NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

JUNE/JULY 1993

Section 51 Report

How Your Subscription is Spent

Annual General Meeting 1993

Spotlight on Midwives

From: NEW ZEALAND COLLEGE OF MIDWIVES (INC)
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Christchurch New Zealand

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POSTAGE PAID
Christchurch NZ
Permit No. 2843

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

MEMBERSHIP APPLICATION FORM

NATIONAL INFORMATION **REGION** ____________

Name ____________

Address ____________

Telephone ________ Home ________ Work

Workplace ____________ ARE YOU CLAIMING FROM MATERNITY BENEFIT SCHEDULE? YES/NO

Date of Birth ____________ 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	

METHOD OF PAYMENT (Please tick your method of payment)

- ☐ Subscription payable to College Treasurer (cheque enclosed)
- ☐ Subscription from salary (please arrange with your pay office)
- ☐ Automatic Payment (contact Treasurer)

REGIONAL INFORMATION **REGION** ____________

Name ____________

Address ____________

Telephone ________ Home ________ Work

Workplace ____________ ARE YOU CLAIMING FROM MATERNITY BENEFIT SCHEDULE? YES/NO

Date of Birth ____________ ARE YOU A MEMBER OF NZNA? YES/NO

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- ☐ Full Membership (Unwaged) $ 50.00 } Indemnity
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- ☐ Associate & Affiliate $ 30.00 }

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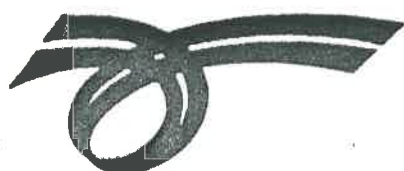
PLEASE RETURN COMPLETED FORM TOGETHER WITH MONEY (IF APPLICABLE) TO YOUR LOCAL REGIONAL TREASURER

WOMEN'S SUFFRAGE
WHAKATŪ WĀHINE
AOTEAROA • NEW ZEALAND
1893-1993



midwife, while in hospital they will see different people every day. Midwives are involved right from ante-natal care, through the birth into post-natal care."

Helen, 42 and a fifth-generation New Zealander, has elected a homebirth for her own delivery in September and will have the help and support of two of her centre colleagues.

Her interest in yoga goes back many years, but it wasn't until she came to Tauranga that she undertook any formal classes.

"There's always been a shortage of instructors in Tauranga," she said.

"Once you go to classes for a few years, you get encouraged into teaching."

As part of her year-long diploma work with the International Yoga Teachers' Association, Helen completed a research project and chose pregnancy as her topic.

She began her weekly ante-natal yoga classes at the Tauranga Yoga Centre in 1988 — that first lesson saw two pupils turn up to be instructed by Helen and a fellow teacher.

As many as 20 pregnant women at a time may attend the Wednesday morning classes at the Elizabeth St West centre, although numbers fluctuate as pupils become mothers.

"The classes aim at building strength, flexibility and stamina for labour, and eliminating and avoiding such things as backache during the pregnancy," she said.

"We assume labour positions to increase awareness of how our bodies work and I try to develop confidence so her body will guide a woman during labour. "A lot of yoga is re-education and trying to lose bad habits developed over many years. Standing, using the feet and legs correctly for proper balance, is especially important for pregnant women. Having the strength to stay upright as long as possible during labour will help ease the birth."

Helen has also completed a three-week intensive teachers' course with a pupil of the world-renowned yoga teacher, BKS Iyengar.

"We have a lot of visiting world-class instructors come to Tauranga. As a teacher, I'm always trying to pick up new ideas."

A vegetarian and a distributor for a low-dairy content range of foods, Helen personally tries to complete three two-hour yoga sessions a week, and has set herself the goal of climbing Mount Maunganui every week for the duration of her pregnancy.

She aims her ante-natal classes at a beginners' level, realising that many pupils have not previously done yoga.

"The pain or discomfort of stretching can be used to simulate the pain of labour," she said.

"Then by using the breath, especially the exhalation, we laern how to relax and let go to to release tension," she said.

"Yoga teaches a lot of discipline and mind control — the mind and body can cause a lot of pain and fear so we must learn to control them.

"Labour is surrendering to a powerful force. We can't control it, but we can learn how to respond to it."

Helen is the first to admit that yoga is no guarantee for an easy birth, but believes the mother's recovery will be faster.

She also believes it is up to women to be responsible for their own bodies and to make themselves stronger and fitter.

"Women these days are a weak bunch, and that contributes to the rise in the birth intervention rate, not all problems are medically induced," she said.

"We drive everywhere, and just don't compare to our grandmothers and great-grandmothers in terms of strength.

"One of the saddest things we have lost is the ability to squat, a position which is not part of European culture, but which undoubtedly aids birth."

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Typesetting
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Printing by
MAS Business Services Christchurch

DISCLAIMER
The articles and reports printed in this newsletter are the views of the authors and not necessarily those of the NZCOMI

NEXT NATIONAL COMMITTEE MEETING

Friday 27th August 1993

AGM to be held on Friday 27th August at 6.00pm at the TRUSTBANK COMMUNITY HOUSE 1st Floor 187 Cashel Street

and National Commitee Meeting on Saturday 28th August 9am at the Midwifery Resource Centre 1st Floor 183 Manchester Street Christchurch

Any contributions to the National Newsletter should be addressed to
Karen Barnes
142 Ilam Road
Christchurch

DEADLINE for the next Newsletter
30 August 1993

Next Newsletter due late September

Editorial

Dear Members,

Welcome to the June/July newsletter. Once again, so much has been happening for midwifery throughout New Zealand. This newsletter contains snippets of these issues.

Despite the recent adverse media coverage on midwives, it was heartening to hear at the recent National Committee meeting all the positive things happening for midwives and consumers on a regional level.

Keep the news rolling in and keep up your good work in promoting your profession in every way where you work.

This issue focuses on Midwives along with other topics of interest - some old, some new. Your views on these topics would be welcomed.

Do remember the upcoming AGM and get your remits in to your regional chariperson and into the National office by the end of July.

Enjoy your reading.

Karen Barnes

MOTHERS

Just as breast milk cannot be duplicated, neither can a mother

SALLY E SHAYWITZ

Annual General Meeting

NOTICE

Please be advised that the Annual General Meeting of the New Zealand College of Midwives will be held on

FRIDAY 27th AUGUST 1993

at 6.00pm

at the

TRUSTBANK COMMUNITY HOUSE

First Floor

187 Cashel Street

Christchurch

Please send your remits to your regional chairperson as soon as possible

Remits close 31 July 1993

HELEN PARSONS ... experienced midwife

SANDRA SIMPSON continues her series of Women's Suffrage Year profiles on local women making their mark.

HELEN Parsons has helped prepare hundreds of expectant Tauranga mothers for labour with pre-natal yoga classes and delivered hundreds of babies over her 14-year career as a midwife.

Now she's considering the whole process anew as she awaits the birth of her first child.

Born, bred and trained as a nurse in Waikato, Helen completed her midwifery training in 1978 at Royal Women's Hospital in Melbourne. She joined Tauranga Hospital the next year.

"I had been in Africa and saw that if I wanted to work there, it would be more useful if I was a midwife," she said. "But I never got back. I came home instead."

Helen, who has also worked as a home-birth midwife, joined Tauranga's first midwifery centre comprising six women working from a central city base on its opening late last year.

Despite being on call 24 hours a day, seven days a week, she is clear about the positive role of midwifery.

"It is a happy time in women's lives and it is rewarding to see healthy mothers giving birth," she said.

"Midwifery is not an aspect of nursing, but has a role all its own. I see mine as trying to be as inconspicuous as possible, but ready should I be needed.

"The involvement of support people, either friends or family, is really important.

"I have to be aware of the mother's needs, both physical and emotional."

Law changes which gave women the option of choosing an independent midwife to deliver their babies are seen as a positive step by Helen, who notes that independent midwives in Tauranga have a "good rapport" with local GPs.

"Independent midwifery allows women total continuous care with the same

Spotlight on Midwives

Midwives celebrate their day

TO CELEBRATE Midwives Day on Wednesday, city midwives will present all babies in their care with a badge and all born on the day with a certificate.

New Zealand College of Midwives regional spokesperson Andrea Gilkison says the city's five midwives are well known to parents who have chosen to have their babies at home.

Local parents are fortunate in having a number of options. Women may choose to have total midwifery care, or shared care with a GP or obstetrician. Both the GPs and midwifery services are free. They can also choose to have their baby at the Palmerston North Hospital's maternity unit, at home or to have a Domino birth which allows the woman to have her baby in hospital then go home.

Mrs Gilkison says the aim of midwives is to protect the normal process of childbirth while monitoring mother and baby for complications which may require a specialist.

Whether it's attending a normal childbirth or caring for "high risk" women requiring a higher level of technological intervention, midwives do have the expertise.

NZ COLLEGE OF MIDWIVES

A TRIBUNE ADVERTISING FEATURE

Sunday 2 May 93

FROM left: Student midwife Chris Holmes, midwife Andrea Gilkison and mother Linda Dubbeldam admire baby Lana born this week at the Palmerston North maternity unit. Andrea has supported Linda throughout her pregnancy and both she and Chris were present during delivery. Midwives usually visit a woman in her own home to monitor her and the baby, and provide information about diet, exercise and the woman's birth plans.

Remits

FOR AGM

By laws

1. That the College close its financial books on the 30th April annually and that an audited set of accounts be available for presentation at the Annual General Meeting.
2. A year's membership to the College shall be from the 01st May to the 30th April.
3. That capitation fees be paid to National Committee as subscriptions are received by the Regions excluding those paid by direct credit.
4. Capitation fees of those paying by direct credit should be paid no later than the end of the financial year.
5. That each Region forward a monthly membership update to the Board of Management.
6. That the rates of membership are:

TYPE OF MEMBERSHIP	TOTAL SUBS	AMT PAID TO REGION	AMT PAID TO NATIONAL
Full : Self employed Midwife	$255.00	$40.00	$215.00
Employed Midwife	$155.00	$40.00	$115.00
Unwaged Midwife or Student	$ 50.00	$15.00	$ 35.00
Associate/Affiliate	$ 30.00	$ 5.00	$ 25.00
Associate with Indemnity	$155.00	$40.00	$115.00

Remit:

Constitutional

RIGHTS AND RESPONSIBILITIES OF MEMBERS

7.7.4 Midwife members have a responsibility to practice in accordance with the standards and Code of Ethics set by the New Zealand College of Midwives.

Remit :

That the Domiciliary Midwives Society of New Zealand be represented at National Committee meetings of the New Zealand College of Midwives.

Rationale:

The Domiciliary Midwives Society was founded in 1982 to represent the interests of midwives attending home births and as such, defended and promoted the Midwifery model of care.

