would be recognised as such anywhere.(2)

If a woman is diagnosed as having gestational diabetes, this constitutes a "high risk" pregnancy because of the risks to the mother and fetus.

These risks include:

Fetal macrosomial and its associated risks related to traumatic and difficult vaginal deliveries and increased instrumental or operative intervention.(3)

Respiratory distress syndrome.

Late still-birth.

Neonatal hypoglycaemia.

Increased incidence of caesarean section.

30-60% risk of maternal type II diabetes developing within 5-10 years

For these reasons the pregnancy needs to be closely monitored and ideally women should be cared for within a multi-disciplinary team consisting of a Midwife, Obstetrician, Diabetes Physician and Dietician.

Work undertaken to date indicates that there are deficiencies in the quality and completeness of information currently collected by the Department in support of claims. This study will give a greater understanding of how practices operate in order to develop efficient processes that promote accurate claiming.

Budget Holding

The work will be used to develop effective and useful monitoring and audit provisions which are acceptable to all those in budget holding and capitation practices.

Investigations

Increased resources will be applied to the identification of high risk claimants and the detection of inappropriate and fraudulent claims.

Fraud Training

This will provide specialist training for staff involved in processing claims, to enhance their effectiveness and increase the likelihood of detecting inappropriate or unusual claims. Additional advanced training will be offered to investigation staff.

Systems Development

Improvements to existing systems of payment will be co-ordinated and prioritised and the appropriate role of computer technology will be determined. Systems development will be co-ordinated with the RHAs.

We are naturally keen to ensure your support for this undertaking, and would appreciate any comments you may wish to make on the plan. We would also be happy to brief appropriate staff on the initiative and manage an ongoing liaison with them. If you want to take up this opportunity the staff assigned should contact Denis Black directly either by writing to the Department or phone (04) 474-8242. We look forward to your response.

Yours sincerely,

Ian Miller
General Manager
Contract Management Group

REMITS TO ICM

On May 4-8th Sally Pairman and Karen Guilliland will be representing the New Zealand College of Midwives at the 23rd Congress of the International Confederation of Midwives in Vancouver, Canada. As a result of discussions on consumer membership at the previous Congress in Japan 1990, New Zealand stated it would present a position paper on consumer involvement in Midwifery for this year's Congress. The following statements and constitution changes are the result of these deliberations.

POSITION STATEMENT

The Midwifery Partnership with Women

The ICM believes that Midwifery is a profession which is based upon a partnership between women and midwives.

In keeping with this belief

i] The Midwifery profession shoud reflect the needs of women in society.

ii] Women should be involved in the development and maintenance of the Midwifery profession.

iii] Midwifery Associations should encourage women/consumers to participate in the activities of their professional organisations.

RATIONALE

Partnership is not the passive "giving women a voice" it is developing and expanding a Midwifery profession together which is truly reflective of the needs of women in society. Joining forces with women succeeds in making the re-establishment of the Midwifery Model synonymous with reclaiming women's control over childbirth. Extending the Midwifery partnership to the professional organisation, development and maintenance of Midwifery gives us a unique identity, social recognition and protects women's choices and self determination. A global acceptance of the partnership model could ensure the survival of an independent Midwifery profession.

SCREENING FOR GESTATIONAL DIABETES

- Carolyn Conroy (Midwifery Diabetic Educator, Middlemore Hospital Auckland -

SHOULD THIS BE DONE ROUTINELY?

As midwives, we have long believed that for the majority of women, pregnancy is a normal physiological event, requiring no medical intervention. However for some women this will not be the case and medical intervention of some description will be required; one such group are those women with diabetes or who develop gestational diabetes.

In the August issue of Maternity Alliance, there was an article criticising the increasing use of routine screening for gestational diabetes. This is an issue that is often discussed in a variety of contexts, but there are certain points that need explaining and clarifying.

