



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

AID *
urch NZ *
No. 2843 *

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NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

National Newsletter
November / December 1993

MORE ON ULTRASOUND

OBSTETRIC REFERRAL GUIDELINES

MIDWIFERY ISSUES UPDATE

National Midwifery Resource Centre
1st Floor 183 Manchester Street Christchurch Tel/Fax 03-377-2732

BOARD OF MANAGEMENT

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NATIONAL COMMITTEE

Northland ROSAMUND RAE P O Box 4219 Kamo Whangarei ALISON CARLIN c/- Antenatal Clinic WBH Whangarei	Waikato/BOP VIOLET STOCK c/- Tauranga Maternity Annex Tauranga RAEWYN PARK P O Box 8064 Glenview Hamilton	Otago JO WALLIS P O Box 6243 Dunedin North
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National Council of Maori Nurses

NATIONAL COMMITTEE CONSUMER REPRESENTATIVES

Maternity Action Alliance Rea Daellenbach 8b McMillan Avenue Christchurch	Parents Centres (NZ) Sharon Cole 12 Elmslie Place Rotorua	Home Birth Assoc Susan Holloway 13 Sutton Street Richmond Nelson
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NEW ZEALAND COLLEGE OF MIDWIVES (INC)
MEMBERSHIP APPLICATION FORM

NATIONAL INFORMATION **REGION** Auckland

Name _____

Address _____

Telephone _____ Home _____ Work _____

Workplace _____

Date of Birth _____

ARE YOU CLAIMING FROM MATERNITY BENEFIT SCHEDULE? YES/NO
ARE YOU A MEMBER OF THE NZNO? YES/NO
ARE YOU A MEMBER OF THE NZNU? YES/NO

TYPE OF MEMBERSHIP

Full Membership (Waged)	\$155.00 } includes
Full Membership (Unwaged/Students)	\$ 50.00 } indemnity
Associate with indemnity	\$155.00 } insurance
Associate & Affiliate	\$ 30.00

NEW	
RENEWAL	
CHANGE	

METHOD OF PAYMENT (Please tick your choice of payment)

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

Membership Number
Allocated _____

REGIONAL INFORMATION **REGION** Auckland

Name _____

Address _____

Telephone _____ Home _____ Work _____

Workplace _____

Date of Birth _____

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RENEWAL	
CHANGE	

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- Subscription from salary (please arrange with your pay office)
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PLEASE RETURN COMPLETED FORM TOGETHER WITH MONEY
(IF APPLICABLE) TO YOUR LOCAL REGIONAL TREASURER

When all else fails, and you're feeling down, treat yourself to a laugh - go on

CROWN HEALTH ENTERPRISES - CHEs

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Chief Executive	Big ChEs
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Community Health Centres	Cottage CHEs
Waiting Lists	Mouldy CHEs
Cafeteria	CHEs Bar
Houseman's Hostel	CHEs Singles
Occupational Health	Kraft CHEs
Hospital Social Club	CHEs Balls
Homebirth Services	Cottage CHEs
The Government	LyCHEs
Crown Health Establishment Unit	CHEs Factory

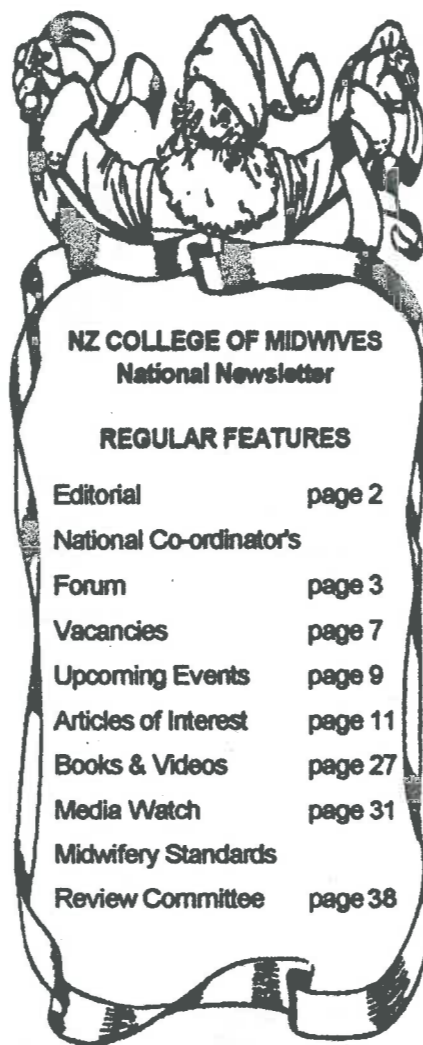
MEMO

All Midwives interested in Computer Data Bases, please contact

CAREY VIRTUE
8 Durham Crescent
Brooklyn
Wellington
Telephone (04) 384-7261



The updated TERRA NOVA Midwifery Database is now available.



**NZ COLLEGE OF MIDWIVES
National Newsletter**

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DISCLAIMER

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

**NEXT NATIONAL
COMMITTEE MEETING**

Friday 04th March 1994
6.00pm
and
Saturday 05th March 1994
9.00am

**NZ NURSES ORGANISATION
OFFICES**

1st Floor
205 Manchester Street
Christchurch

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

DEADLINE

for the next Newsletter is
30th January 1994

Next Newsletter will be due out
mid February 1994

PUBLISHING DETAILS

Editor - Karen Barnes
Typesetting by - Margaret Stacey
Printing by MAS Business Services Chch

EDITORIAL

Dear Members,

In my line of business, I haven't a clue about the intricacies of the Midwifery profession and have always left the editorial to the Editor (that's Karen Barnes) but as she is away on maternity leave, I am happy to be writing this, our final editorial for 1993.

Our congratulations to Karen and Kevin on the birth of their third son, Nicholas, who weighed in at 10lbs! Karen will be back on board for the next issue of our newsletter.

As we draw to the close of yet another year, we look back on what's happened in each region and to the College as a whole - the College has been ever so busy. Our membership has also increased substantially. Turn to the National Co-ordinator's Forum page for all the updates. **And remember the College Conference - August 1994!**

We would like to thank those of you who have contributed to our newsletter over this last year and to those of you who will be contributing in the new year.

May we take this opportunity of wishing each and every one a very Merry Christmas and a Happy and Prosperous 1994!

Happy reading,

Margaret

Margaret Stacey



Quotable Quotes

Even if you're on the right track, you'll get run over if you just sit there. - Anonymous -

You'd better not compromise yourself. It's all you've got.

- Janice Joplin -

Tuesday's child is commonplace

U.S.

More American babies are born on Tuesday than any other day of the week, according to the National Centre for Health Statistics. And babies are least likely to be born on the weekend because caesareans are not planned for weekends. Further statistics show that 1046 boys are born for every 1000 girls and doctors attended 94.8% of birth, midwives 4.4%.

NZ Doc - World News - 28/10/93

- 2. Outcomes**
 - 2.1 What were the outcomes for women and babies?
 - 2.2 Were the outcomes expected or unexpected?
 - 2.3 What changes need to be made?
- 3. Interventions**
 - 3.1 What interventions were used?
 - 3.2 Is the use of intervention appropriate?
 - 3.3 What changes need to be made?
- 4. Adequacy and Appropriateness of Information Provided**
 - 4.1 Is the information of high quality?
 - 4.2 Is it up to date?
 - 4.3 Is it in an appropriate form?
 - 4.4 What improvements are needed?
- 5. Advocacy**
 - 5.1 Does the practice include an advocacy role?
 - 5.2 Is referral made to advocates?
 - 5.3 Is advocacy occurring at all?
 - 5.4 What improvements are needed?
- 6. Informed Consent**
 - 6.1 Does the practice reflect a commitment to informed consent?
 - 6.2 What improvements are needed?
- 7. The Rights of the Birthing Woman**
 - 7.1 Does the practice reflect respect the rights of the woman?
 - 7.2 Does the practice allow sufficient time for the woman's needs to be met?
 - 7.3 What improvements are needed?
- 8. Contacts and Support**
 - 8.1 Does the Midwife have good personal support?
 - 8.2 Does the Midwife have good professional support?
 - 8.3 Is there an established system for obtaining a second opinion and receiving backup?
- 9. Education**
 - 9.1 Has the midwife taken part in any education courses?
 - 9.2 Were educational updates appropriate and successful?
 - 9.3 Has the midwife a projected plan for ongoing competency evaluation?
- 10. Evaluation**
 - 10.1 Was the review process satisfactory?
 - 10.2 If not, why not and what needs to happen?
 - 10.3 What response will be included in the letter to the midwife?