Many midwives currently practicing independently are or have been members of the DMS. The DMS is affiliated to the NZCOM (Inc) and would like to have its views represented at National Committee level where it would be able to maintain a link with the roots of the midwifery movement in New Zealand. The DMS would fund the attendance of its representative to National Committee meetings.

INFORMATION

INFECTIOUS DISEASES NOTIFIABLE TO MEDICAL OFFICER OF HEALTH

1. **"Neonatal Infection"** - Any infant who within 14 days or whilst in a maternity hospital exhibits one of the following:

(a) Congenital Rubella
(b) Congential Syphyllis
(c) Eye Infection Gonococcus
(d) Gastro-Enteritis
(e) Listeriosis
(f) Meningo Encephalitis
(g) Septicaemia
(h) Staphylococcus Skin Infection
(i) Streptococcal Infections Group A & B
(j) Toxoplasmosis

2. **"Peurperal Infection"** - Any woman who within 14 days of childbirth or abortion or whilst in a maternity hospital, has a temperature of 38°C or over or who has any infection either generalised or local arising from the genital tract or breasts.

You can notify these to your local district office

Breastfeeding reduces ear infections by half

Breastfeeding can cut the risk of infant ear infections in half, according to a study of over 1000 infants conducted in the US.

Infants fed only breast milk for the first four months of life suffered only half as many severe or recurrent middle ear infections during their first year of life as infants who were never breastfed.

Exclusively breastfed babies had 40 per cent fewer infections than infants who were breastfed but also were fed other foods before they were four months old.

"Four months is good and six months is even better, with a 60 per cent reduction in ear infection risk," said Dr John Ev, a paediatrician in the study team.

Antibodies in breast milk make it more difficult for the bacteria to attach to the linings of the throat and Eustachian tubes

The researchers are unsure why breastfeeding protects against infection but there are indications that both the action of breastfeeding and the content of breast milk may play a role.

Antibodies found in breast milk make it more difficult for the two most common bacterial culprits in middle ear infections *Streptococcus pneumoniae* and *Haemophilus influenzae* to attach to the linings of the throat and Eustachian tubes, said Dr Ev, associate professor of paediatrics at the University of Arizona.

When babies are breastfed, it's also less likely that fluid will enter the Eustachian tubes, where it may cause irritation and inflammation.

"Babies tend to nurse in an upright position, because that's the most natural and comfortable," he said. Bottle feeding a baby while it is lying down by propping up a bottle in the baby's cot may encourage fluid back up.

Middle ear infections are one of the most common childhood illnesses in the US, with two out of three infants suffering at least one ear infection during the fist year of life.

The study, which appears in the May issue of *Pediatrics*, bolsters the recommendation of the American Academy of Pediatrics that women exclusively breastfeed for the first four to six months of life.

In the US only half of all mothers attempt to breastfeed. By four months of age only one in four infants is still nursing and fewer than one in six is exclusively breastfed. *MTNS*

NZ Doctor Article 10 June 1993

An insight into the workings of the medical discipline. There was no call for Guidelines for doctors however but a very public call for midwife monitoring.

Reprinted from NZ Medical Journal

Medical Practitioner's Disciplinary Committee: Inadequate antenatal management

A general practitioner and a specialist obstetrician have been found guilty by the Medical Practitioners Disciplinary Committee of conduct unbecoming a practitioner for their inadequate predelivery management of a woman who subsequently died after developing eclampsia.

The patient had been under the care of her general practitioner at the time her first child was born in February 1988. Following the birth of that child there were complications and the baby was transferred to the nearby base hospital with the patient being admitted as a boarder mother. While in hospital she developed post partum toxaemia but the general practitioner received no information about this event.

In 1991 she became pregnant again, and this pregnancy was uneventful until mid-August. At that time her blood pressure showed some increase and on 27 August 1991 her general practitioner noted mild facial oedema, BP of 130/100 mmHg and protein in the urine, a trace to 1+. He referred the patient to a specialist obstetrician and gynaecologist in the same medical centre. Initially the general practitioner spoke in person with the specialist and told him that she had a trace of protein in the urine. In his referral, he mentioned a trace to a +. The specialist was unaware of her past history, although he was told that she had high blood pressure during her first pregnancy. He measured her blood pressure at 140/90 mmHg but was confident that baby and mother were well. He wrote to the general practitioner noting that the patient should be watched carefully and that she should have her blood pressure checked three days later with the possibility of a repeat scan the following week. In fact she returned to her general practitioner two days later on Thursday 29 August. At that stage her BP was 130/90 mmHg and had between a trace and 1+ of protein in her urine. He considered that her toxaemia was settling and that he should not see her again until Tuesday 3 September, ie, in 5 days time. No arrangements were made for monitoring in the intervening period. Late on 2 September the patient was admitted to hospital experiencing severe upper abdominal pain. On admission blood pressure was measured at 240/110 mmHg. She had a fit soon after arrival and both the general practitioner and the specialist were summoned and an emergency caesarean section was carried out. Despite treatment in the intensive care unit of the hospital and later the nearby base hospital she did not recover from her eclampsia and the complications of her toxaemia worsened to an extent that she died on Monday 9 September 1991.

The committee found that the general practitioner knew that the patient's blood pressure had been elevated but settled during her first pregnancy. The committee considered that the general practitioner failed to interrogate the patient sufficiently to ascertain the significance of that previous blood pressure rise and as a consequence failed to incorporate that fact into the management of her second pregnancy. After her referral because of the rise in her blood pressure, facial oedema and proteinuria, he failed to adequately follow her up with close monitoring of both blood pressure and proteinuria. The committee did not accept that the general practitioner had handed total management of the patient to the specialist obstetrician as there clearly was a continuing obligation upon him to closely monitor and watch his patient's progress. The committee concluded that the general practitioner had a professional responsibility to either monitor the patient himself or arrange for hospital staff to do this for him. To leave her unmonitored for a period of 5 days was unacceptable and a serious error. With regards to the specialist the committee noted that the patient was referred to him with a rise in blood pressure proteinuria and facial oedema. Although he obtained the history of a rise in blood pressure during her first pregnancy this was not in the committee's opinion explored sufficiently. The committee also concluded that the specialist's report back to the general practitioner contained insufficient instruction for adequate monitoring. The committee concluded that a specialist of his standing should have ensured that this patient who was very much at risk was accurately and frequently monitored. The committee considered that his instructions to the general practitioner should have been specific given that he correctly noted that "we shall have to watch things carefully". At the very least he should have instructed the general practitioner to see the patient at intervals not exceeding three days. The committee considered these shortcomings on the part of the specialist fell into the category of conduct unbecoming a practitioner. Both doctors were directed to pay a penalty of $400, to contribute $5000 each towards the cost and expenses of and incidental to the enquiry. The committee directed that the secretary cause a notice stating the effect of this order to be published in the New Zealand Medical Journal without disclosure of the names either of the patient or the medical practitioners involved.

National Co-ordinator's Forum

It's official - Midwifery is a partnership with women! At the ICM Congress in Vancouver in May, the New Zealand position statement published in our last newsletter was endorsed by the ICM Council. The accompanying constitutional changes which would have made consumer involvement more accessible within ICM however were not accepted. Sally Pairman and myself are not disheartened by this as we see the public declaration of the midwifery partnership as a giant step forward for world midwifery.

Recognising the women centred philosophy that is so important to achieving healthy womenhood would not have been possible three years ago, such was the depressed/oppressed and sublimated state of many of the world's midwives. To have come this far in three years is an indication of midwifery's uphill recovery process and one which makes the heart sing! Attending and participating as New Zealand delegates in the Vancouver Conference was also a wonderful affirmation of New Zealand Midwifery and our chart busting progress. The world's midwives not only showed their appreciation of our partnership model but held it out as one to aspire to for women and midwives in their own lands. I was particularly elated when, after presenting my paper, I was approached by several African midwives who said the partnership model was one they saw working for them also.

It is gratifying that the Midwifery philosophy of equality and knowledge sharing is transferrable across cultures. There were some western countries however which still exhibit a very medicalised view of Midwifery and it was distressing to hear these comparatively priviledged countries and their midwives concentrating on gaining acceptance by other professions (medical and nursing) rather than developing midwifery's unique identity.

It was very exciting to be part of Canada's victory legislation announced by their (woman) Minister of Health during the opening of Conference, making midwifery legal in Canada. The Canadian midwives also operate on a very consumer oriented partnership and it was because of this that they were able to succeed in changing the law. Their midwifery model and direction is very similar to ours (in fact Joan Donley was one of their International Consultants involved in their direct entry curricular development).

It is significant, I believe, that when a country sets out to develop a midwifery profession from scratch and after consulting with all countries and professions, it chooses independent practice, direct entry education and consumer partnership at all levels of development.

Other exciting outcomes were the endorsement of strong position statements on intervention in childbirth, home birth, indigenious women and anti war. (We hope to publish these in the next issue of the Journal together with a fuller report of the two weeks Congress and Conference).

Internationally, midwives have started to accept the necessity of being political. What an affirmation for New Zealand Midwives as forerunners in the politicalisation and emancipation of midwives and women. We were further supported by my re-election as the ICM Representative to the United Nations Bangkok Office.

Sally and I were pleased to have formal (if over breakfast can be viewed as such) talks with the American College of Nurse-Midwives and have set up the process of on-going liaison between our two Colleges. Together with them and the Australian College we also discussed ways in which our respective countries could sponsor developing countries in our areas to achieve safer motherhood by the promotion of midwifery and midwives.

There were 18 New Zealand Midwives at the Conference, seven of whom presented papers - not a bad effort for a fledging organisation. A copy of the proceedings is at the Midwifery Resource Centre (all four volumes and 9kgs of them!). Write to us with a stamped addressed envelope for a copy of the summary of papers.

Incidently, after the conference, I went on to Africa to visit my new grandson and his parents and was privileged to be a visitor at the Harare Maternity Unit. To view the overcrowding, the Aids epidemic, the poverty, the maternal and perinatal mortality and morbidity experienced by these black women and their midwives brings our "problems" into humble perspective. As midwives in New Zealand battle often against each other, over money, position and status, these midwives must attend up to 100 women giving birth in **one shift** with minimal equipment and in a frighteningly overcrowded environment. They do it with dignity and skills which most of us are not required to exhibit in a lifetime of experience.

NZ HERALD 20/04/93

Doctors worried by midwife 'grey area'

By KAREN HOLDOM, health reporter

A "dangerous grey area" between the work of independent midwives and doctors is still putting mothers and babies at risk, says the chairman of the medical practitioners disciplinary committee, Dr Dean Williams.

The committee is an arm of the Medical Council.