We are all aware of the risk factors for gestational diabetes that are quoted in any text book. What we must remember is that many of these risks are only identifiable in multiparous women, and it is more difficult to clearly identify those primagravidas that might be at risk.
The question must be asked - do we want women to unnecessarily experience a stillbirth or have a traumatic delivery of a baby that may weigh more than 5kg simply because we do not advocate routine screening even within high risk communities.

Like many other diseases the prevelance of diabetes varies between different ethnic groups, and whilst the rate of type II diabetes is only about 2-3% within European groups, it can be as high as 8-10% within some Polynesian groups. For this reason routine screening is being advocated in Polynesian women and high risk ethnic groups such as Maori, Indian and Chinese women.(1)

Very few women with gestational diabetes ever demonstrate classical signs of diabetes because many of the symptoms are masked by pregnancy. These include frequency of micturition, tiredness and increased thirst. Glycosuria is an unreliable indicator of diabetes in pregnancy, because of changes that occur in the renal threshhold.

Taking the above into account, the only reliable way of screening for gestational diabetes is through a blood test.

Once women are diagnosed with the GD "disease" they become high risk which reduced their choices and options predisposing them to more interventions. They are also subjected to constant tests and monitoring of the baby continuing throughout and after the birth. Rahima is critical of this over-management that persists in spite of the fact that if controlled there is no more risk of problems than with women who do not have gestational diabetes.

There are women with consistently high blood sugar levels which will increase the risks to themselves and their baby who need insulin or diet intervention. Consistently high levels can result in the baby getting too much sugar and growing too large which can cause problems at the birth. These babies may end up with shoulder dystocia, forceps, c-section and other trauma. The baby produces extra insulin to handle the excess sugar and can be hypoglycemic with tremors at birth. The incidence of jaundice is also higher.

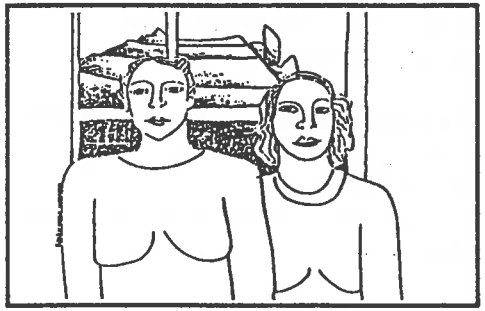
50% of women with one or more risk factors develop GD but 50% don't. The risk factors are:

- over 30
- obesity
- diabetes in the family
- previous baby or their own brith weight over 9 pounds
- previous pregnancy with gestational diabetes
- problems such as stillbirth

Urine tests done at antenatal visits aren't very good indicators as about 1/6 of all pregnant women spill glucose in their urine. The renal threshold for sugar changes during pregnancy as does the excretion rate. It is estimated that 75% of people shown by the GTT to have impaired glucose tolerance never actually develop diabetes. The test can't be good for mothers since a pregnant woman should not fast for 8-12 hours and the glucose often makes her vomit. The better a woman's nutrition, the less likely her body is to be accustomed to large doses of straight sugar. The effects on the baby of glucose flooding after several hours fasting is unknown.

In *A Guide to Effective Care in pregnancy and Childbirth* by Enkin, Keirse and Chalmers they reviewed all the literature in English to determine the efficiacy of the glucose tolerance test for gestational diabetes. They conclude that except for research purposes, all forms of glucose testing for gestastional diabetes should be stopped. They suggest that women in whom overt diabetes is suspected should be followed with repeated fasting or blood glucose estimation 2 hours after meals throughout pregnancy.

They go on to state that the diagnosis of gestational diabetes, as currenlty defined, is based on an abnormal glucose tolerance test and the risk of this "condition" has been overemphasised. No clear improvement has been demonstrated with insulin treatment for gestational diabetes, and screening of pregnant women with GTT is unlikely to make a significant impact on perinatal mortality.