MIDWIFERY STANDARDS REVIEW COMMITTEE

The development of these committees over the last three years has been challenging and exciting as we work with consumers to have a women-centred approach to professional review. Several formats and documentation have been piloted over this time and we are now ready to combine all our experiences into a more standardised approach. The work of the Auckland Home Birth Association in developing our review process has been invaluable. They have provided balance and wisdom into our quality assurance programmes which make the review process a valuable learning experience for midwives and a safety net for consumers.

Each midwife reviewed is required to give a report on her years practice supplying statistical data and self evaluation. She is also required to provide evidence of client satisfaction. The Review Committee provides the annual report form and the client evaluation questionnaire.

For more information, please contact your Regional Chairperson/Secretary.

TERMS OF REFERENCE

1. To annually review and evaluate the practice of each independent midwife against the NZCOMI Code of Ethics and Standards of Practice.
2. To act in partnership with consumers of midwifery services to ensure the accountability of midwifery practitioners.
3. To provide a forum in which to share knowledge, resources and information.
4. To review complaints relating to independent midwifery practice according to the prescribed procedure.
5. To provide an opportunity to review any difficulties arising.
6. To bring any matters to the attention of the appropriate bodies, with recommendations.

CONFIDENTIALITY

- (1) Confidentiality shall be maintained within the committee for all aspects relating to individual cases.
- (2) If a committee member is found to have breached confidentiality that member shall be asked to resign from the committee.
- (3) On booking, all consumers shall be informed of the existence and procedures of the Midwives Standards Review Committee. Consumers should know that information regarding them will be used for review, education and statistical purposes.

CHECKLIST FOR REVIEW PROCESS

1. Midwifery Model
 - 1.1 Does the practice reflect the midwifery model?
 - 1.2 What changes need to be made?

NATIONAL CO-ORDINATOR'S FORUM



As 1993 draws to a close I thought it may be useful to outline the progress that Midwifery has made over the year.

Team Midwifery within the hospital setting has started to take off much to the excitement of those of us who have been waiting for a long time to see independent practice and continuity of care for women extended to employed Midwives. The College has been working with Steph Breen and Mary Slater of the NZNO in developing packages which recognise midwives increased responsibility and scope of practice.

The achievement of pay equity for midwives claiming under the Maternity Benefit is an invaluable benchmark for hospital midwives when negotiating their changes in practice through the variance clause in the Nurses national award system. The College urges hospital midwives contemplating continuity of care within their hospitals to talk with NZNO and the College before approaching CHE management to discuss wages and conditions. The hospital midwives who have been working in "Know Your Midwife" schemes over the past year have valuable information to share on the benefits and pitfalls of working in such a scheme. Consequently the College and NZNO are in a good position to negotiate some exciting and innovative packages which not only provide increased job satisfaction but recognise the value of Midwifery care and the midwives who provide it.

It is important in this politically volatile climate for all midwives to be united on the subject of their worth to ensure the recent

equity gains for our women-dominated profession are not lost in the competitive games being presently played by CHE management as they try to "secure" the market. Midwives must remember the point of the changes to the Midwifery profession was to highlight birth as a primary health event and for women and their families to be in charge of their own reproductive lives. Continuity of care and knowing your own midwife should be women's choice regardless of where the midwife works or from which source her income is derived. All midwives are funded by the state and it is our vision that through the change in service emphasis, society will once again accept birth as a normal life process.

The Maternity Benefit Schedule negotiations are underway yet again and the first meeting between the College, the NZMA and the combined RHAs has been and gone without any problems. We meet again on December 15th to discuss our various positions. It was pleasing to note the RHAs opening position was women centred and ensuring women's choice. We believe agreement on how maternity services are paid for is possible in this climate.

There remains questions however on the long term methods of payment once RHAs start contracting for maternity services regionally. The College urges caution on the part of independent groups of midwives when approaching RHAs for contracts. Whilst the Maternity Benefit is operational it offers standardisation and we may not need consortiums or groups of IPOs (Independent Practitioners Organisations) particularly in the short term.

Please be aware that any "pilot" schemes individuals/regional groups of midwives negotiate will have an effect on the long term viability of the Maternity Benefit Schedule. Any separately negotiated contract which involves midwives as a lesser partner or in fragmented care (eg paid at an hourly rate by a GP or Obstetrician) seriously undermines the profession. Recently, the Physiotherapists Association was reported as saying "Employment of Physiotherapists by GPs is ethically unacceptable it takes away professional independence which is not good for the operator or the patient"

It may be the College remains the national "IPO" and in this way ensures a cohesive method of payment for midwives.

In recent correspondence with the RHAs involved in the Maternity Benefit Schedule we are reassured "... All RHAs are committed to the negotiations for improved purchasing of maternity services which are equally available to all practitioners. We are committed to open and frank discussions on improving services to the benefit of both women and practitioners..."

The College believes we can accept these assurances and slowly work together towards a satisfactory outcome for all.

The granting of access agreements for midwives use of hospital facilities is also an increasing problem as CHEs settle into competitive mode. CHEs all over the country are adopting discriminatory and anti competitive practices specifically designed to obstruct independent midwives. Some examples include:-

- denying midwives access while granting them to doctors.

- denying midwives employed by the CHE (even part-time) access for independent work. All these hospitals employ doctors who are also in private practice and have access requirements.
- only granting access to midwives if they have worked in that CHE.
- charging midwife clients for antenatal classes (GP clients are not charged).
- denying postnatal facilities for Midwife only clients.

All of these strategies are unacceptable and legally indefensible. Despite CHEs apparent zeal to privatise their services, they are still publicly funded institutions obliged to provide access for their populations regardless of the care giver. As midwives, we must recognise that to submit to these tactics is to deny the purpose of the re-establishment of the Midwifery profession. We must promote birth as a primary health event and the midwife (wherever she practices) as an independent professional who practices in her own right.

As a profession, we have an obligation to ensure a quality service and that midwives are accountable for the service they provide. The Midwifery Standards Review Committees established initially by the Domiciliary Midwives and the Home Birth Association have been promoted by the College as the vehicle for all self employed midwives to be reviewed. This year has seen remarkable development and commitment to the process by midwives throughout NZ.

Regions have piloted different mechanisms and documentation and we have learnt a variety of skills as a result. The College is particularly keen to see this type of quality assurance also extended to employed midwives who provide total care and some CHE managers have shown an interest in developing reviews in this manner.

Half ante-natal class 'had birth problems', 'Women want continuity in maternity care'

by Robin Munro

Half the mothers in a recent Christchurch Parents' Centre ante-natal class had problems when they gave birth at Christchurch Women's Hospital, says the class leader, Mrs Glenys Fry.

She said yesterday 12 mothers attended classes in September and October. One woman gave birth at Burwood Hospital. Six experienced "very bad standards of nursing" at Christchurch Women's because of a lack of time and staff.

Mrs Fry's comments follow midwives' criticism last week of overcrowding causing unsatisfactory standards of care.

Mrs Fry said yesterday one mother had a caesarian birth. She could not leave her bed because she was on an intravenous drip. Her call for attention took three hours to be answered.

Three babies of first-time mothers had had bad jaundice because they had in-

sufficient breast-feeding. Their mothers' requests for the babies had not been able to be answered promptly. Another woman was sent home bottle-feeding because staff did not have time to help her establish breast-feeding.

A class of 12 from last December had resulted in only one complaint. Then Christchurch Women's had taken bookings only for women expected to have complications, or willing to be discharged early. Bookings have been opened, but should be restricted again, Mrs Fry said.

Mrs Ed Shepherd, the manager of women's health for Healthlink South, said yesterday she would be concerned to discover any of the situations Mrs Fry had described. "I would be very keen to receive information directly from the women to enable us to investigate."

Mrs Shepherd said customer satisfaction surveys had shown high levels of satisfaction.

Women want more accountability and continuity in maternity care, says a report commissioned by the country's four regional health authorities.

The report, by Coopers and Lybrand, says women would be better served by a system that integrates all components of maternity care.

The system would provide women with information to make decisions about the best care for them and their babies.

It could include options for meeting their medical, psycho-social, cultural, and geographical needs during pregnancy and after birth. Women could choose a provider to co-ordinate their maternity care. Although that provider might not give all the care, it would be accountable for its standard and continuity.

The report also calls for a national perinatal data base to record information on ante-natal, labour, birth, and post-natal services and the outcomes of these.