Dr Williams says in its latest annual report that protocols must be urgently drawn up defining when a doctor should be called to a difficult birth.

"It is not acceptable for professional jealousies and differences of opinion to put anybody at risk," he said from Hamilton last night.

He referred to a case last year in which differences of opinion between a doctor and an independent midwife led to crucial delays in a difficult childbirth.

The baby was born brain-damaged.

Dr Williams said the grey area between the work of the midwives and doctors needed to be addressed "before further serious calamities occur."

"As the doctor is almost always the one who is called in to pick up the pieces, it is very much in the interests of the profession to ensure the proper handover rules are determined and applied.

"This will not only ensure the welfare of the patient but protect the doctors from very difficult situations."

Dr Williams' annual report has been printed in the latest issue of the *New Zealand Medical Journal*.

In it he notes the concerns of the committee at the number of complaints it gets relating to either a slow response or lack of response to signs of foetal distress.

"This committee encourages all personnel conducting obstetric care to draw up and to agree on standards of care which are known and accepted to be safe and to be in the best interests of both mother and unborn child."

Dr Williams said part of his duty as chairman of the committee was like that of a coroner — to remind professionals and the public of dangers and difficulties.

"When you see people not taking sufficient notice of a baby in foetal distress you need to remind people that this is urgent.

"It is no use having someone sitting on their thumbs. We are really reminding the profession that it needs to get its act together."

In his report Dr Williams said the committee had received a total of 258 written complaints in 1991.

Inquiries into 239 complaints were completed, compared to 229 in 1990, and formal inquiries were held into 17 complaints (20 in 1990).

More than half of the complaints (54 per cent) related to general practitioners, with 45 per cent related to consultants. One per cent related to resident medical officers and registrars.

Psychiatrists, orthopaedic surgeons, general surgeons and obstetricians and gynaecologists were the principal targets of complaints.

Accident and emergency clinics have been "over-represented" in the number of complaints against them, Dr Williams reported.

"It would appear to some extent at least that public expectation of these clinics is often higher than the clinics are able, or perhaps willing, to supply.

"In many cases continuity of care appears to be absent, and this often leads to insecurity and anger in the patients."

He noted that there had been an increase in complaints from provincial centres and rural areas.

This suggested that patients in those areas now had a higher expectation of their medical advisers and less confidence in their doctor's judgment. Those trends had been evident for some years in the main centres.

The grounds for complaint in 41 per cent of cases related not to clinical management but to how a doctor's practice operated, while 17 per cent of complaints related to inappropriate treatment.

June 24, 1993 PRESS 26/6/93

Midwives

Sir,—I am astonished to learn that public funding of maternity services can be misused to the degree that midwives can earn up to $200,000 a year for providing private care. It is obviously untrue that midwives provide nursing services within the hospitals and so reduce costs. All maternity hospitals have to be staffed by midwives to look after their patients. I suspect that the ward staff would be happier to be left alone to get on with the job they are trained to do. The introduction of the private midwife scheme was the brainchild of Helen Clark. It is an expensive way to prove a political point.—Yours, etc.,

DAVID DUMERGUE.
June 25, 1993.

Sir,—In reply to D. Dumergue (June 26), some reality needs to be injected into this issue. I am a self-employed midwife who provides care for women from pre-conception to six weeks post-birth. I get $20 a visit for ante-natal and post-natal care, ranging from visits of half an hour to one and a half hours. I do get paid $70 a half-hour for care during labour. An average length of time at a birth is six hours. I do not get paid for pre-conceptual care, telephone consultations and care between two and six weeks. My service is 24 hours a day, seven days a week and I work an average of 70 hours a week. I have four years intensive education and update my knowledge and skills constantly. My taxable income for 1992-1993 was $39,000. It is time to recognise this fiasco for what it is — a gender issue. Doctors, lawyers, accountants and plumbers can all earn $200,000 a year and nobody questions it. A highly skilled, woman-dominated profession with the potential to earn $200,000 a year? Now, that is questionable. By the way, what is the value of life?—Yours, etc.,

JULIE RICHARDS.
June 29, 1993.

~~Press~~ 1/7/93

Midwives' pay

Sir,—Private midwives a misuse of public funding? Definitely not. David Dumergue (June 26), perhaps blinded by the figure of $200,000 (which, incidentally, is not what the majority of midwives earn), seems to be missing some valid points. Private midwives were not introduced to score political points nor solely for cost-effectiveness. The scheme provides women a choice about their and their baby's care during and after pregnancy and labour — the existing system was failing some women. Private midwives provide a continuity of care which is extremely important — a constant presence of a familiar person in whom there is confidence. Payment for private midwives includes recompense for ante-natal and post-natal visits as well as for the labour. No comparisons can be made with hospital midwives until the costs of GP ante-natal visits, district midwife post-natal visits and costs of maternity hospital equipment, etc., are included. Having experienced both services, I know funding for private midwives is well spent.—Yours, etc.,

KAREN KENNEDY.
June 27, 1993.

Sir,—With reference to the current debate on the cost of midwifery services, has anyone thought to ask why, within 2½ years of such a service becoming legal, about 25 per cent of women in childbirth are choosing their own midwife to care for them? Could it have anything to do with midwives' commitment to non-interventionist childbirth? Midwifery-only care is legally permitted only for "normal childbirth". Think of the savings to the health system of non-interventionist childbirth. According to the Core Health Service Report (1992) intervention in childbirth cost $55,388,687 for the year ending June 1991! The financial incentive for midwives to facilitate "normal childbirth" must be to the benefit of both women and taxpayers.—Yours, etc.,

CHRIS HENDRY.
June 26, 1993.

Midwives' pay

Sir,—Spurred by greater free choice, growing numbers of women are opting for midwives when birthing. Given the fact that most women can dictate their manner of care, the recent anti-midwife sentiment is quite alarming. This apparently orchestrated campaign against cash-rich midwives is ill-conceived and ill-informed. The six members of the Independent Midwives Practice in Christchurch share no such alleged wealth. On average, we earnt $13,600 last year, from which we paid income tax, ACC and overheads, with no paid annual leave or sick pay. We looked after 290 women — some before, during or until two weeks post-delivery. We are on call 24 hours a day, seven days a week, providing a quality service for women and their families. We do not believe this is a misuse of the maternity benefit, but taxpapers' money well spent for a quality service.—Yours, etc.,

NORMA CAMPBELL.
JEANNIE MATHEWS.
KAREN BARNES.
CAROL BARTLE.
LINDA COLLIER.
BRIGID MIERAS.
June 30, 1993.
CHCH PRESS

Mt Roskill. AUCKLAND

Nice earner

Sir,—It was with amazement that I read L. Beynon's letter stating that independent midwives receive $69.80 a half hour at a delivery, and that this is taxpayer funded.

This hourly rate would fund, for example, seven emergency room nurses, or six emergency room doctors, or three qualified surgeons in a public hospital.

While it is manifestly a nice little earner for midwives, I must agree with your correspondent that it is not an efficient use of the health dollar.

A. Montgomery.

Which brings me back to our current battles. I hope reading the above brings you back to earth as it did me. All problems are relative however and New Zealand women and midwives expectations must also be met. Neither of course, should it detract from the success we enjoy as an egalatarian society.

The College is presently arranging to meet with the Nurses Organisation to discuss the upcoming pay negotiations for hospital employed midwives. There are positive signs in several areas that continuity of care will attract higher salaries for the midwives involved. This is, as expected, a flow on effect from the successful pay equity for self employed midwives. We hope together with NZNO to expand this further. (Any suggestions/ideas, please contact us.)

We understand the Medical Association will still not take part in any discussions with the Health Department (Ministry it is now) and ourselves over the interpretation of the Maternity Benefit Schedule until there is a review of the Minister's decision. This means self employed midwives will continue to be paid out on the old schedule until someone makes a decision to either open up the Dept of Health report on the Tribunal for submissions yet again or a judicial review is taken by the NZMA. The doctors are still calling for a 26% increase and a return of the prolonged attendance fee. It makes me wonder why midwives were singled out by the media while the NZMA maintain such a position in today's economic climate.

August is AGM time - any remits or topics for discussion, please forward to your regional chairperson before 21st July.

BIRTH REGISTERS

Available from the Wellington Region, P O Box 9600
Cost $17.50 (incl $2.50 P&P)

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

Register of Cases (Personal)

Midwife : ______________________________

Practicing Cert No : ______________________________

Address : ______________________________

From the Treasury

TRIBUNAL EXPENSES UPDATE

Average donation received per head per region as at the 26 June 1993.

Region	Amount
Northland	$80.90
Auckland	$24.92
Waikato/BOP	$22.58
Eastern/Central	$18.44
Wanganui/Taranaki	$ 9.70
Wellington	$21.66
Nelson	$35.71
Canterbury/West Coast	$59.74
Otago	$49.21
Southland	$15.75
National Average	$30.50

A big THANK YOU to those of you who have made a donation towards helping meet this expense.

SUBSCRIPTIONS NOW OVERDUE

You should have renewed your subscription for this financial year on 1st May. Check with your Regional Treasurer to make sure you are up to date as this will be the last newsletter you receive unless your subscription has been paid. Also remember, you will not be covered for Indemnity Insurance if you have not paid your sub!

Letters to the Editor

"Last time I can check that throat for you, I'm afraid. I start training as a midwife next Monday."

Midwives' pay

Sir,—A midwife diagnoses, investigates, prescribes, monitors, observes, educates, advises and supports women and their families during pregnancy, childbirth and early parenting. She is also required to act on her knowledge. She resuscitates and stabilises babies who are slow to life and prevents women succumbing to the occasionally life-threatening birth process. A women using the services of her own midwife is less likely to have a forceps or caesarian delivery, fewer episiotomies, less need of pain-relieving drugs; she has bigger babies, fewer premature babies and breastfeeds more successfully. Does David Dumergue (June 26) not think this 24-hour health service is worth at least as much as a pet's veterinary service, a defendant's criminal defence lawyer, a family court psychology service, a real estate agent's commission or a drainlayer's after-hour fix-it service? However, when taken over the 10-month time frame midwives work within, none reaches the hourly income possible in the above examples.—Yours, etc.,

KAREN GUILLILAND.
June 30, 1993.

Independent midwives — against and for

Sir.—Those in favour of independent midwives trot out the old adage of continuity of care. This so-called continuity lasts until the baby is delivered — thereafter all care is given by hospital-based midwives save for about half an hour to one and a half hours daily when the "independent midwife" visits her client.

On discharge the client is visited daily for however long the independent midwife deems it necessary, at $20 a visit and $1.60 a kilometre.

Having had all my children in hospital and received excellent care and teaching with all three, I do not think the independent option is at all cost-effective.