RESOLUTION

Constitutional Change
Constitution para 5

Members of the Confederation shall be

Add new paragraph:

iii) In countries where consumers are represented on the Midwifery Association, that association may become a member provided that

a) the Association's function is to conduct and promote the objects of the Midwifery profession.
b) the majority of members and office bearers are midwives.
c) the spokesperson for the association is a midwife.

An association applying to become a member of the Confederation shall

Amend to:

i) consist primarily of midwives recognised by their government or professional organisation as being competent to practice midwifery.

RATIONALE

In New Zealand membership with the New Zealand College of Midwives is a philosophical and political necessity. It was this partnership with women/consumers which reinstated independent midwifery in New Zealand. New Zealand legislation also requires consumer participation in the regulation and discipline of health professionals. The New Zealand College of Midwives consumer membership reflects this cultural and political environment.

The ICM Constitution should enable other midwifery organisation to follow this partnership model if that is culturally appropriate and required to progress Midwifery development within their countries.

COMPUTERS IN MIDWIFERY

The NZCOM is supporting the development of a Midwifery information system. The National committee have decided to work with Terra Nova Pacific service to achieve this.

Major advantages in the establishment of a midwifery data base are that:

1) The college can collate statistics from independent midwives nationally and can produce reports on national midwifery practices and trends and also reports for individual midwives if required.

2) The college will have a comprehensive collection of data for any midwifery research and as a basis to negotiate for midwives at a national level.

3) Midwives can buy a licence and use the program to collect their own statistics and produce annual statistics for their reviews, RHA contracting, etc and can send on their data by disk rather than writing out forms. They will also be able to use it to produce claim form data for maternity benefit claiming or RHA contracting.

For those not using computers, forms would be provided. These would be filled out by individuals and entered on the College system by a data entry person.

With the system there would be a number of customised reports e.g
- annual standards review statistics
- national statistics on outcomes etc
- home births data set
- claim form report
- Account book

To use this system you will need the following:
- An IBM compatible personal computer with a 386 or higher processer
- Hard disk with 13 megabytes of free space
- Microsoft Mouse or other compatible pointing device
- EGA or VGA or compatible monitor
- Two megabytes of random access memory (four or more is recommended)
- MS-DOS verson 3.1 or later and Microsoft Windows version 3.0 or later.

Articles of Interest

Topic for Debate - Editor's note
Both these articles raise very pertinent questions regarding continued screening for Gestational Diabetes. I would invite further comments and information from those who have an interest in this area, or have dealt with this issue in their practice. Please address all correspondence to Karen Barnes, 328 Blenheim Road, Christchurch 4

SCREENING FOR GESTATIONAL DIABETES

There appears to be an increasing trend in some parts of New Zealand to routinely screen for gestational diabetes (GD) particularly amongst Polynesian women. Well known American author of Special Delivery, Rahima Baldwin also notes this trend in the United States. The American Diabetes Association now recommends that all pregnant women be screened for GD between 24 and 28 weeks of pregnancy.

It is interesting that there is disagreement in the studies about the "normal" levels for pregnant women and whether they should be higher or lower than non-pregnant women.

Rahima records that 30% of pregnant women routinely fail the glucose challenge test and experience the anxiety of returning for the more rigorous glucose tolerance test (GTT). Yet, according to the American Diabetes Association, only 2-3% of all pregnant women have actual blood sugar levels above those deemed normal for pregnancy.

Of these 2-3% diagnosed because they failed the test (rather than exhibiting clinical symptoms), only 15% will be prescribed insulin for the remainder of the pregnancy.

This means that the result of universal screening finds that less than one percent (.45%) of all pregnant women have blood sugar levels requiring insulin therapy.

Rahima raises the question of whether the women who failed the test did so because of the nature of the test.

85% of women who fail the GTT and are diagnosed with GD can keep their blood sugar levels within normal range through diet and exercise. She questions how many otherwise healthy pregnant women are incapable of handling 8-12 hours of fasting followed by 100 gms of glucose (the equivalent of about 4 candy bars), but are quite capable of maintaining normal blood sugar levels on their normal healthy diets.