STAFF MIDWIFE



**WAIRARAPA
HEALTH**

Ref No. PS 931108

Applications are invited from qualified midwives seeking the opportunity to work in our Level II Maternity Annex at Masterton Hospital. The unit is fully integrated and gives midwives the opportunity to care for ante-natal, post-natal and neo-natal patients as well as women during labour and delivery.

The nursing services at Masterton Hospital is committed to providing excellent nursing care and does this through the team approach.

Wairarapa offers an attractive, happy working environment and lifestyle. For further information contact Beryl McCormick, Maternity Unit Manager, on extension 4111.

Conditions of appointment, job description/person specification and application form can be obtained from Personnel Services, Masterton Hospital, or by phoning (06) 378-2099, extension 5201.

Wairarapa Health has a policy of equality of opportunity in employment.

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VACANCIES - MIDWIVES

I write to you seeking your assistance. I have been having some difficulty recruiting staff Midwives to work at Whakatane Hospital. Should your office receive any enquiries from suitable applicants, I would be most grateful if you would refer them to me.

The unit at Whakatane offers Level II care, does approximately 1,000 deliveries per annum of which 70% are performed by midwives. We have full specialist O&G and Paediatrician cover. Midwives have the opportunity to practice continuity of care as ante natal, intra partum and post natal services are all on the one level, clients may then receive domiciliary care in their home by the same midwife if this is required. The unit is very client focused, warm and friendly.

Please direct all enquiries to Karen Smith, Manager, Women, Child & Family Health Services at the above address.

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The following are extracts from the Listener's feature on women in Parliament.

- NZ Listener November 1993

JENNY SHIPLEY

Women can say some things that men can't. I remember a caucus discussion about sexually transmitted disease. I think I used some rather colourful language about the realities of chlamydia and other sexually transmitted diseases. The men believed that if you don't tell them, they wouldn't be screwing behind the bike sheds.

I said just forget it. The best you can hope to do is to give reasons why they shouldn't be sexually active. I don't think we've ever had better reasons why we should have a group of chaste young people, in terms of at least making the choice of being sexually active. I want young people to have good information so that young women know they're running the risk of cervical cancer and the wart virus by early sexual activity. We now know a whole lot of things we didn't know in my generation. I think young women are entitled to know about that. I also think young men are entitled to know that they may be carriers of the wart virus that causes cervical cancer.

The argument was, if you didn't tell them, would they do it? And, thank goodness, at the end of the day, the majority of the caucus - and we were in Opposition then - came around to the view that, given the reality that young people were sexually active, they needed to have the data. Or at least it shouldn't be a criminal offence to talk to them about it, so they could make choices.

Another instance that was relatively funny - again it was in Opposition - where we had to decide our position on the Midwives Bill. On this particular day Katherine [O'Regan] and Ruth [Richardson] and I were in the caucus. Don McKinnon was the health spokesman and he started off saying this is a piece of legislation on which we would have to decide a policy position.

And there were the most extraordinary speeches from a series of male colleagues. Sir Robert Muldoon, who had just come out of hospital with heart surgery, said that modern drugs were very technical and he didn't think that anyone other than GPs should be able to administer anything. He was sure that women didn't know what was good for them.

These speeches went on and one and on, and there was a point where the three of us just burst out laughing. We thought it was the funniest thing we'd ever heard. Katherine spoke first, then I spoke, and I said I was interested in how many of the men in caucus had been present at a birth. I didn't actually ask them to put their hands up, because I thought that was going a little far.

are better equipped to give her emotional and physical support, which we believe will lessen complications and the need for intervention."

Nicky Temperton, who gave birth at the hospital, said she had found it distressing. "I was surrounded by strangers, talking over my head. There was no privacy and it was a degrading experience."

Many general practitioners fear the scheme will undermine their role in antenatal care. Bill Styles, chairman of the Royal College of General Practitioners, thinks it will reduce co-operation between GPs and obstetricians, leaving midwives isolated. "Many GPs do not want to be involved in the delivery, but we do want to play a part in antenatal care because we have known the woman before pregnancy and will treat her and her baby afterwards. I believe a lot will decide they want their GP to be involved."

Reaction has been mixed among Queen Charlotte's obstetricians, but Keith Edmonds, who has been on the steering committee, supports the concept. "Whether women get better care under this system is something we will be evaluating over the next three years. If it proves beneficial we will be recommending it all over the country. It is not about creating independent midwifery on the NHS but about giving midwives more responsibility and the right to do things in the way they want to. I will see slightly fewer women with problems rather than seeing ladies who have normal pregnancies."

Some colleagues, however, leading members of the Royal College, believe midwives are unqualified to detect problems in pregnancy at an early stage and fiercely resent suggestions that birth at home is no more risky than hospital deliveries. This point of view, and the system it justifies, was described last week by Luke Zander, one of the few general practitioners in the country who will attend home births, as a "cemetery approach" - pregnancy as a disaster waiting to happen.

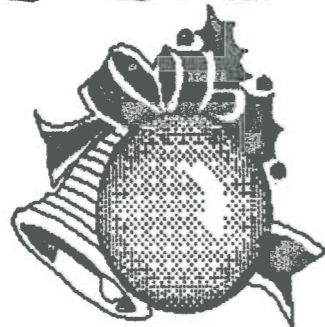
Home birth for women has always been feasible, but, as Lady Mancroft found, there is professional obstruction. "St Thomas's hospital did not give out information about home births and when I asked for a domiciliary midwife I was told that there were not enough to go round."

When it was discovered that her baby was breech, the medical profession could conceive of nothing but a caesarean. "One obstetrician asked why I did not just let him take it out next Thursday. I told him it was a baby, not a tumour. It became clear that the only way I could try a normal delivery was to pay for an independent midwife."

Lady Mancroft went into labour at home, attended by Val Taylor, an independent midwife. After 27 hours she went to hospital with her midwife and two hours later gave birth to 6lb 14oz Georgia. "I didn't need drugs or an epidural, and there were no tears and no stitches. It was wonderful. By 6am we were back at home having breakfast.

"If something had gone wrong, then of course I would have had an operation, but at least I would have been given the chance to try. I'm by no means a natural birth fanatic, but I believe birth has become too mechanical, too clinical."

- Liz Lightfoot - *Style & Travel*, Sunday Times London 17/10/93



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WELLINGTON	569-3539	CHRISTCHURCH	338-1936
DUNEDIN	474-0722		

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INDEPENDENT MIDWIFE NEEDED

We desperately need an independent midwife for the Maniototo - an area of Central Otago. We average about two births a month, plus there would be work with an independent midwife in Alexandra (an hour's drive away).

We have a pleasant 2-bedded maternity unit, but also have homebirths. We have a wonderful GP! All equipment, including a homebirth kit, is available to use.

For more information, please contact:

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Gimmerburn
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CENTRAL OTAGO
Telephone (03) 444-9085

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UPCOMING EVENTS

NZCOM CONFERENCE 1994

"The Culture of Midwifery : Celebrating Women & Family"

13, 14 and 15 August 1994

Te Papaouru, Ohinemutu, Rotorua

CALL FOR ABSTRACTS : Forward abstracts for papers to :
Nita Van Boven, c/- Post Office, Lake Okareka, Rotorua.

The 5th Midwifery, Neonatal and Paediatric Nursing Conference

March 18, 1994

Abstracts close December 10, 1993

Contact : Barbara Dromgool
Department of Nurse Education
Woden Valley Hospital
P O Box 11

WODEN, ACT 2606 Australia Ph 06-244-2259 Fx 06-244-3112

MURRAY ENKIN & DORIS HAIRE TOUR OF NEW ZEALAND

May 1994

More details in February newsletter or from your local chairperson

Women's Studies Association Conference 1994

Friday 26 to Sunday 28 August
Victoria University of Wellington

CALL FOR PAPERS

Contact : Conference Papers 1994
WSA (Wellington) P O Box 5043 Wellington
by 31 March 1994 or talk to:

Anne Else, Phone/Fax (04) 475-9958, Tania Rei Phone/Fax (04) 495-5268

The following articles are from the UK and give an overview of the current English culture in which Midwives work.

Home Delivery



When Lady Mancroft's private GP confirmed her first pregnancy last year, she did not, like most of her friends and relatives, immediately telephone the Portland Hospital. She chose to

avoid consultant-dominated private hospitals, where induction and caesarean rates are high, opting instead for a home delivery on the National Health Service with help from a domiciliary midwife.