It is not at all surprising that obstetric units are short of staff. Independent midwifery is obviously an extremely lucrative business.

Pamela O'Brien.
Papakura.

Sir,—Responding to "Independent midwives fine — at a price," it is disappointing to read, in this year of women's suffrage, of the scorn towards independent midwives.

Women have fought hard for a service that provides continuity of care for themselves and babies. We welcome the taxpayers' money to enable this choice.

Statistics prove that women have less intervention during childbirth and spend a shorter time in hospital attended by an independent midwife.

This makes considerable savings on our health service; more if a home birth is chosen.

For the money the independent midwife receives she is on call seven days a week, 24 hours a day with no annual leave or sick pay included. Tax, GST and overheads are deducted from this amount

The hospital midwives provide different midwifery care and are given an inadequate salary for this which includes annual leave and sick pay.

They work a rostered eight-hour shift, five days a week with no interruption to family life.

All midwives can become independent practitioners if it is such a lucrative source of income. We have not noticed midwives leaving in droves to do this very demanding but satisfying job.

Carolyn Fitch,
Rotorua Independent
Midwives United.

27.5.93

The following is a small selection of media response

Midwives 1, doctors 0

The National Government may have scrapped Labour's pay equity laws, under which women stood to get the same pay as men for work deemed to be of equal value, but one group of female workers seems likely to achieve that goal anyway. The Maternity Benefits Tribunal supported by the Health Department, has recommended that midwives should be paid the same as doctors for attending women during pregnancy and childbirth.

The Medical Association, ever vigilant in defending doctors' monopoly privileges, had argued that general practitioners were capable of dealing with complications and should accordingly be paid a higher fee. By focusing on the risk factor in pregnancy, the doctors sought to establish their indispensability. But the vast majority of pregnancies proceed normally, and are well within the competence of a qualified midwife. In fact a doctor admitted to the tribunal that he could not deliver a baby without the assistance of a midwife. Does the reverse apply?

The College of Midwives argued that midwives were skilled at detecting abnormalities and could call for specialist help if necessary. In normal circumstances, however, they provided the same outcome as doctors - a safe pregnancy and birth. The tribunal accepted the proposition that midwives should therefore receive the same payment. That finding will be applauded, especially by the increasing number of women who exercise the option - available since 1990 - of being cared for through pregnancy by a midwife rather than the traditional GP.

THE ONLY MEDIA ARTICLE TO UNDERSTAND THE EQUITY ISSUE?

EVENING POST
Thurs Apr 24, 1993

Salary publicity criticised

Publicity about how much midwives earn suggests that midwives, unlike doctors, are not entitled to high salaries, a spokeswoman for midwives in the Nelson region says.

Bronwen Pelvin, of the College of Midwives, asked why income details of the five highest-paid midwives had been targeted in the Health Department release.

Her comments came after figures were released showing this group earned more than $200,000 in the 10 months to the end of April.

The figure showed midwives claimed an average of $2000 a birth in maternity benefit claims, compared with doctors claims of an average of $1200 a birth. Ms Pelvin said midwives were being picked on in the release. "Is it that, somehow, midwives are not entitled to be earning big salaries?"

However, department spokesman, Peter Abernathy said the department had not initiated the release itself. It was prompted by a journalist's official information request.

Similar public information had been given on general practitioners claims, he said.

Ms Pelvin said the 14 midwives who worked in the Nelson region earned between $40,000 and $80,000 a year for their services.

"There is nobody in the Nelson region who would be making anywhere near $200,000," she said.

She wondered why income levels for top earners in other medical fields had not been publicised.

NELSON EVENING MAIL 29 June 1993

Ever wonder how your subscription is spent? Where does it go? What do you get for your money?

The following is an approximation of where your money goes.

Item	Amount
To Region for local running costs	$ 40.00
Indemnity Insurance & Administration	$ 17.00
Journals	$ 10.00
Newsletters	$ 8.00
Rent - Midwifery Resource Centre	$ 2.50
Co-ordinator's Salary/PAYE/ACC	$ 40.00
Typing/Secretarial Support	$ 10.00
Accountant/Treasurer for keeping financial books	$ 2.10
Postage	$ 1.30
Phone Calls/Tolls	$ 2.50
Airfares/Travel (National Committee)	$ 5.00
International Confederation of Midwives Capitation	$ 3.20
International Representation at Congresses	$ 2.00
Postal Box Rental	$ .15
Subs and Affiliations	$ 1.00
General Expenses/Library Resources	$ 2.00
Workshops/Seminars	$ 1.00
Telecommunication Equipment	$ 1.25
Computer Equipment/Software for National Statistic Data/Research	$ 5.00
	$155.00

Have you purchased your copy of the

NZCOM Breast Feeding Handbook $19.95 or $22.00 incl P&P
NZCOM Standards for Practice Handbook $5.00

Both these books are available from your Regional Committee or from the Board of Management, P O Box 21-106, Christchurch

What does the College do for You?

It provides :

- A Midwifery focus and voice
- National cohesion and a contact point for both women and midwives
- National and regional input and monitoring of midwifery educational curricular through
    - Polytechnics
    - Universities
    - NZ Qualifications Authority
    - Nursing Council of NZ
- Post graduate midwifery update and reskilling courses
- Accreditation of post graduate courses
- Research development
- Promotion and development of
    - Standards of Practice, Education and Service
    - Code of Ethics
    - Guidelines for Practice
- Monitoring of Standards of Practice through Midwifery Standards Review Committees
- Accreditation of Midwife practitioners
- Data collection and interpretation of Midwifery services, trends and statistics
- Liaison and consultation with women's health and consumer bodies
- Representation on statutory committees
    - ACC
    - Nursing Council of NZ
    - Maternal Mortality Research Committee
- Consultation to Government Ministries
    - Health
    - Women's Affairs
    - Social Welfare
- Regional and National consultation and input into health policy
    - Regional Health Authorities
    - Ministry of Health
    - Crown Health Enterprises
- Liaison with Health Authorities in developing priorities in maternity services

Chch Press 08/07/93

Doctors plan fight over maternity fees

PA Auckland

Doctors are preparing to take court action to fight maternity services fees set by the Minister of Health, Mr Birch.

The chairman of the Medical Association, Dr Alister Scott, says the association has written warning the minister that if it does not hear from him today it will seek a judicial review of his decision.

Mr Birch announced a 10 per cent increase in the fees at the end of May.

His decision angered doctors, who felt it disregarded the findings of an independent Maternity Benefits Tribunal set up to review the fees.

The tribunal in January recommended that maternity fees should be increased 26 per cent.

The Health Department said this was excessive and recommended a 10 per cent increase.

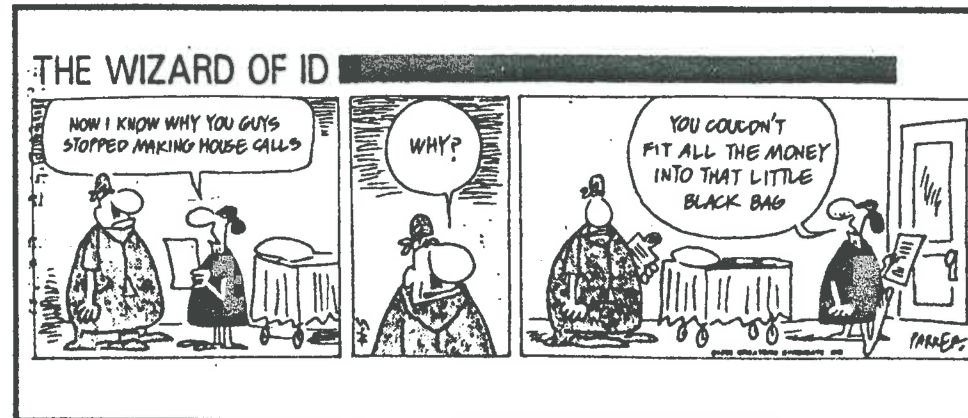
One of the key changes in the new fee schedule is the abolition of a $139.60 an hour fee traditionally paid to general practitioners for prolonged attendance at birth.

Since a 1990 law change that allowed independent midwives to handle uncomplicated deliveries without a doctor present, midwives have been claiming the "prolonged attendance" allowance when they stay with a mother throughout the labour.

As a result, a small number of midwives have earned as much as $200,000 a year in maternity fees. Mr Birch replaced this fee with a new "conduct of labour" fee of $90.80 an hour.

Dr Scott said the new schedule introduced a number of anomalies and "quite perverse" incentives for practitioners.

"Doctors will see that the only way they can continue in providing maternity care economically is by linking their own services with those of midwives, because the schedules allow both midwives and doctors to claim."



Here's what the Minister had to say last year . . . . .

THE OFFICE OF THE
Minister of Health

12 June 1992

Dear Karen Guilliland

Thank you for your letter of 25 May 1992 in which you express your concern over the public nature of the debate over maternity services, and the lack of progress on the maternity benefit negotiations.

I certainly appreciate the restraint which the NZ College of Midwives have shown in avoiding "negotiation by media". I understand that you have discussed this with David Curry of the Department of Health and that he has explained to you that the delay in recent times has resulted from our attempts to establish tripartite discussions.

Having been unsuccessful in establishing agreement to tripartite discussions we are now at a stage where separate negotiations between the Department and the NZ Medical Association, and the Department and the NZ College of Midwives have been proposed. I am advised that Mr Curry has very recently written to you to suggest a meeting framework and a date on the same basis as a proposed meeting with the NZ Medical Association.

I hope that these discussions will in fact take place, but in the event that they do not proceed I will establish a Tribunal to consider representations from all three parties.

Thank you again for your letter. I appreciate the points you make in relation to childbirth options and the responsible way in which the College has handled the sensitive issue of benefit negotiations.

Yours sincerely

Simon Upton
Minister of Health

PARLIAMENT HOUSE, WELLINGTON, NEW ZEALAND PH 4719 - 97?

- Service Provider Specification
- Submissions on current issues related to maternity services
- Individual and collective advice and referral mechanisms for midwives and consumers on health related and employment issues
- Individual and collective advice on contracts for service
- Fee negotiation for the Maternity Benefits Schedule
- Liaison with the NZ Nurses Organisation on wages and conditions of employment for employed midwives
- Advise and consultation on the development of continuity of care and midwifery practice under the WHO definition of the midwife for midwives and midwife managers
- Indemnity Insurance, advice and administration
- Midwifery representation at Nursing Council, Midwifery practice enquiries and reviews for both employed and self employed midwives
- Publication of newsletters and journals
- Library and reference resources
- Media promotion and marketing
- Membership to the International Confederation of Midwives
- International recognition and consultation
  - World Health Organisation
  - Representation at United Nations
  - Other Midwifery Organisations
  - International Consumer Organisations

NOTICE FOR SELF EMPLOYED MIDWIVES

At the last National Committee meeting the financial position and priorities of the College were discussed at length. The expectations from Government, Regional Health Authorities and Crown Health Enterprises in relation to self employed midwives have become overwhelming. The workload this has generated for the College has far exceeded the income originally budgeted for and the personnel ability to manage.