We have no way of knowing how many women diagnosed with GD by the GT test never had high blood sugar when eating their normal diets. Rahima suggests that women suspected of having a problem be sent home with a glucose meter that she has been taught to use. If she returns with normal readings then the condition does not exist for her.

AUSTRALIAN COLLEGE OF MIDWIVES CONFERENCE

"MIDWIFERY - A FAMILY AFFAIR"

15-17 September 1993
Adelaide South Australia

Cost :	Early Bird Registration (before 14 July 1993)	$420.00
	Registration	$470.00
	Daily Registration	$170.00
	Students/Retired Midwives	$250.00

Enquiries to:

Karen English/Jan Wood
GPO Box 2471
Adelaide SA 5001
Ph 08-267-5466 Fx 08-267-4031

AOTEAROA WOMEN'S HEALTH GATHERING

WAHINE TOA

WOMEN BE STRONG

FAFINE IA MALOSI

A gathering for and by women to celebrate our past, present and future involvement in health.

To be held on the 6,7 and 8 August 1993 at the Takapywahia Marae in Porirua.

You can attend, join in the weekend activities and/or run a workshop.

Interested?
Write to us at P O Box 9130, Wellington

A FEDERATION OF WOMEN'S HEALTH COUNCIL'S EVENT FOR SUFFRAGE CENTENNIAL YEAR

If you want to write your own reports you also need a relational data base that will read paradox tables eg Microsoft Access or Paradox.

Individual licences will be worth approximately $1000 depending on the level of services required. The system will be piloted in Wellington in the next few months and it is hoped that it will be available by the middle of the year.

If interested, please contact your local chairperson or:

Carey Virtue
8 Durham Crescent
Wellington

STOP PRESS

PROFESSIONAL INDEMNITY INSURANCE

The College is required to renegotiate its policy annually. We have been unable to keep the premium to last years level therefore also unable to increase the Limit of Indemnity. It remains at $200,000 any one claim/$400,000 in one year.

We believe this cover to be adequate for the upcoming year. Independent Midwives who require additional cover however can do so under our policy on an individual basis with the Insurance Brokers. Please contact:

Julianne Harvey
MARSH & MCLENNAN
P O Box 699 DX 8163
WELLINGTON Ph (04) 385-0124

if you wish to take advantage of higher cover at an additional premium.

NELSON ENVIRONMENT CENTRE

P O Box 715
Nelson
Telephone 548 9390

Premises at:
27a Alma Street, Nelson

NZ College of Midwives
P O Box 21106
Edgeware
Christchurch

20th April 1993

Kia Ora,

I am currently researching aspects of use of sanitary pads, tampons and disposable nappies. I am interested in hearing from anyone who would like to share experiences with regard to these products and/or their alternatives. Also from anyone who is interested in promoting this issue in their area. We are launching an awareness campaign in June (Women & The Environment month) as part of Suffrage Year.

I would also be interested in knowing if there is a belief among midwives that there is a risk associated with the use of these products? Is there a general opinion on the suitability of using disposable nappies on infants?

Are midwives aware of such things as vaginal ulcers and toxic shock syndrome as a result of using tampons?

Articles or contacts etc ... regarding this broad and important subject would be most appreciated.