"People thought I was slightly mad," she said. "They couldn't understand why I didn't want to spend \$4,500 to have my baby delivered privately by consultants who want to go and play golf or who expect babies to come to their timescale. I didn't want to be induced or end up with a caesarean section and have my husband coming in afterwards with champagne and flowers. It may suit other women, but it wasn't right for me."

Lady Mancroft does not see herself as a feminist, but on the subject of childbirth her views are distinctly women-oriented: she believes that the predominantly male obstetric profession is preventing women giving birth naturally.

There are 908 senior male obstetricians in England and 208 women. Just 34 senior obstetric posts are held by women in Scotland and only one in Northern Ireland. For the past 30 years midwives, an almost exclusively female profession, have been regarded highly by women but seen by obstetrician largely as their handmaidens.

Lady Mancroft, 31, believes that male obstetricians have built up such a complicated clinical service that they have frightened

women about childbirth: "Our ability to have babies without fuss has been taken away, and midwives within the National Health Service have been deprived of their true role, which is to support a woman through pregnancy and use their skills and experience to help her give birth naturally."

Next month, a scheme at Queen Charlotte's and Chelsea Hospital in West London will revolutionise the role of midwives. Usually, they rotate between antenatal clinics, wards and delivery suites, making it practically impossible for a woman to be delivered by a midwife she knows or has met before. One pregnant woman at Queen Charlotte's last year saw 37 different people up to and including the birth.

The new scheme, which will run alongside the traditional system, will take midwives out of the hospital and into the community. Working from home and on 24-hour call with mobile phones, they will visit pregnant women in their homes, book them for scans and accompany them to hospital for the delivery.

Twenty-four midwives, each with a caseload of 40 pregnancies a year, will take over the care of women who choose this system. They will remain employees of the hospital and work in pairs to provide back-up for each other. The project will be limited to the London postal districts W12 and W3 for the next three years, after which it will be evaluated before a decision is made to extend it. Consultant obstetricians have agreed to co-operate with the scheme and will become involved where there are complications or at the woman's request.

Barbara Jones, midwifery manager at Queen Charlotte's, believes the midwives will be happier, even if they work longer hours, because they will be fulfilling the role for which they are trained. "The most difficult part of our job is to walk into delivery rooms and build a rapport with a woman we have never met. If you know the woman, and her attitudes to pain-relief and childbirth, you

GPs should ensure that all their asthmatic and diabetic patients are transferred to the care of hospital clinics. High strength steroid aerosols should play no part in a GPs pharmaceutical budget and the responsibility for prescribing these and dealing with patients who claim to have lost them should rest squarely on the regional health authorities and their hospital clinics."

Ethnic and Maori medicine, GP says, are simple matters easily dealt with and could be aided by the government arranging a brief diploma course which would include attendances on marae, discussions with tohungas and a "grasp of essential Maori words and phrases".

Where Maoris or women want Maori or women doctors, it will be the regional health authorities and not GPs which will deal with the request, including the provision of free transport for patients in country areas to Maori or women doctors in towns.

As a last bit of advice, GP says, doctors should spruce up on their manners and their computer keyboard skills.

"Grumpy doctors without keyboard skills will soon be sent down the road by the regional health authorities."

- Graham Hunt



Home birth campaign divides consultants

- by Our Health Services Correspondence
- London Times 13/10/93

A division is growing among senior obstetricians over whether home births are safe. A campaign launched yesterday to improve the opportunities for women to choose a home birth was backed for the first time by consultant obstetricians. They publicly criticised the Royal College of Obstetricians for opposing the movement.

Dr Luke Zander, a GP obstetrician in London who launched the campaign, accused the college of adopting a "cemetery approach" to childbirth which was inappropriate for a natural, low risk process.

Donald Gibb, consultant obstetrician at King's College Hospital, London, and a fellow of the royal college, said: "There is a perception among senior obstetricians that women and midwives interested in home births are mad, bad and marginal. They are not.

They are intelligent and sensitive and want to be involved in a choice about this most important biological event in their lives."

Malcolm Pearce, consultant obstetrician at St George's Hospital, Tooting said that three quarters of women had normal deliveries and did not see an obstetrician. "I would like to suggest that half the obstetricians in this country be made redundant," he said.



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ARTICLES OF INTEREST

Minimum scans only

Prenatal ultrasound scans should only be carried out when there is clear clinical need, according to medical director of ultrasound and prenatal diagnosis at National Women's Hospital, Alastair Roberts.

Debate on the cost/benefit of ultrasound scanning and its impact on the outcome of pregnancy has been raging in the major medical journals.

The latest is a Western Australian study published recently in the *Lancet*, linking growth retardation in fetuses with repeated scanning.

Dr Roberts said while the study raises more questions than it answers, it shows there are still sufficient unknown factors to warrant caution.

In a randomised study of 2834 women, half received a single ultrasound examination at 18 weeks' gestation and had had ultrasound imaging and continuous wave Doppler flow studies at 18, 24, 28, 34 and 38 weeks.

The study reported significantly higher intrauterine growth restriction of the fetus in women who received intensive ultrasound testing.

"Repeated prenatal ultrasound imaging and Doppler flow examinations should be restricted to those women for whom the information is likely to be of clinical benefit," said researchers.

Dr Roberts said ultrasound should be offered to all pregnant women at 18 weeks' gestation because other studies and experience have shown clear benefits of the tests.

Calls to limit number of scans paid by MBS

- NZ Doctor News 11/11/93 -

There should be a limit on the number of scans the maternity benefit subsidy will cover unless there are proven clinical reasons that more are necessary, said the medical director of ultrasound and prenatal diagnosis at National Women's Hospital Alastair Roberts.

A Ministry of Health spokesperson said it is likely that, in the near future, there will be a set number of scans paid for by the maternity benefit.

She said the use of perinatal testing will be considered along with everything else in the RHAs' current review of maternity services and benefits.

Dr Roberts does not agree with recent statements from US researchers that ultrasound should never be conducted in low risk pregnancies.

"They report an abnormality detection rate of around 16 per cent, and therefore the possible risks outweigh the benefits. However, in New Zealand and most European countries, the detection rate is usually around 50 per cent and we believe the benefits of one scan are clear."

However, US researchers said in the *NEJM* and the *American Journal of Obstetrics and Gynaecology* recently that the benefits are confined to those at risk of complicated pregnancies due to diabetes, high blood pressure or kidney disease.

MEDIA WATCH

Babies join in celebrations

About 200 babies and toddlers turned up with their parents for a Suffrage Year picnic at the Groynes yesterday.

The picnic was organised by the Domino Midwifery Service to celebrate two years of operation and renew contacts with families.

The service provides free maternity care to women and their families throughout pregnancy, labour, and delivery in hospital. It also provides post-natal care at home. Demand still exceeded the service's ability to cope, said a spokeswoman, Mrs Dianne Clay.

Over two years the service had expanded from two staff to seven. Some 400 families had now used it and had been the pioneers in experiencing a different type of maternity service by getting to know the midwife before the birth.

- Chch Press 15 Nov 1993



Sick folk waste of time, say doctors

- National Business Review 16/4/92

Family doctors could soon be turning away certain "expensive" patients in the interests of earning a living if the advice of their professional association is anything to go by.

The General Practitioner Society has produced what it calls a disaster plan to cope with the demands - and restrictions - of the new regional health authorities.

The plan, outlined in the latest issue of the society's newsletter, *GP*, lists activities GPs may "safely engage in" and those to avoid if they want to earn a living.

The don'ts or the doubtfuls include obstetrics, chronic disorders, hypertension, Maori and feminist issues, and naturopathy and iridology.

The growth areas recommended for GPs to expand include physiotherapy, and counselling.

GP predicts family doctors might lose their obstetric business to "overpaid" midwives as, it claims, this is where the government's sympathies lie.

"Advanced qualifications in obstetrics will provide no use or benefit in many areas," says the newsletter. "Midwives will soon be able to do what they have always wanted to, that is, to get rid of the GP and call in the specialists themselves."

GP warns the management of chronic diseases such as asthma or diabetes could "wreck the budgets" of GPs contracted to regional health authorities.

The results of this research reinforce clinical understandings of the difficulties sexual abuse survivors may experience in dealing with gynaecological issues and problems. They also suggest that sexual abuse survivors may have increased birthing and breastfeeding difficulties due to their sexual nature.

I found this to be a very helpful, readable piece of research. One I would wish to use in my practice when caring for sexual abuse survivors, and would certainly recommend that abuse survivors and their partners read, as well as midwives and other health professionals caring for birthing women.