The subscription fee to the College was estimated as adequate and fair when based on the work required prior to contracting and the incomes of employed midwives.

Employed midwives are required to belong to NZNO for their industrial representation and pay over $200 for this service. As the College provides the industrial service for self employed midwives, the National Committee proposes there be a fee attached to this service over and above the subscription for hospital employed midwives. This would require acceptance at the AGM and would not come into force until the start of the next financial year in May 1994.

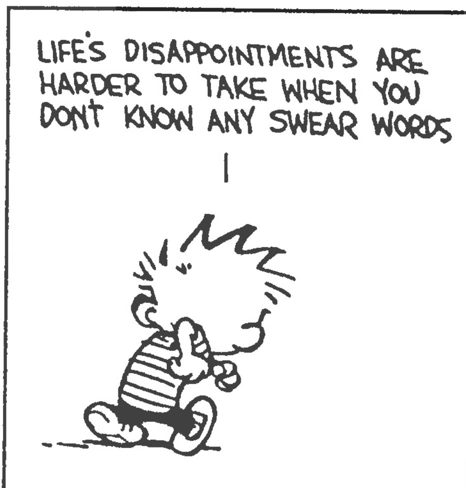
Unfortunately the College faces the probability of further substantial expenditure in the ongoing negotiation of the Maternity Benefit Schedule this year and cannot sustain this on the present subscription and service all the other requirements of the College.

This notice is a respectful request for the payment of a $100 levy from every self employed midwife which will cover this financial year. The National Committee acknowledges and is grateful for the generous response of midwives to the Tribunal expenses and appreciates it is asking for another committment from its members.

The $100 levy can be paid to **The Treasurer, Board of Management, NZCOMI, P O Box 21-106, Christchurch**

Media Watch

In their apparently organised anti-midwife campaign over the last year or so, the NZMA seems to have "forgotten" the reason Midwives continue to be paid on the current Maternity Benefit Schedule, namely the NZMA always refused to discuss or negotiate more appropriate ways of changing the schedule for maternity services. The Media ignores this and talks about "failure to reach an agreement" - you can't agree if one party never comes to the meeting! The NZMA demanded a Tribunal because they thought their legal capacity to remove Midwives from "their" schedule was superior. Unfortunately for them even a QC can only work within the facts and the College's non-legal but infinitely grounded Midwifery representation proved to the Tribunal the equity of Midwives service. It is disappointing in the extreme that the populist media continue to deride midwives for the same earning capacity doctors enjoy. Perhaps even in Suffrage Year New Zealanders have not internalised the right to equal status for women? Or is it that the power brokers are determined to quash midwives success in case their "little women" get ideas above their situation?



How else do the NZMA get away with taking the Minister's decision to judicial review demanding a return of **their** $140 per hour and a 26% increase to the rest without a murmur from the Press?

It is extremely disappointing.

Book Review

Positive comments from one who knows!

PROTECTING, PROMOTING AND SUPPORTING BREASTFEEDING : the Handbook of the NZ College of Midwives Inc, Dunedin 1992.

An excellent low-cost manual with some excellent pictures and diagrams. I am not sure of the basis of the advice to discard breastmilk expressed when a mother has a fungal infection, as Breastmilk has anti-candidal activity. And I think a brief outline of the significance of autocrine control is needed in the next edition. However, I can happily recommend this text.

Congratulations to the Committee which put so much effort into it. Available from NZCOMI Breastfeeding Committee, P O Box 21-106, Christchurch, New Zealand.

- Maureen Minchin -
Author *"Breastfeeding Matters"* and Breastfeeding Activist

BOOKS FOR MIDWIVES : Revised Edition 1993. A classified survey of the entire range of available books applicable to Midwifery. This catalogue of available books is supported by the Royal College of Midwives.

A copy is available as a reference in the Midwifery Resource Centre or your own copy could be bought from Books for Midwives Press, Downs Court, 29 The Downs, Altrincham, Cheshire, England WA14 2QD
Phone 061-929-0190
Fax 061-941-6124

PERINEAL REPAIR BOOK - Australian College of Midwives. This book was advertised in our last newsletter. Please note, ***PAYMENT IS REQUIRED IN AUSTRALIAN DOLLARS*** (A$25)

STOP PRESS

On July 1st an amdendment was made to the Social Security Act enabling Midwives to complete medical certificates relating to pregnancy and childbirth for sickness benefit purposes.

The following instructions have been sent to all Income Support Service District offices

5. *Section 56(1) - Medical Certificates For Sickness Benefit Due To Pregnancy May Be Signed By Midwives*

5.1 Recent changes to the Nurses Act recognise midwives as independent practitioners. A midwife with a current practicing certificate will have the authority to provide certification of pregnancy for Sickness Benefit applications. A list of registered midwives with current practicing certificate is held by SCOPE.

5.2 Medical certificates signed by registered midwives confirming pregnancy at 28 weeks, or identifying complications with the pregnancy prior to 28 weeks, are to be accepted for Sickness Benefit.

5.3 Medical certificates signed by registered midwives for conditions other than those relating to pregnancy and child birth, are **not** to be accepted. The reverse side of the Sickness Benefit medical certificate will be amended to include reference to registered midwives being able to complete medical certificates.

MIDWIVES AND YELLOW PAGES

After correspondence with Telecom Directories, there will be a "MIDWIFE" classification available in all directories from 1994

PRESCRIPTION PADS

Midwife Prescription Pads are available at $5 each
Each pad contains 50 sheets
Contact your regional chairperson to order these

Section 51 : Advice Notice

- Julie Richards

Under Section 51 of the Health & Disability Services Act 1993 RHAs must inform practitioners who claim any benefit on behalf of their patients/clients of any change to the claiming process.

By now all midwives who have made a claim from the maternity benefit should have received a document from your RHGA titled "Advice Notice to Practitioners Providing Maternity Services"

If you have not received a copy and have been claiming from the maternity benefit or are to commence claiming from the maternity benefit, notify your RHA who will forward a copy to you.

This Avdice Notice is to inform all practitioners who make claims from the maternity benefit that RHAs have now taken over the maternity benefit schedule. The terms and conditions for provision and payment of services is detailed in this document.

The goal of the Advice Notice is to reiterate the present situation for at least nine months and give RHAs and practitioners time to establish contracts.

The College worked extensively on this document with RHAs over a very tight time frame. During negotiations many changes were made to the document in order for it to accurately reflect the present situation.

You will be aware that the Appendix I "Schedule of Fees for Maternity Services in Relation to Maternity Benefits" is the present schedule and not the revised schedule as per the MOH's recent decision. As this Advice Noitice is related to the terms and conditions as of the 1st July 1993, when the new schedule of fees is to commence a further Advice Notice will be sent out with the new schedule of fees.

We are aware that it is an extensive document that may require further explanation. If you have any queries please contact your regional chairperson.

Remits from the 1993 National Conference of the Home Birth Associations' of Aotearoa

To the Minister of Social Welfare & Opposition Spokesperson on Social welfare, The Minister of Health & Opposition Spokesperson on Health, The Public Health Commission & The Regional Health Authorities.

1) The Home Birth Associations' of Aotearoa oppose the governments suggested proposal to withhold Family Support payments from parents who do not immunise their children.
We feel this is an invasion of their parental rights. It also incorrectly assumes that all parents who do not immunise do so as a result of lack of information or concern, when in reality this is frequently an informed choice.

To the Minister of Health & Opposition Spokesperson on Health, The Public Health Commission & The Regional Health Authorities.

2) Due to the favorable outcomes of Home Births, The Home Birth Associations' of Aotearoa strongly oppose the establishment of rigid protocols or "risk lists" which would restrict the women's free choice of who her caregiver/s would be and where she could give birth.
The responsibilities for these choices belong with the women, not to the medical profession.
We believe each case should be individually assessed in consultation with the midwife, GP, or specialist of her choice.

3) The Home Birth Associations' of Aotearoa oppose the routine use of ultrasound scanning during pregnancy.

4) The Home Birth Associations' of Aotearoa demand that the Minister of Health & Public Health Commission provide funding for home help services for all women postnatally, for a minimum of 20hrs, to be used at any time chosen by the mother, over a 6wk period.

5) The Home Birth Associations' of Aotearoa strongly urge that the cot death research programme inform all women that research supports the safety of a baby sharing a bed with parents who don't smoke.

To the Minister of Education & Opposition Spokesperson on Education, The Otago Polytech & the Auckland Technical Institute.

6) The Home Birth Associations' of Aotearoa strongly recommend that the experimental status of the Direct Entry Midwifery at ATI & Otago Polytech be removed.

GUARDIAN
WEEKLY May 2. 1993

Birth's labour's lost

*More and more pregnant women are opting for caesarean sections. **Heather Welford** reports*

HAPPY CHILDBIRTH? Comedian Joan Rivers has a line for it: "Just knock me out at the first twinge, then wake me up in the hairdresser's."

More and more women these days are sharing that view. Far from planning a natural, non-medicalised birth, they are opting for the ultimate intervention, caesarean section. Aware of the trend, doctors at Crewe's Leighton Hospital reviewed all the sections carried out there over six months last year. They found "patient's request" was the third most common reason for a section planned in advance.

Jude Adeghe, obstetrics and gynaecology registrar at the hospital, says, "The demand is becoming quite significant and it's almost entirely from women who have had a previous unpleasant labour, ending in an emergency caesarean. Difficult labour can lead to a resolve never to go through the experience again."

Angela is still troubled by memories of the fear and pain she experienced during the birth of her son a year ago. Her labour had slowed, then stopped and she was given prostaglandin pessaries to kick-start it. The pain became worse after the midwife broke her waters but TENS, entonox and pethidine failed to help, and Angela had already decided against an epidural.

The baby was in a posterior position (with his back towards Angela's back) and was attempting to exit face-first. Angela and her partner were left alone for long periods and after 12 hours, she was desperate. "I can remember saying, 'For God's sake, knock me out'." She was finally delivered under general anaesthetic and says now, "I can only contemplate another pregnancy if I am guaranteed a caesarean."

Women who actively want sections are part of the reason for the apparently unstoppable rise in the UK section rate. Figures show about 13 per cent of all births happen this way, despite the misgivings of many mothers, midwives and doctors, worried that the British rate will eventually rival the US figure of 24 per cent.