Ange Palmer - PROJECT CO-ORDINATOR

FEDERATION OF WOMEN'S HEALTH COUNCILS AOTEAROA - NEW ZEALAND

INFORMATION PAPERS AVAILABLE

Accident Compensation : A Woman's Issue
Compiled by Sandra Coney
Price $6

Ensuring the Cervical Screening Programme Survives the Health Changes
Price $6

Consumer Consultation, Representation and Participation
Price $5

Abortion Services and the Health Changes
Price $8

In Recognition of Older Women
Compiled by Audrey Fenton
Price $8

A Health Commissioner for New Zealand
Price $8

All Papers are spiral bound and can be ordered from:

The Federation of Women's Health Councils
CPO Box 853 Auckland
Ph (09) 520-5175 Fax (09) 520-4152

Upcoming Events

NATIONAL HOMEBIRTH CONFERENCE

May 14th-16th
Held at Camp Columbia, Pukerau, near Gore Southland
Cost : $80 for whole weekend + Meals (children FREE)
$10 Day Registration + extra for meals and accommodtion

Topics of Workshop cover:
- breastfeeding a fussy baby
- how to change a posterior position
- prayer in pregnancy and birth
- herbalism and holistic health

and much more

Registrations closed 02 April but late registration fee is $10.

For further information, contact :
Glenys Lieshout
21 Clifton Street
Invercargill
Ph (03) 217-0328

SPIRITUAL MIDWIFERY

with
RACHANA
International Therapist & Birth Educator

5-Day Workshop for Women

Celebrate Universal
Girl Woman
Mother Woman
Wise Woman
Get to know Family Birth/Life Patterns
Power, Transformation, Healing
Self-Delight

1993 WORKSHOP WELLINGTON

2-5 Day Workshop
5th-9th June 1993

Free Introductory Talk
- 7.30pm 4th June -
at YMCA

For further information contact:

Liz Burton
Ph (04) 384-5714

PERINEAL REPAIR

by Michelle Nisbet RM
& Bronwyn Rouse RM

Review by Jenny Gamble RM
ACMI Accredited Midwife in Independent Practice

The authors of this compact book have met their aim of bringing together the current knowledge about perineal repair. Comments and suggestions are well supported by research where available and the options of other experts if data is not yet to hand.

The book is divided into three sections. Section 1 briefly reviews the literature on perineal repair, summarises the pros and cons of current repair techniques and discusses suture materials.

Section 2 comprehensively covers normal anatomy, gives step by step instructions for perineal repair followed by a summary of the procedure and a list of common mistakes. Care of the perineum in the puerperium is also included.

Section 3 identifies the principles of knot tying, knotting techniques and include clear easy to follow diagrams of knot tying.

The book has a clear and concise table of contents and full references are provided.

Throughout the book, tables and diagrams readily orientate the reader and assist the beginner to grasp vital concepts and skills. The drawings by Bronwyn Rouse are excellent.

I have a collection of articles, manuals, wall charts, videos and models on perineal repair, but this book is by far the best.

The purchase price of $25 is very reasonable This book should be a prescribed text for all student midwives. Doctors and midwives in clinical practice would benefit from reading this book and reviewing their technique regardless of how long they have been practicing.

Bronwyn Rouse, Judi Brown, Michelle Nisbet

THE PERINEAL REPAIR BOOK

The Perineal Repair Book was written by Michelle Nisbet and Bronwyn Rouse. The book was launched on November 18th by Professor Alistair McLennan and Judi Brown. National President, ACMI, during the City Seminar conducted by the ACMI South Australian Branch at Enterprise House, Unley, SA.

This book is available from:
Australian College of Midwives Inc.
260 Albert Street
East Melbourne Vic 3002.
Cost: $25.00 (includes postage)

THE OPEN POLYTECHNIC OF NEW ZEALAND DISTANCE LEARNING PROJECT FOR MIDWIVES

- Chris Hendry

DIPLOMA IN CLINICAL PRACTICE

The Open Polytechnic of New Zealand will be offering a choice of 6 midwifery modules within their Diploma in Clinical Practice for Nurses and Midwives. The NZCOM has undertaken responsibility for assesing and advising on the Midwifery modules, all of which have required extensive changes to fit New Zealand setting.

CURRENT PROGRESS ON MIDWIFERY CORE MODULE

The Core Midwifery Module has now been placed on the word processor with the current changes made but there are still some changes to make and further consultation with both practitioners and Maori.