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I.C.E.A. MIDWIFERY COMMITTEE

I know much less of the work of this committee, except that they are supporting the move to legalise midwifery in both the States and Canada. With the enviable success of the College of Midwives here in introducing the new legislation, New Zealand has much to offer other countries in terms of experience and expertise. It would be good to have a New Zealand representative on this ICEA committee too. If you are a midwife and childbirth educator, interested in networking internationally through the ICEA committee, please write to me (Jenny Drew) for more information - or direct to Pat Predmore, Chair ICEA Midwifery Committee, 5335 Jaime Lane, Flushing MI 48433 USA. I'm sure Pat would also welcome midwifery articles from New Zealand, to give a broad perspective.

- Jenny Drew -
ICEA NEWS Oct 1993

The Routine Antenatal Diagnostic Imaging with Ultrasound (RADIUS) trial studied the benefits of ultrasound screening in more than 15,000 women at low risk of complications.

Author Michael LeFavre of the University of Missouri School of Medicine said routine ultrasound screening does not result in healthier babies and simply adds millions of dollars to the cost of health care in the US.

He estimates that in the US routine screening involves an average of 1.6 ultrasound scans per patient.

The RADIUS trial compared the benefits of ultrasound screening in 15,151 women at low risk for pregnancy complications.

Half were assigned to receive either two routine ultrasounds, one at 15 to 22 weeks and the other at 31 to 35 weeks. The others had scans only when a potential problem arose or there was a risk of complication.

Although the women who underwent routine screening had significantly more scans (an average of 2.2 per patient versus 0.6 per patient in the problem-only group), there were no differences between the two groups in the rates of fetal or neonatal deaths, preterm birth, induced abortions, tests of fetal well being, caesarean section, total hospital days or bed rest. Scans don't alter abortion rate

While more birth defects were detected in the women who had routine ultrasounds, this had no significant effect on abortion rates, said Dr LeFavre.

As well, no difference is shown between the health of babies and mothers between the two groups in significant cohorts, such as women who gave birth past their due date; had twins or triplets; or who gave birth to small or low birth-weight infants.

The only difference between the groups is that fewer women in the routine screening group require drugs to induce labour than do women in the problem-only group (3.4 per cent vs 4.2 per cent).

Dr LeFavre said he does not consider this a significant health benefit since some clinicians now question whether labour-inducing drugs should be used at all.

Dr LeFavre stressed that the study only looks at low risk women and its results may not apply more widely.

"We don't know whether ultrasound in other women is beneficial or not."

He will continue to recommend ultrasound for many including those pregnant women who don't know their dates.

He also recommends them for women who have irregular cycles, diabetes, high blood pressure or renal disease, and if twins are suspected.

Dr David Grimes, an expert in prenatal care at the University of California, San Francisco, said routine ultrasound should not even be an option for the healthy woman.

"We can't waste time and money on programmes that are of unproven value or, in this case, of no value.

"We have to ask ourselves what benefits could have been accrued if the same amount of time and money had been spent on programmes of proven benefit, such as mammography, cholesterol screening, prenatal care or Papsmeas," he said.

A meta-analysis of randomised control trials published in the BMJ in July this year concluded that routine ultrasound scanning does not improve the outcome of pregnancy in terms of live births and Apgar score."

It said scanning is effective in detecting fetal growth retardation, multiple pregnancies and severe malformations. Perinatal mortality is reduced because fetuses with severe malformation are aborted in the early stages of pregnancy rather than dying perinatally.

"Routine ultrasound scanning in pregnancy is indicated only if explicitly performed to exclude congenital malformations.

"For many women, routine ultrasound scanning may be of considerable benefit by offering the option of an early abortion of a malformed baby and by reducing concern of giving birth to a malformed baby.

"This value must be weighed against the risk of false positive diagnosis of malformations.

"If a woman does not consent to screening for malformations, however, routine ultrasound is not indicated."

Epidurals may stop in Northland

- Christchurch Press 16/11/93 -

WHANGAREI - Whangarei anaesthetists are threatening to stop giving epidural (spinal anaesthetic injection) pain relief to pregnant women.

A specialist anaesthetist, Dr Rod Harpin, says the ban could come as anaesthetists become increasingly scared they will end up in jail if anything goes wrong.

Their fears arise from a combination of the 1961 New Zealand Crimes Act and recent revisions of conduct for epidural procedures. The Crimes Act says medical practitioners are criminally liable in the event of patient death because of "human error".

The revisions for epidural procedures deem anaesthetists to be ultimately responsible for the patient when an epidural is given.

An increasing number of investigations by police into the deaths of patients elsewhere in the country meant Whangarei anaesthetists were becoming jittery and would probably stop giving epidurals for pain relief in the next few weeks, Dr Harpin said.

The epidural revisions say there must be enough skilled staff available at all times to handle any complications. In Whangarei that was a problem because the hospital did not have the staff to ensure sufficient on-site medical assistants, Dr Harpin said.

No anaesthetists lived at the hospital and, if complications arose, the patient could be dead by the time the anaesthetist arrived. To avoid criminal liability anaesthetists would simply stop giving epidurals, he said.

The situation produced huge ethical dilemmas for anaesthetists who had been trained to make the patient as comfortable as possible.

Circumstances such as the urgency of the

Betty acts as a midwifery consultant and is involved in the Special Interest Section of the College of Midwives. She is a foundation member of the college.

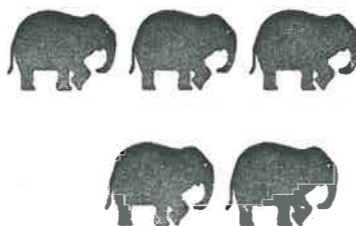
Earlier this year she attended the International Confederation of Midwives Triennial Congress in Canada - along with 2800 midwives. She says the New Zealand college is unique internationally in having consumers on its boards of management and it is this support from consumers that has allowed midwives to achieve autonomy. The International College of Midwives has now accepted in principle the idea of consumers being involved.

Her most vivid memories of the congress are of the sharing and networking and some very good papers and she believes New Zealand is ahead in lots of practices.

On her travels she visited a birth centre in New York which was a demonstration centre and also the Bronx Birth Centre. The latter was very laid back and had the same sort of atmosphere that is now provided for birthing women at the Papakura Marae Birthing Centre, also with an ethnic mix on the staff.

Childbirth Choices, Dr Adrienne Bennett, Wendi Etherington, Dr Daphne Hewson, Viking Pacific penguin Books (NZ) Ltd, 1993.

- Parents Centre Magazine 1993



CHILDHOOD SEXUAL ABUSE, SEXUALITY, PREGNANCY AND BIRTHING

- By Patrica Smith

- Reviewed by Andrea Gilkison

This book, I believe, is essential reading for all midwives. Patrica Smith, in completing her master degree in Guidance and Counselling, has researched connections between childhood sexual abuse and sexuality, pregnancy and birthing in one woman's life. She presents her findings in a way that makes compelling reading.

As Kitzinger (1983) suggests: 'The relationship between natural childbirth and sexual feelings is well established.' Another author cited in this publication, Newton (1979) suggests that women have three interpersonal acts of reproductive behaviour - intercourse, birthing and breastfeeding - and wrote that a woman's psychological and physiological responses to all three are similar.

This forms the basis of Smith's (1993) research, as she follows through one woman's life story of sexual abuse as a child, sexual difficulties as an adult and her birthing and breastfeeding experiences - showing direct links in coping strategies that this woman formed in childhood and carried through to adult life in dealing with sexuality and birth experiences.

CHILDBIRTH CHOICES

Anna Saunders interviewed Betty Jenkins about Childbirth Choices

Independent childbirth educator Betty Jenkins believes *Childbirth Choices* really gives women the chance to make informed choices, helping them retain control over their bodies during the birth process.

Betty is an independent childbirth educator based in Auckland and she recently wrote the foreword to the new Australian book on birth endorsing the book for the NZ College of Midwives.

Women today have lost touch with their bodies and doctors do not trust women to know their bodies, she says.

She believes women should plan for birth but it is also important not to have too fixed an attitude as things can change and the woman herself can change during the birthing process. "There should be no guilty feelings but the woman should feel pleased and proud at what she has achieved".

New Zealand is way ahead of Australia, according to Betty. There it is still routine to do enemas and public shaves, which haven't been performed in this country for some years. But she did concur with the authors that there were as yet no formalised standards for childbirth education, through both New Zealand and Australia are working towards this eventual aim.