However, while acknowledging a mother's fear of repeating a difficult labour, researchers ask whether she can always make an informed choice. For example, mothers may not know why they had their section — important information, as many are due to causes unlikely to be repeated.

Dr Edith Hillan, from Glasgow University's Department of Nursing Studies, surveyed nearly 600 women who'd had a section. Three months after delivery, she compared their hospital notes with their responses to a questionnaire. Twenty-two per cent didn't know why they'd had a section, had understood wrongly or were only partially correct.

Sarah Clement, psychologist and author of The Caesarean Experience (Pandora), found her own survey showed women are sometimes given poor information. "Mothers are often told that if they go into labour, they're likely to end up with another section anyway. In fact, research shows this is not the case. They are also told the length of their labour will be limited and they'll have extra monitoring, but there's little research to justify this approach." Clement is not surprised that, as a result, a proportion of women will decide to skip the preliminaries and choose an elective section.

Author Margaret Jowitt, whose book Childbirth Unmasked (Peter Wooller) posits a strong link between stress hormones and difficult labour, asks why many women find labour so unpleasant that they dread a repeat performance. "Too often, hospitals treat women as faceless incubators. Women are bossed about in labour, by doctors and midwives they don't know and can't trust. All this causes the stress hormones that impede the course of labour."

It is also true that some interventions bring their own problems and that women and their partners are often left to cope alone. Isn't it possible, argues the natural birth lobby, that given more midwifery support and less intervention, fewer women would need the drastic rescue-remedy of the knife? Jowitt says, "It's a question of who controls childbirth: mothers or hospital staff."

Whatever mothers want from childbirth, they may have to confront this control — and the story is the same for women who want to avoid a section. According to Gina Lowdon, of the Caesarean Support Network, "Getting an intervention-free vaginal delivery after a caesarean is more difficult than a repeat section."

Lowdon, who helps run the network's V-BAC (Vaginal Birth After Caesarean) Group, says many women are up against doctors who try to frighten them into agreeing to another section. "A vaginal birth after a section needs confidence — but women who have had a section may feel very unconfident, and it's the same for their doctors."

Lowdon's group aims to build that confidence by giving women the facts and by sharing positive experiences. She points out, nevertheless, that women have individual responses to deciding what to do next time. "It's a bit like travelling along a dangerous road — which is what childbirth can feel like — in a vehicle that's already let you down once. Some women prefer to drive themselves; others want to be the passenger."

Lowdon believes the effects of caesarean section are still underestimated. One woman who set up a support group for caesarean mothers was sneered at by an obstetrician. "Good God," he said, "there'll be a support group for ingrowing toenails next."

Caesarean birth takes a toll, however. Maternal deaths are rare in the West but women are still more likely to die as a result of a section than a vaginal birth, and any abdominal surgery carries with it a small risk of damage. Edith Hillan found high instances of depression, backache and tiredness among mothers who'd had a section, and they also took longer to feel close to their infants.

But if women know the cons as well as the pros, then who is to say no? A 1986 survey showed that 90 per cent of obstetricians would refuse to carry out a requested section — but Jude Adeghe believes that figure is now out of date. "In my experience, women are no longer the passive recipients of care, and obstetricians are becoming less authoritarian. For some mothers, a joyful birth experience is only possible by avoiding the fear of another traumatic labour."

Knife lines

Caesarean section is done under general anaesthetic or epidural anaesthetic, which leaves one fully conscious but numb from the waist down. The surgeon makes a six-inch cut in the abdomen, almost always horizontal, across the top of the pubic hairline ("a bikini cut"). A similar cut is then made in the uterus and the baby is delivered through the opening. The placenta and membranes follow. That takes up to 10 minutes; the stitching up takes about 30.

Midwifery Information Management System

Further update on Perinatal Database

For More Information, Call: John Stroh, Terranova Pacific Services Ltd. (04) 568-4585

For Release 8:00 AM EST
July 1, 1993

Press Release

Miwifery Information Management System

Terranova has come to an arrangement with The New Zealand College of Midwives regarding the release and distribution of a "Shareware" - Midwifery Management Information System for Independent Midwives in New Zealand. This arrangement is based on the following:

- **Midwives should have a say in the design of the product.** Although the data elements may be influenced by the requirements of contracting RHAs and by access agreements with hospitals and clinics it is felt that the profession should be involved in many aspects of the final product design. The College will consolidate the feedback from these discussions and will make recommendations to Terranova. The design of the final product should satisfy the reporting requirements to the College and contracting parties in the Health System.

- **The "Shareware" approach to distribution offers several significant benefits:**
  1. The shareware data-entry and reporting model is provided on an "honesty-box" basis: Users who are satisfied that they are making productive use of the model, that is can enter data and produce reports for their practice, are asked to contribute $NZ250 into the Terranova Development fund. A receipt will be issued on request. Details are included in the online documentation for the model.
  2. There is no restriction on the distribution or copying of the shareware model. This will encourage networking on the feedback and day-to-day use of the model.

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- **The Model is distributed as a simple, self-installing MS-Access (*.MDB) fille.** Users will be responsible for the purchase and installation of a copy of Microsoft Access before the model can be used. Users will also need to learn how to use the standard MS-Access product before they can use the model. As a way of evaluating the solution, users may wish to approach their local software suppliers who may be able to arrange a demonstration. You may find that MS Access has many other potential uses for the management of you practice.

- The Model is designed to run on a standard DOS/Windows, PC configuration that will support Microsoft Access. Users are responsible for the choice of any software and hardware, and should base any decision to proceed with the installation of the Shareware model on their own evaluation of any products purchased for use with the model. Microsoft Access is currently being used by members of the College.

- **The Shareware solution runs on standard PC products.** Your local dealer can provide you with advice and possibly arrange support and education. Discuss the configuration you require for your particular environment with your local PC dealer. You may wish to run other windows-based word-processing or spreadsheet packages. In general terms, we have found that satisfactory performance using MS-Access can be achieved on a 386DX with 4MB of RAM. Hard Disk Space is largely determined by your other PC application requirements. You may be able to achieve bargain purchases on 486s that are only a few hundred dollars more expensive. You will need a 300dpi HP compatible printer (could be a Deskjet) and a VGA screen for the final MIMS solution.

Further information, if required, is available from Carey Virtue
8 Durham Crescent, Wellington

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The Press 22/6/93

Smoking link to bed-sharing in cot deaths

By ANNA DUNBAR

The message to parents to stop sharing the bed with their babies has been withdrawn, says the Canterbury Cot Death Society's director of education services, Mrs Stephanie Cowan.

"The modified message is that it is smoking that makes bed-sharing dangerous, which is likely to be a much more acceptable message to people who treasure the practice of sleeping with their babies," she said.

"Babies who sleep on their side or back, are breast-fed and smoke-free are much more likely to survive than babies who sleep on their tummies, are bottle-fed, and live in smoking families."

Mrs Cowan said there were rules for safer bed-sharing.

- Parents should avoid bed-sharing if the mother was a smoker, or smoked in pregnancy, if they had drunk alcohol, taken drugs, or were heavy sleepers.
- Where babies shared the bed, parents should lie the infant on its back; avoid falling asleep with baby on the breast; and make sure he or she could not slip under the blankets or roll on to the tummy.

Mrs Cowan said parents had been confused whether bed sharing increased the risk of cot death, she said. Maori and Pacific Island parents, for whom this was a valued practice, had been especially angered.

A recent meeting called by the Public Health Commission, which included Cot Death Society researchers, decided the present evidence for bed-sharing as a risk factor was conflicting.

Mrs Cowan said non-smoking mothers should be aware there was a slight increase in the risk of cot death through bed-sharing but that needed to be weighed against the benefits.

These included ease of breast-feeding, which itself was a protection against cot death, stronger infant bonding, better opportunities for rest and sleep for the mother, allowing her better to care for her infant and other members of her family.

Mrs Cowan said 11 babies had died of cot death in Christchurch last year compared with eight in 1991. Most of these were under five months old and were subject to one or more of the major risks.

The Canterbury Area Health Board's community pediatrician, Dr Rodney Ford, said the next big step in the prevention of cot death was to encourage mothers who smoked during pregnancy to cut down and quit.

"If mothers smoke more than 20 cigarettes in the two weeks after pregnancy their babies are six times more at risk of being cot death victims. If the father smokes and the mother smokes over 20 cigarettes the baby is 7.4 times more at risk," Dr Ford said.

A smokefree pregnancy project called ACT NOW was planned for the winter.

Evening Standard 24.5.93

Natural healing better, midwives say

LONDON. — Women suffer less pain if they are not stitched up after childbirth, a study has found.

They can also resume sexual relations more quickly.

Midwives who conducted the study said natural healing processes enabled twice as many women to have sexual intercourse within six weeks of giving birth.

The study of 75 women in south-west England found that four out of 10 experienced no pain when tears resulting from childbirth were left unstitched. Another 44 percent experienced only mild pain.

But the study found that 47 percent of those who did have stitches complained of moderate to severe pain.

"Within a week of birth, 74 percent who had a tear without sutures felt comfortable, compared with 20 percent who had been sutured," said Maureen Head, a midwife with Wiltshire Health Care Trust, which carried out the study. "Sexual intercourse was resumed within six weeks by 63 percent who did not have tears stitched — more than double the number who had."

NZPA-Reuter

Fertility drugs link to cancer is investigated

BY SANYA BAKER

Claims that fertility drugs may increase ovarian cancer risk have been referred to the Adverse Reactions Committee by the Department of Health.

The Committee will be considering a recent US review study at its next meeting on 28 July.

The 12 US case-controlled studies reviewed in the *American Journal of Epidemiology* showed that white women who had used clomiphene citrate or human menopausal gonadatrophin had three times the risk of invasive epithelial ovarian cancer than women without a history of infertility. When comparing women who have never been pregnant, those who had taken fertility drugs were 27 times more at risk.

Treated women also had four times the risk of ovarian tumours of low malignant potential compared to the case controls.

"To our knowledge, these are the first reports of a significant association between ovarian cancer and fertility drugs," said an editorial in *Fertility and Sterility*, published in February 1993.

"At present, there is no need to change medical practice regarding use of fertility-enhancing drugs. There is enough cause for concern, however, to slightly alter the physicians' approach to counseling patients," commented the editorial.

The reviewers suggested that patients receiving fertility drugs should be advised on the possible increase in risk with special attention to women who wish to donate eggs, particularly repeat donors.

"(This is) because they derive no reproductive benefit from their fertility drug exposure."

They also suggest the maintenance of careful records of fertility drug treatment and family history of cancer of any kind.

Department of Health therapeutics division evaluation team leader Mark Rowland said although there is no causal link established in the review, the department believes it worth bringing to the attention of the ministerial advisory committee.

If there are serious concerns a new policy will be implemented rapidly, he said.