ORGANISATIONAL AND ASSESSMENT STRUCTURES

UNIT CO-ORDINATOR: There will be **one** unit co-ordinator for **each** module. This person will monitor the module nationally and will be nominated by NZCOM.

This midwife will:

- ensure marking monitoring and support for markers
- cross mark the first 5 scripts from each marker
- be responsible for learning contracts with students
- provide info on the module
- advise on provision of new markers

CLINICAL TEACHING ASSOCIATE

It is envisaged that there will be a CTA (midwife nominated by NZCOM) in each centre where there are a concentration of those undertaking the midwifery module. Currently two midwives have been trained for this role. This person is responsible for the **clinical assessment** while other midwives who have experience in assessment of written assignments will mark the **theory component** of the module.

APPROVAL OF THE DIPLOMA IN CLINICAL PRACTICE

This has now been approved by the Academic Board of the TOPNZ, but as each paper is also a stand alone module the formality of having each module reviewed is currently being undertaken. Once the modules have been altered to suit the NZ midwifery setting, the assessment process has to be approved by the Twin Rivers University, because each module is able to be cross credited to their BSc Nursing.

AVAILABILITY OF MODULES

It is proposed that from **July 1993** nursing modules (many will be attractive to midwives) will be available. We are not sure if we can move as quickly with the Midwifery Core Module.

ANYONE WANTING INFORMATION ON ANY OF THE MODULES CAN PHONE TOPNZ ON FREEPHONE 0800 507 333

URGENTLY NEEDED

The names of midwives who have the interest and experience to become involved in the planning and organisation of the TOPNZ project in distance learning for midwives.
The potential is there to gain some income from this project.

Please send names to
Chris Hendry
47 Kilmarnock Street
Christchurch
Phone 348-9347

Book Reviews

HEARING MY MOTHER'S VOICE

A Study of Sisters and Mothers
by *Beverley Morris (1992)*

Book Review by Chris Hendry

This book represents the results of an interesting research project carried out to determine to what extent women in the 1980s are influenced as mothers by their experience of being mothered themselves.

Basically, two generations of New Zealand mothers childrearing patterns were investigated. The present generation of mothers interviewed consisted of 50 pairs of sisters who were not only requested to share information on their own childrearing practices but were asked to reflect on their own mothers practices as they perceived them.

The interesting conclusion Morris came to on completion of this research was that there apperared to be a dynamic relationship between a mother and each of her children (I could have told her this!!!) She found that the sisters each had unique and at times differing views of their mothers as disciplinarians and care givers. The assumption was made that the personality of the child has a greater part to play in childrearing practices than any other influences.

An easy and interesting read for midwives and mothers. Great resource for those of us undertaking further studies.

NOW AVAILABLE

- A 76-page report looking at the childrearing practices of 50 pairs of sisters
- Published by the New Zealand Council for Educational Research
- Order from -
  NZCER Distribution Services
  P O Box 3237
  WELLINGTON

STOP PRESS

MATERNITY BENEFIT SCHEDULE UPDATE

The final decision with regard to the Maternity Benefit Schedule now lies with the newly appointed Minister of Health, Bill Birch. The New Zealand College of Midwives received the report of the Tribunal in late March with instructions for it to remain confidential until the Department of Health's response to the report was released in late April.

Both of these reports supported equity of payment for midwives and doctors, that is, one schedule for midwives and doctors and equal pay for equal work. The New Zealand College of Midwives and NZMA were then invited to submit comments to the Minister of Health on these reports. The closing date for this was the 7th May 1993.

Although we agree with the overall intent of the proposed schedule, there continues to be aspects with which we do not agree. All Chairpersons have copies of all submissions and reports if you wish to view these.

If the Minister follows through with the recommendations of the Tribunal, the Department of Health and New Zealand College of Midwives, we have victory for midwives and women.

At last, pay equity set a legislation! We could not have come this far without huge personal and professional commitment from all those involved in the Tribunal. Thank you.