She is impressed with the amount of research backing up material in the book and says the authors, a senior lecturer in psychology, social worker and childbirth educator and another senior lecturer who is also a childbirth educator, worked hard to provide a balance between the medical of childbirth and the natural approach.

"it is not a book about natural childbirth nor a medical handbook, but provides a good balance between the two and supports this with research and references". She believes this approach will allow women to make informed choices.

One of the book's strengths lies in its challenging of myths which the authors describe as practices or beliefs that ignore research findings. Myth headings include The safest place to have a baby is in hospital; Birth shouldn't be painful; Birth plans put people's backs up; It's easier to take the medical package; Test results are accurate; The safety of ultrasound has been established; Episiotomy prevents problems.

These and the chapter headings that begin with questions - How will I know when I'm in labour? Does anything help the pain besides drugs? give the book a consumer focus. Betty describes the book as easy to read with a good format. She says it is a very good reference manual and all childbirth educators should have it in their libraries.

Betty trained as a general nurse and after having her family, trained in midwifery in 1971. She worked at National Women's Hospital for many years, finally working on the administration side.

She became an independent childbirth educator after the health system was restructured three times in 4 years. She now teaches private classes in preconception, antenatal and early parenting for the first 6 weeks. She also takes first aid courses and a paediatric first aid course for young mothers.

situation, the high risks involved, the patient's state of health and the care the patient had previously received were not taken into account by people who did not understand the situation, he said.

The Society of Anaesthetists' president, Dr Hugh Clarkson, said anaesthetists feared manslaughter charges if the patient died. Dr Clarkson, from Waikato Hospital, said anaesthetists worked under intense police scrutiny because, under the Crimes Act, they could be held accountable in the criminal courts for even a small error.

-NZPA

Breech delivery and epidural analgesia

- MIDIRS Midwifery Digest (Sept 1992) -

Objective: To examine the effect of epidural analgesia on the progress and outcome of spontaneous labour in women with a singleton breech presentation at term (≥ 37 weeks).

Design: A retrospective study.

Setting: Data Bank, Aberdeen Maternity Hospital.

Subjects: 643 women (273 primiparae and 370 multiparae) with a singleton breech presentation and spontaneous onset of labour term.

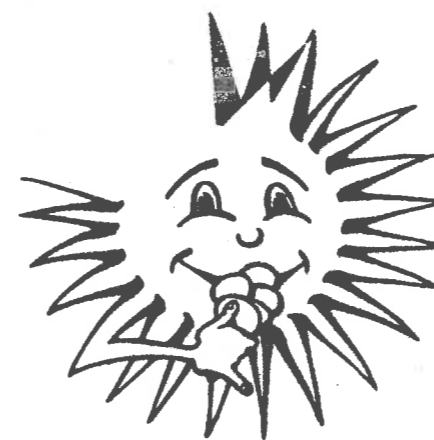
Outcome measures: duration of labour augmentation of labour with oxytocin infusion; caesarean section rates.

Results: Epidural analgesia was associated with a significantly increased need for augmentation of labour with oxytocin infusion ($p < 0.001$) and longer duration of labour ($p < 0.001$), irrespective of parity. Comparing women who had epidural analgesia with those who did not, there was no significant difference in caesarean

section rates in the first stage of labour in primiparae (odds ratio 1.79; 95% CI 0.88-3.63) or multiparae (odds ratio 0.97; 95% CI 0.48-1.96). Epidural analgesia was associated with a significantly increased likelihood of caesarean section in the second stage of labour, both in primiparae (odds ratio 5.43; 95% CI 2.46-11.95) and multiparae (odds ratio 5.37; 95% CI 2.07-13.87). The increased likelihood of caesarean section in the second stage in primiparae with epidurals was independent of the extent of cervical dilatation (< 3 cm or > 3 cm) on admission. However, in multiparae with epidurals, the difference in second stage caesarean section rate was significant only when initial cervical dilatation was < 3 cm (odds ratio 3.65; 95% CI 1.14-11.65).

Conclusion: Epidural analgesia was associated with long duration of labour, increased need for augmentation of labour with oxytocin infusion and a significantly higher caesarean section rate in the second stage of labour.

Chedhe YC, Mahmood TA, Dick MJ, and others. *British Journal of Obstetrics and Gynaecology*, vol 99, no 2, February 1992, pp 98-100



MATERNITY MORTALITY IN NEW ZEALAND

- The New Zealand Medical Journal
8 September 1993 Volume 106 No 963

DR Aickin, FRCOG, FRNZCOG, FRACS,
Professor of Obstetrics and Gynaecology,
Christchurch School of Medicine,
Christchurch.

Abstract

New Zealand's maternal mortality rate in the triennium 1986-8 was reviewed in comparison with the rates from Australia and the United Kingdom during 1985-7.

The New Zealand rate of 9.6 obstetric deaths/100 000 total births was higher than that for the United Kingdom (6.2) and Australia (4.4). Six of 16 deaths in New Zealand during the triennium were caused by sepsis, including five cases of puerperal infection with group A beta-haemolytic streptococci. Careful analysis of maternal deaths in New Zealand remains an important priority to provide audit of the performance of maternity services.

Deaths associated with pregnancy and the puerperium in New Zealand have been assessed and reported since 1969 through the provisions of the Maternal Mortality Research Act (1968) and its amendments. The Maternal Deaths Assessment Committee, a statutory group established to carry out the requirements of the Act, was recently reconstituted. The first report produced by the new committee records analysis of deaths which occurred during the triennium 1986-8. Although numbers of deaths in a relatively small population are too few to justify comment about

trends over short periods of time, the cumulative reports from successive committees provide an important source of audit of the performance of New Zealand obstetric services. During 20 years (1969-88) there have been 429 deaths from a denominator population of 1 121 177 total births, a rate of 39 deaths per 100 000 total births.



Drugs popular

A survey of 25-year olds in London shows that 97 per cent have tried marijuana. The *Time Out* magazine research also found that 40 per cent had used amphetamines, 38 per cent ecstasy, 33 per cent LSD, 32 per cent cocaine, 3 per cent heroin and 2 per cent crack.

NZ Doc World News 28/10/93

Govt backs midwives

A government report in the UK has recommended that midwives should provide maternity care rather than GPs or hospital consultants, who should only be used in complicated cases. Author of the report Baroness Cumberlege said the report is not a charter for midwives, obstetricians or GPs, but rather a charter for women. The Royal College of Obstetricians and Gynaecologists has denounced the report saying every pregnant woman must be reviewed by a medically qualified person, while midwives said it offers nothing short of a revolution in women's health care.

NZ Doc World News - Oct 1993



BOOKS & VIDEOS

NOTABLE WOMEN IN NEW ZEALAND HEALTH (Te Hauora Ki Aotearoa: Ona Wahine Rongonui)

By Patricia Sargison, published by Longman
Paul in association with the Department of
Health, 86 pages, paperback, \$14.95

Historian Patricia Sargison assembles the stories of 21 women who have made an impact on attitudes and developments in health in New Zealand. The adaptation of traditional Maori healing to treat European infectious diseases opens the book with the story of Hawkes Bay healer Te Hura.

The theme of cultural cross-pollination and working for Maori health continues with Akinihi Hei and the Maori Health Nursing Scheme, Te Puea Herangi and Erihapeti Murchie and the Maori Women's Welfare League.

French nun Mother Mary Joseph Aubert cared for both Maori and European in defiance of Church authorities and society conservatives and raised money through herbal remedies based on Maori lore. Campaigners for the health of women and children, Health Camps, Plunket, Family Planning and public health are included.

Christchurch's much loved nursing pioneer Sibylla Maude is featured along with Grace Neill who introduced nursing registration and Health Department heavy-weight and nursing education reformer Mary Lambie.

The collection covers more modern issues of research, career demands, choice and informed consent through the stories of Muriel Bell, Alice Bush, Anne Hall, Joan Donley, Sandra Coney and Phillida Bunkle.



UNFINISHED BUSINESS

edited by Sandra Coney

Five years after the release of the report in August 1988, what has happened? Following the Inquiry into the treatment of women at National Women's Hospital, Judge Silvia Cartwright made sweeping recommendations for change.

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Women's Health Action
PO Box 4569
Auckland 1

RMI opposes prescribing guidelines for GPs

- NZ Doctor - 28/10/93

National guidelines for general practice prescribing are under fire from the Researched Medicines Industry Association (RMI).

In a discussion paper on the Core Services Committee consensus development conferences, the RMI says nationally set standards appear to have limited impact in practice.