Breastfeeding decreases the incidence of jaundice

There was a strong dose-response relationship between feeding a frequency and a decreased incidence of significant hyperbilirubinemia on day 6. The results demonstrate that frequent suckling in the first days of life has numerous beneficial effects on the breastfed, full-term newborn.

Yamauchi Y, Yamanouchi I. Breastfeeding frequency during the first 24 hours after birth in full-term neonates. *Pediatrics*, 1990

Breastfeeding has health benefits for the mother

A marked reduction in the risk of developing epithelial ovarian cancer was associated with ever having breastfed

Gwinn ML, et al. Pregnancy, breast feeding, and oral contraceptives and the risk of epithelial ovarian cancer. *J Clin. Epidemiol*, 1990

A dad's knowing touch

A new study finds that most fathers can recognise their newborn babies just by stroking the backs of the infants' hands.

About 61 percent of blindfolded dads chose correctly from a group of three babies, much better than the 33 percent one would expect from pure guessing.

Similar results for mothers were reported last year. But the mothers were also shown to recognise their infants by stroking the cheeks whereas fathers in the new study could not, researchers said.

The difference might arise because fathers tend to touch their infants' faces far less than mothers do but frequently touch hands during play, said a psychologist, Dr Marsha Kaitz.

AP New York

Upcoming Events

a) **BIRTH & BABIES IN THE 21ST CENTURY**
November 5, 6, 7 1993
Centra Hotel, Auckland

A conference for midwives, doctors, obstetricians, paediatricians, physiotherapists, birth educators and those with a special interest in birth within a multicultural society.

Speakers include Sheila Kitzinger, Judith Mair, Patricia Buckfield, Ellamein Emery, Hilary Tupling and Gillian Turner.

For further information : Birth in the 21st Century
Box 52-065
Kingsland Auckland 3

b) **WOMEN'S SPIRITUALITY - MAKING CONNECTIONS**
June - August 1993
Auckland University

Weekly Sunday sessions led by women from different religions/spiritual tradition, culminating in a weekend celebration.

For further information : Centre for Continuing Education
University of Auckland
Private Bag 92019
Auckland

c) **24th TRIENNIAL CONGRESS OF ICM**
26-31 May 1996
Oslo, Norway

To add your name to the mailing list for information, contact :
Team Congress
P O Box 6
N-6860 Sandane Norway

d) **MIDWIFERY TODAY**

3rd Annual West Coast Conference
3-6 March 1994
Eugene, Oregon, USA

1st Annual East Coast Conference
8-11 September 1994
NYC, New York, USA

For further information: Midwifery Today
P O Box 2672
Eugene
Oregon 97402
USA

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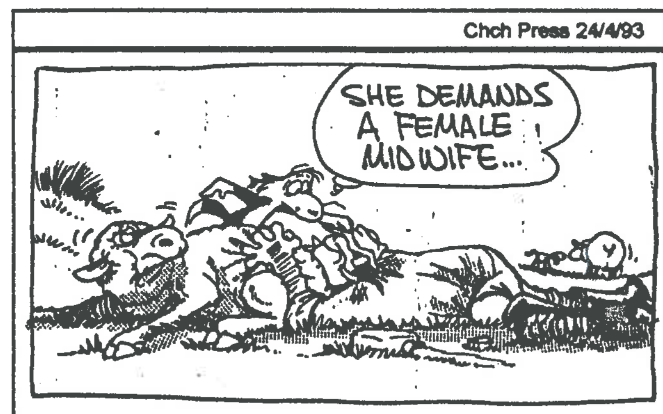
e) **PARENT CENTRE CONFERENCE**

20-22 August 1993
Auckland University

"The Politics of Parenting - Celebrating 40 Years of Parent Centre and Suffrage Year"

For further information: Barbara Lowe
Telephone 09-483-9501



Chch Press 24/4/93

more likely to have problems. In the case of a difficult birth, such as breech or one requiring the use of forceps, the baby is at risk of bleeding from trauma. Other risk factors indicated in the literature are maternal use of barbiturates or antiseizure medications, or fetal anoxia from such causes as abruptio placentae or placenta previa. These babies certainly require the administration of vitamin K as prophylaxis of HDN. Further studies are needed to determine whether vitamin K administration is needed in the normal newborn of the well-nourished woman.

Brenda Vall

Guest commentator Brenda Vail is a Certified Nurse Midwife whose interest in the question of vitamin K prophylaxis and hemorrhagic disease of the newborn was sparked by the questions of childbearing couples coming to her for prenatal and obstetric care. She lives in Owings Mills, Maryland USA.

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MOTHERS

Now, as always, the most automated appliance in a household is the mother

BEVERLEY JONES

The Press - 29/06/93

Acne medication warning

PA Wellington

The Health Department yesterday linked acne treatments containing a vitamin A derivative called tretinoin with birth defects.

"Women who are pregnant or intending to become pregnant are advised not to use these preparations," the department's therapeutics manager, Dr Bob Boyd, said.

The department would act to restrict tretinoin's availability.

Skin preparations containing tretinoin are sold in New Zealand as Retin-A (in gel, cream or liquid form) and Airol (a lotion).

Dr Boyd said there had been four reports, including two from Australia, of children born with congenital malformations after tretinoin preparations were used in early pregnancy.

"The possible association between the two events needs to be clarified but there is now sufficient evidence to indicate caution."

Dr Boyd said the department's concerns had been heightened by increased publicity for preparations containing tretinoin.

These products were originally introduced as acne treatments but recently they had been promoted in magazine articles as beauty preparations.

If used in this way or on sun-damaged skin, more tretinoin would be absorbed and the potential risk could be increased.

Tretinoin preparations can only be sold by a pharmacist but the department has asked the Medicines Classification Committee, due to meet next week, to make tretinoin a prescription medicine.

Tretinoin belongs to the class of medicines called retinoids which are known to interfere with the development of bones in the skull.

This can result in birth defects such as cleft lip and palate, brain malformations and eye abnormalities

Further comment on Vit K

ICEA Review
FOCUSING ON TODAY'S ISSUES IN PERINATAL CARE
Vol. 9 No. 3 INTERNATIONAL CHILDBIRTH EDUCATION ASSOCIATION, INC. December 1985

Vitamin K Prophylaxis and Hemorrhagic Disease of the Newborn

Although the administration of vitamin K to prevent hemorrhagic disease of the newborn (HDN) has been a routine procedure for many years, articles questioning its utility were still being published as late as 1971. Hemorrhagic disease of the newborn was first described by Townsend in 1894. In 1929, Dam noted that the hemorrhagic disease occurred in chicks on a fat-free diet. The deficient substance was unknown at that time, but it was found that hemorrhagic disease could be prevented when chicks were fed seeds, cereals and green leafy plants. It was proposed that the unknown substance in these foods that prevented hemorrhagic disease be called "vitamin K."[1]

The bleeding tendency in newborns was thought in the 1940s to be caused by low prothrombin levels. Subsequently it was found that there were other alterations in coagulation at birth which could cause bleeding. Currently the accepted definition of HDN by the American Academy of Pediatrics is *any bleeding problem due to vitamin K deficiency and decreased activity of factors II, VII, IX, and X."*[2] Platelets are adequate in number at birth and fibrinogen levels are also within normal levels in affected newborns. The level of prothrombin at birth is adequate, but falls by the second to third day. Gradually it rises until it approaches normal by the tenth day.

It has been thought that newborns were unable to synthesize their own vitamin K because their intestinal tract was not colonized by bacteria.[3] An article written in 1974 and recently cited in *Lancet*, however, stated that *there is no evidence in man that the bacterial forms of vitamin K, menaquinones, are either absorbed or related to prothrombin synthesis.*[4,5]

The utility of vitamin K administration to the newborn has been controversial. Although Vietti, Murphy, James, and Pritchard found that vitamin K decreased bleeding from circumcision, they felt that the *high incidence of spontaneous neonatal hemorrhage reported in the older literature was due in part to sepsis and trauma and that the decrease of the disease has been a result of better obstetric technique and control of infections.*[6]

There have been many variations in the studies which make it difficult to evaluate the utility of vitamin K administration. The dosage,[7] the route of administration, and the time of administration all varied. In many of the early studies, the vitamin K was given to women in labor. The effectiveness of vitamin K in preventing HDN depended upon how soon the women gave birth and the dosage given. Other studies focused on administration to newborns.

Some of the studies have shown the influence of other factors such as administration of vitamin E or vitamin C or the use of certain drugs such as barbiturates on the incidence of HDN. Of special interest is the fact that breast milk has about one-fourth of the vitamin K activity of cow's milk[8] and that HDN occurs almost exclusively in the breastfed baby who has not received vitamin K prophylaxis. Since most of the early studies were conducted on indigent populations, a question of the relationship between poor nutritional intake on the part of the mother and the clotting mechanism of the infant has been raised and further study in this area recommended.[9,10] Recently Dr. Louis Hellman, who participated in several of the studies done at Johns Hopkins Hospital (Baltimore, Maryland USA) stated that he felt that since maternal diets are generally so much better than those in the studies cited, vitamin K therapy was not routinely needed today.[11]

At present the therapeutic regimen recommended by the Committee of Nutrition of the American Academy of Pediatrics is:

> Commonly employed synthetic water-soluble analogues (menadione, menadion sodium bisulphide (Hykinone), and menadione sodium diphosphate (Synkavite) are all probably safe and effective when administered in proper dosage. However, the margin of safety is almost certainly greatest with vitamin K-1 (Phytonadione, Mephyton, Aqua Mephyton, Konakion), and this derivative is considered the drug of choice. A single parenteral dose of 0.5 to 1 mg or an oral dose of 1 to 2 mg is probably adequate for prophylaxis, but it may be necessary at times to repeat this dosage for treatment, and larger doses will generally be necessary for treatment of infants whose mothers have received anticoagulant therapy. Oral, intramuscular, or intravenous routes are feasible for vitamin K-1 and all synthetic analogues except menadione. This is not used orally. At the present time it is recommended that vitamin K be given to the infant at birth, rather than administering it to the mother prenatally.[12]

Certain babies are at special risk for bleeding problems. It is well accepted that premature babies are

Managing suspected listeria in pregnancy

A British Medical Advisory Committee has recently completed its report on the management of suspected cases of listeriosis in pregnant women.

It advises pregnant women against eating soft ripened cheeses, all types of pate, and all cooked-chilled meals and ready-to-eat poultry unless thoroughly re-heated.

The report says that all pregnant women who develop flu-like symptoms should be monitored in case they develop persistent pyrexia.

Blood samples should be taken from those with a pyrexia of 38°C which does not resolve with 48 hours. If the woman becomes seriously ill she should be admitted to hospital where intravenous antibiotics may be given.

The report recommends using ampicillin and amoxycillin, or if the patient is allergic to penicillins, erythromycin.

For those women who do not need to be in hospital the report recommends taking blood cultures and starting oral amoxycillin without necessarily waiting for results.

The working party has acknowledged that there is little scientific data to support this advice but claims that, given the known safety of the drugs and the potential for preventing serious disease in the fetus, it is the right thing to do.

Hard to diagnose without tests

In the absence of laboratory results, the diagnosis of listeriosis is difficult. There are no clinical signs so examination of the patients must be thorough to rule out any other likely cause of flu-like illness or pyrexia in order to detect any complications and to ensure that the fetus is healthy.

If no clinical explanation can be found for the fever this increases the possibility that the true cause is listeriosis.

The report recommends a full history is taken to exclude other causes of febrile illness with or without headache. Recent travel and the woman's occupation may be relevant both in considering the differential diagnosis and to assess dietary exposure.

Although a history of eating high risk foods increases the probability of listeriosis the report says a diagnosis of listeria should still be considered in patients who do not report this.

Materno-fetal listeriosis can occur at any time during pregnancy. During the bacteraemic phase of the disease, the mother may experience a mild, flu-like illness with fever, headache, back pain and occasionally gastrointestinal symptoms. It is easy to mistake the symptoms of lower back pain for those of urinary tract infection.

Listeriosis in some mothers is asymptomatic and only diagnosed retrospectively after an adverse outcome. Placental transfer of the organisms may result in spontaneous abortion, stillbirth, premature labour or delivery of an infected baby.

Neonatal listeriosis presenting in the first weeks of life has a high mortality.

Testing TIMES

Mary Newburn, the Head of Policy Research for the Trust, takes a look at the times we live in.

What has led one woman to legal action because she was denied it and others to claim 'it may be described as an expensive way of causing extreme anxiety to every pregnant woman'?

Answer: maternal serum screening or the 'triple test'.

Michelle Huberman, the *Sunday Times* (August 23, 1992) reported, is claiming £1 million damages for herself and her baby, Analie, who was born with Down's Syndrome. Huberman, despite paying for state-of-the-art maternity care at the Garden Hospital, London, was not offered the blood test which will screen for Down's Syndrome, a choice she says she should not have been denied. Her consultant, Yehudi Gordon, defended his decision not to offer the test on the grounds that it leads to a significant increase in the number of young women being referred for diagnostic amniocentesis, a procedure which carries a 1 in 100 risk of miscarriage.

Until comparatively recently Down's Syndrome screening was limited to diagnosis following amniocentesis, offered only to older pregnant women. By screening the oldest 5 per cent of pregnant women, about one-third of affected pregnancies were identified.

DIAGNOSTIC TESTS

Amniocentesis is an invasive and costly procedure. It cannot be performed until the second trimester of pregnancy and it causes a small but significant number of avoidable miscarriages. Much attention has therefore been given to developing alternative methods of identifying affected pregnancies.

In the amniocentesis test fetal cells are collected in a sample of amniotic fluid. The procedure cannot be performed until there is sufficient fluid to enable a needle to be introduced into the uterus and some fluid taken without harming the baby or disturbing the pregnancy. As an alternative, chorionic villus sampling (CVS), a diagnostic test which takes cells from placental tissue, was developed. The major advantage of CVS is that it can be performed before 12 weeks. The major drawback is that randomised controlled trials have shown that it is associated with a greater risk of miscarriage than amniocentesis[1]. Other serious problems include a small but significantly greater incidence of misdiagnosis. Given the limited alternatives, for some women CVS may be the test of choice. However, it is not suitable for widespread use for women of all ages.

RISK PREDICTION

More recently attention has turned to maternal serum screening, a non-invasive procedure in which a blood sample from the woman is analysed for biochemical markers. This test predicts the chance of an individual woman having an affected pregnancy; it is not a diagnostic test.

The so-called 'triple test' provides a calculation of the chance of Down's Syndrome, based on maternal age and the measurement of markers for alphafetoprotein (AFP), human chorionic gonadotropin (hCG), and unconjugated oestriol (uE). The triple test has been pioneered in this country at St Bartholomew's Hospital, London. The test is non-invasive, relatively cheap and, in itself, carries no risk of miscarriage. It can be offered to all women, thus increasing their knowledge about their pregnancy and enabling them to make an informed choice, but there are drawbacks which some feel outweigh the benefits. Critics point out that there are routinely 'false positive' results (that is women labelled high-risk whose pregnancies are in fact normal) as the test is simply predictive and not diagnostic. Furthermore, there is also a problem of 'false negative' results (missed cases).

The St Bart's team predict that their test will detect two out of three cases of Down's Syndrome, almost all cases of anencephaly, and four out of five cases of spina bifida. However, recently published results show that in practice, of 12,603 women of all ages who accepted the triple test, only 48 per cent (12/25) of Down's pregnancies were identified[2]. Thus, so far this test has been unable to identify half the Down's pregnancies (in other words the false negative rate is high) but it has identified a higher proportion than a screening policy offering amniocentesis alone to women over 37 years.

SCREEN POSITIVE

Initially, 5.7 per cent of women were told they had a 'screen positive' result (including 4.9 per cent of women under 37 years who would not in other circumstances be considered at high risk). By taking account of gestational development on the evidence of ultrasound scanning, this was reduced to 4.1 per cent for all women, and to 3.3 per cent of women under 37 years. Of all women in the confirmed screen positive group, only 1 in 43 (n=12) actually had an affected pregnancy; the corresponding proportion for women under 37 was 1 in 57. Thus from the point of view of an individual young woman, 56 out of 57 were 'unnecessarily' given cause to feel considerable concern. Furthermore they were all faced with the decision of whether to accept the offer of amniocentesis for diagnostic purposes which might reassure them all was well or might confirm Down's Syndrome, or might induce a miscarriage. In this study only 75 per cent of the screen positive group accepted an amniocentesis.

Of the 12 screen positive women who were subsequently found to have an affected pregnancy, seven were aged under 37 years and five were older. One of these women was among the 25 per cent who declined amniocentesis. Nine of the remaining 11 had a termination of pregnancy, one declined and one left the country. One other woman with a Down's pregnancy was initially screen positive but was reassured on the basis of her ultrasound results that her pregnancy was, after all, unlikely to be affected. At the accepted rate, four accidentally induced miscarriages might be expected among the 397 women who accepted amniocentesis.

POSSIBILITIES

Several things are evident from this study. The use of maternal serum screening for all women highlights the possibility during pregnancy that young women may have affected pregnancies. By identifying in a very inexact way some of those young women who have an increased chance of having a Down's baby, the test causes considerable anxiety and presents them and their partners with the need to make some very difficult decisions. In addition, the triple test leads to increased medical interventions in normal pregnancies and the incidence of avoidable miscarriage. However, it does somewhat increase young women's opportunities to make choices. In this study a small number of Down's pregnancies were identified in women under 37 which otherwise would not have been.

For women over 37 years the triple test provides a less interventive alternative to amniocentesis as a first step. Particularly for those prone to miscarriage or particularly anxious about time for having babies running out, any chance of avoiding amniocentesis with its miscarriage risk will be welcomed. But the same limitations apply: the screening procedure is not diagnostic. In the Bart's study two of the seven Down's pregnancies among women over 37 were not identified.

TRIPLE PLUS

In an effort to reduce the number of false negative maternal serum screening results, the Leeds Down's Syndrome Screening Service is now offering the 'triple-plus' test, which includes the measurement of an additional biochemical marker, such as neutrophil alkaline phosphatase (NAP). Using this test they believe that it is possible to increase the number of Down's pregnancies identified without raising the false positive rate substantially.

HERE TO STAY

None of these observations begins to touch on the very difficult social and moral issues raised by more aggressive screening policies, nor on the economic arguments which have exercised those purchasing and providing healthcare. There are also other important clinical questions, many of which were raised in correspondence with the *British Medical Journal*[3].

The one thing that is certain is that screening will not go away. The scientific barriers will continue to tumble and the financial pressures will increase as healthcare costs rise. Furthermore, despite the price to be paid, demand from parents seems likely to continue as the idea of 'informed choice' becomes increasingly common currency. ■

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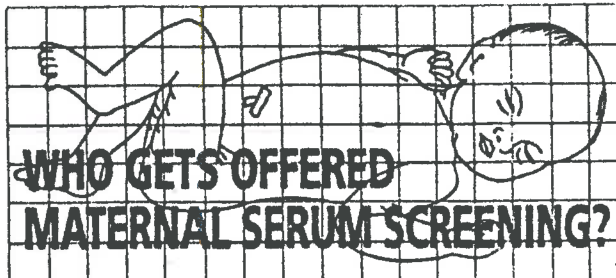

WHO GETS OFFERED MATERNAL SERUM SCREENING?

In a review of Down's Syndrome screening in Britain in 1991, Wald, Wald and Smith[1] found considerable variation in terms of the proportion of women being offered screening tests, the procedures being used, and the kind of analysis being done. At that time, 95 of the 200 health districts and boards (47.5 per cent), offered no serum screening for Down's Syndrome, providing amniocentesis to all pregnant women above various specified ages. A further 12 health districts and boards offered serum screening to 'older' women only (typically women over 34 years). The remaining 93 districts and boards provided serum screening for women of all ages, in at least part of their area. Of those that offered serum screening 'about half' used alphafetoprotein (AFP) alone and the other half AFP with other serum markers.

The Leeds triple-plus test is being sold to NHS districts, hospital trusts and GP fundholders. It is also available privately, at over twice the price, for a fee of £88 + VAT. A test kit can be ordered by women by post and taken to a midwife or GP for blood to be taken for despatch to Leeds. ■

Reference

[1]Wald, N *et al*., 1992: The extent of Down's Syndrome screening in Britain in 1991. *The Lancet*, 340: 494

Addresses

Department of Environmental and Preventive Medicine,
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Charterhouse Square,
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Telephone 071 982 6143

Down's Syndrome Screening Service,
Institute of Epidemiology,
34 Hyde Terrace,
Leeds, LS2 9LN.
Telephone 0532 344013

OTHER TESTS

In addition to maternal serum screening tests, there are a variety of quite different diagnostic procedures under investigation. Attempts are being made to obtain fetal cells for analysis from samples of mothers' blood and from cervical smears or mucus plug biopsies. None of these methods is yet sufficiently developed to be used in practice.

A quite different approach to identifying Down's pregnancies is being developed at King's College Hospital, London, based on the identification of a 'black space' or nuchal tissue marker behind the developing fetus's neck using ultrasound scan at 11 weeks' gestation. Further research is underway to establish the associated risks and benefits.

Reprinted from

CENZ

News & Views

June 1993