"American studies suggest that guidelines emanating from consensus development conferences are unlikely to affect practice, unless other factors promoting change are present."

The RMI suggests that at the outset the effectiveness of practice guidelines both in changing behaviour and in improving the quality of care should be questioned.

"It is necessary to consider the demand from GPs for clinical choice and the need for innovation in treatment," says the paper.

The Core Services report on the use of minor tranquilisers receives special condemnation.

The RMI says the process by which panel members reached consensus was not open and the degree to which the guidelines are opinion or based on scientific evidence

is not clear in the report.

If GPs are forced to work within guidelines through audit or contracts this "may block the access of physicians and patients to necessary services wrongly labelled as 'inappropriate'".

And the RMI questions the motives behind the guidelines.

"The guidelines appear to have been aimed at cost containment within the Pharmaceutical Benefits Scheme rather than improved patient care," says the paper's summary.

The RMI says in order to achieve enhanced education of the medical profession it is better to support continuing medical education than to use resources in setting guidelines.

Its member companies possess a wealth of knowledge on pharmaceutical products and their use in treatment that currently assists GPs to make appropriate prescribing decisions.

"The RMI asks what further role it could play in providing a level of postgraduate education to GPs. Guidelines would then be unnecessary except for use in the more complex areas of medical treatment."

Is the six-week postnatal vaginal exam redundant?

- Medic Alert - 14 October 1993

A British Consultant, Dr Tony Noble, while endorsing the need for a six-week postnatal visit, suggests the routine vaginal examination is unwarranted and should be limited to women with specific indications.

Since studies have shown the vaginal examination seldom pays dividends (and even then treatment is rarely needed) the emphasis of this visit should be on general maternal concerns such as backache, depression and contraception, and infant feeding and immunisation.

Obstetric texts recommend a six-week postnatal vaginal examination but this practice has been questioned because it seems arbitrary and may mean more important issues pertaining to mother and child are overlooked.

In one series in which 150 women underwent routine six-week postnatal vaginal examination, only 25 were found to have an indication and pathology was apparent in only six (three each with bulky but symptomless uterus or cervical ectopy). None required treatment.

Some clinicians advise against intercourse soon after delivery but many women resume sexual activity between two and four weeks after childbirth. This may cause discomfort but generally is not considered harmful.

Most patients regard a vaginal examination at six weeks as a necessary inconvenience. Resources and time spent may be better employed in counselling.

A vaginal examination should be conducted if symptoms indicate it is required eg, discharge or painful intercourse, or the patient requests an IUD be inserted. Examination should also be undertaken if a repeat cervical smear test is required.

Those with stress incontinence can be examined to determine whether pelvic exercises are strengthening the correct muscle groups.

Women who experience serious complications of pregnancy or delivery will be required to visit the obstetrician around this time.

Noble T. BMJ 307:608, 18 Sep 1993

U.S

Pregnancy stays up

A consistent US teenage pregnancy rate over the past decade indicates an increasing number of teenagers having sex and uneven accessibility of family planning and abortion services. Despite national goals to reduce the rate, statistics signal that a larger number of teenage pregnancies resulted in live birth in the late 1980s than during previous years.





Law of consent still applies in emergencies

Doctors working in emergency medicine can face a dilemma arising from conflicting considerations: on the one hand an ethical and possibly legal duty to intervene to save a patient's life, and on the other a potential legal liability if proper consent has not been given.

Basically, a doctor who carries out a medical procedure on a patient without gaining effective consent could be open to action for damages for the reason that he or she has committed the tort (or civil wrong) of battery.

This has been defined as "the application of force to the person of another without lawful justification even though it neither does nor is intended nor is likely or able to do any manner of harm." The requirement of "lawful justification" referred to in this definition may be satisfied in a number of ways, eg, where the patient consents to whatever is being done or when authority has been given by application of statute.

It should, however, be borne in mind that a bona fide belief that a procedure is in accordance with accepted medical practice and in a patient's best interests will not generally be a defence to an action in battery.

ACC does not cover all events

It is well known that there is a general immunity from civil action as regards events giving rise to cover under the

accident compensation legislation. In context, this includes matters coming within the concept of a medical misadventure.

However, not every untoward event in health care will give rise to a medical misadventure. In this regard, the relevant provisions of the legislation effective since 1 July 1992 have narrowed the meaning of the term in several important respects.

Apart from the limited situation in which a medical misadventure is confined to circumstances involving a failure to exercise reasonable care and skill, ie, negligence. Therefore, in general there is not immunity to an action in battery; this being something outside the current statutory definition of a medical misadventure.

An additional factor is that cover under the accident compensation legislation will only arise if a "personal injury" has resulted. This will not necessarily be the consequence of urgent medical treatment. Indeed the object of the treatment is to save life and avoid harm.

Implied authority

An authority to carry out a medical procedure in an emergency situation might arise in terms of a consent that could be said to be "implied" in the circumstances or by virtue of necessity.

In so far as the first of these principles is concerned, one commentator has observed that "consent may be given expressly, as when a patient authorises a surgeon to perform an operation,

Primary care spending

NZ Doctors News - 14/10/93

Spending related to primary medical care rose 6.1 per cent a year between 1982 and 1991, according to the analysis of Wellington community medicine professor Laurence Malcolm.

But the GMS benefit rose 12.1 per cent, maternity benefits by 11.8 per cent and ACC related physiotherapy by 10.5 per cent over the same period.

From 1990 to 1992 there was an inflation-adjusted drop in overall primary care related spending of 0.5 per cent - far less than the budgeted decrease which took account of major increases in user part charges and prescription charges.

Last year saw an overall increase in spending in the area of 1.9 per cent with a 16.4 per cent rise in maternity benefits and 10.1 per cent in laboratory benefits.

Over the 13-year period to 1991 GP workloads appeared to diminish with GMS data showing a decline in median/mean workloads by 480 per GP to 7044 consultations per year.

"The overall conclusion of this study is that the increase in expenditure reported is largely related to the decisions of GPs to incur primary medical care expenditure without budgetary limitations," reports Professor Malcolm.
by Cecily McNeil

"Another reason for Midwives to be united"

Whistleblowers victimised

An Australian study of 35 people who blew the whistle on corrupt, wasteful or dangerous practices in their organisations found that eight had lost their jobs as a result of their action, 10 had been demoted and 10 had resigned or retired early due to ill health related to the stress of being considered a "snitch".

The study reported in the *BMJ* shows:

- 29 had symptoms they attributed to stress ranging from sleeping problems, anxiety, depression and hypertension
- 13 were forced by their employer to see a psychiatrist
- 15 felt they were the victims of lies, deceit or corruption
- five had been physically attacked or harassed.

NEW ZEALAND DOCTOR 14 OCTOBER 1993 59

Do you sometimes lambaste your staff, angered at their lack of ability? ... Perhaps you should look deeper. Stuart Young, executive chairman of an innovative Wellington aluminium company, recently spoke on this subject ... "Just as a good tradesman never blames his tools, a good manager never blames his staff. That's what management is - the selection, training, motivation and empowering of good people. Frankly, if you have lousy staff, you're a lousy manager," he said.

- The Main Report - 19/11/93

Although the grading system introduced in 1988 was expected to reward clinical practice and eliminate the need to move into management in order to advance one's profession, the effect has been quite different.

There are now many midwifery managers with very limited clinical experience, who had quickly realised that advancement could be gained via management-related qualifications, plus a constant readiness to apply for higher posts. A year or so in a management position looks good on the application for a job on a higher rung, with the result that an impressive CV is acquired.

How deeply do prospective employers inquire into the support given to colleagues while in such posts? Do they ask what innovatory changes the candidate initiated while in a position to do so?

The ever-increasing commercialisation of the NHS has already affected the quality of service, not always for the better. Clinical management is now showing signs of strain, especially in the maternity services, where far too many midwives are working in an atmosphere of confrontation with their midwifery managers, instead of mutual support.

The tide will inevitably turn, and it will be interesting to see how many innovatory models of maternity care reach the crest of the wave, successfully riding the storm. It would be sad if too many of them are sucked back into the maelstrom for lack of strong, supportive and imaginative leadership.

Performance pay 'a failure'

LONDON - Performance-related pay failed to motivate workers and could even demoralise staff, according to a report yesterday.

A survey of 1000 employees found most were neutral or negative about PRP, throwing considerable doubt on the benefits claimed by employers.

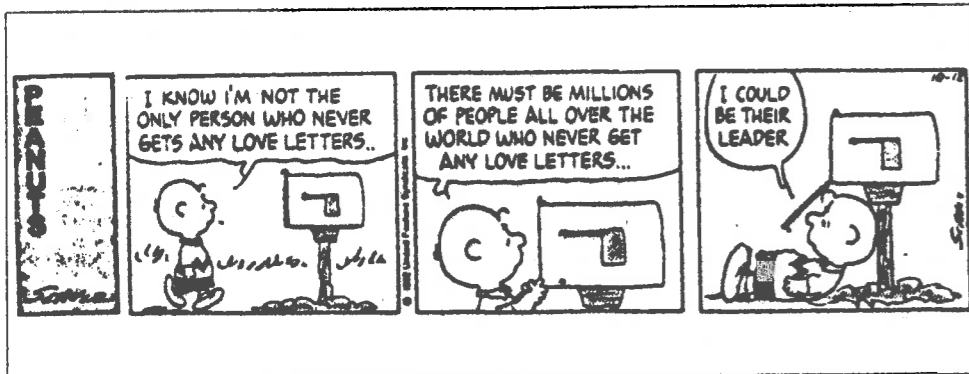
Pay rises linked to performance were said by bosses to motivate workers, help retain highly regarded staff, and change the culture of an organisation for the better.

But the experience of employees did not match the expectations, said the Institute of Manpower Studies.

Its survey of workers in a county council, a food retailer, and a building society found PRP did not motivate workers and could even demoralise staff.

- PA

- Christchurch Press 24/11/93



but it may just as well be implied: actions often speak louder than words. Holding up one's bare arm to a doctor at a vaccination point is as clear assent as if it were expressed in words."

A possibly stronger (and arguably broader) basis for the administration of emergency medical treatment without the patient's consent is that afforded by the doctrine of necessity.

The scope of this principle is far from certain but it may be invoked in the following situations:

- * In circumstances of emergency, particularly where the patient is unconscious and therefore unable to give an effective consent.

- * Where procedures are carried out in surgery (eg, removing tissue or an organ) beyond those originally anticipated. These steps might be legally justified if the problem could not have been reasonably foreseen, or the tissue of organ removal is necessary to preserve the patient's life or health and the procedure could not reasonably be postponed.

- * In certain extraordinary circumstances, eg, to remove a toxic substance ingested by a patient who has attempted suicide.

Express refusal poses problems

The position of a doctor faced with an express refusal of treatment by a patient is particularly difficult. A doctor will, in emergencies, inevitably feel a professional duty to intervene to save a patient, the doctor is at risk of a possible liability for damages for the tort of battery.

One of the leading cases on point (decided in Canada in 1990) involved a Jehovah's Witness who was severely injured in a motor vehicle accident and taken unconscious to hospital where

she was attended by the defendant doctor. A card was found in the patient's purse which identified her religious affiliations and expressly prohibited blood transfusion "under any circumstances". The plaintiff's wishes in this regard were confirmed by the plaintiff's daughter who was in attendance at the hospital.

The defendant attempted to maintain the plaintiff's vital function with artificial alternatives but eventually felt compelled to administer a blood transfusion. Although successful in saving the patient's life the defendant was held liable to pay to the plaintiff a substantial sum by way of damages.

The Court held that "a competent adult is generally entitled to reject a specific treatment or all treatment ... even if the decision may entail risks as serious as death and may appear mistaken. Regardless of the doctor's opinion it is the patient who has the final say on whether to undergo the treatment. While in an emergency the doctrine of necessity may protect the physician who acts without consent, the doctor is not free to disregard a patient's advance instructions."

A somewhat different approach was followed in a 1992 English case. This case concerned a 20-year-old pregnant woman admitted to hospital after a car accident. The patient had been brought up in a Jehovah's Witness family but had subsequently rebelled against that faith. While conscious at the hospital she verbally (following discussions with her mother who remained a strict adherent) refused a blood transfusion on the basis some relative beliefs were still maintained.

This was confirmed by the signing of a refusal of consent form. Notwithstanding this, the lawful administering of a blood transfusion was authorised by the High Court and affirmed on appeal.

The judgement of the Court of Appeal of England was based on three factors. Firstly, it was concluded that the patient's physical and mental condition was such as to reduce her capacity to make a decision declining treatment essential to save her life.

Secondly, (by contrast with the decision at first instance), it was held that the overwhelming influence of the patient's mother meant that the refusal of consent would not be considered to have been real or genuine.

Thirdly, the reasoning of the High Court was upheld to the effect that even if a patient has the capacity to decide and has exercised that right, the question must still be asked as to whether that decision extends to all circumstances.

On this basis it should be asked whether a patient's decision can be taken as extending to a new, perhaps unforeseeable, circumstance which might arise where, for example, he or she becomes unconscious.

According to the Court, "what doctors cannot do is to conclude that if the patient still had the necessary capacity in the changed situation he would have reversed his decision. This would be simply to deny his right of decision. What they can do is to consider whether at the time the decision was made it was intended by the patient to apply in the changed situation. It may well have

been so intended."

Following the 1992 ACC legislative changes, there are few legal obstacles to a civil action for the tort of battery.

These issues have yet to be addressed in New Zealand in anything like a definitive manner. However, one of the few New Zealand cases to address the matter of consent at the higher levels included an acknowledgement of the "patient's obvious right to make his own choice as to what is to happen to him".

On appeal, the point was also made that "an individual patient must... always retain the right to decline operative investigation or treatment however unreasonable and foolish this may appear in the eyes of his medical advisers".

It should finally be noted that section 11 of the New Zealand Bill of Rights Act 1990 expressly provides that "everyone has the right to refuse to undergo medical treatment".

Graham Rossiter is a senior lecturer in health care law at Massey University.

NZ Doctor Medical Law - Nov 1993



LOST LEADERS

Midwives need supportive and imaginative managers but sadly this is not always forthcoming, says Isabel Kargar

- Nursing Times, vol 89, no 9, 3 March 1993, p26

The tide of change in maternity care and midwifery practice is rising rapidly, and where there is strong, supportive and sensitive midwife management, opportunities are being seized and innovative changes are made, introducing a more responsive, client-led service.

Most of these changes involve negotiation with hospital management and professional colleagues at all levels. Few 'grass-roots' midwives feel confident about tackling this and rely on senior midwives to act on their behalf. This exposes the vital element in the whole equation because, to be successful, these midwife managers must have a conviction that the proposed changes will benefit women and their attendants, and that the new system will also be economically acceptable.

Some clinical midwives, having asked women in the community about the kind of service they want, have successfully persuaded their midwife managers to facilitate the necessary changes. These managers, although not initiating the changes themselves, have not been obstructive, once convinced of the value of the proposed changes.

In some cases, the inspiration has come from the midwife managers themselves, who have dealt sensitively with objections from reluctant

staff and eventually overcome the obstacles, to be rewarded by colleagues' support and enthusiasm for the new models of care.

Unfortunately, there are still far too many units where midwifery managers not only do not initiate improvements in the service but actually block the efforts of any midwives suggesting changes in practice for the benefit of the women they care for.

Where did these managers come from? How did they climb the ladder from clinical midwifery into management without becoming aware of the deleterious effects of rigid protocols and practices? Where were they when the clamour for a midwifery-led service was finally acknowledged as being justified?

Career patterns in the National Health Service have undergone tremendous changes in the past few years. Until the early 1980s, on qualifying a midwife could expect almost automatic promotion to ward sister level after a year or so as a staff midwife in her training hospital. Other promotion opportunities lay in the many similar posts available elsewhere in the country, or into community midwifery. Several years' practice at this level gave the midwife a good clinical background as well as an appreciation of the pleasures and pressures of responsibility. Later, as nursing officers and

Officers and directors of midwifery services, this experience was usually acknowledged and respected by the rest of the staff.

There was a confidence on the part of most medical and midwifery practitioners that although some women might indicate a preference for an alternative model of care, they could be easily reconciled to the orthodox model, using the age-old adage of 'we know best'. Most modifications of practice were made at the instigation of the consultant, and midwives usually adapted their practice to conform to the new policies.

The picture today is vastly different. Tremendous changes have taken place in both camps, with many women no longer accepting the paternalistic attitudes of their attendants and midwives themselves having been forced to recognise that their practice must become woman-centred. These two movements might have united to form an ideal maternity service, giving satisfaction to both parties, but for a third element, equally momentous, which took place at the same time.

The several waves of reorganisation within the NHS management structures, which took place in the mid-1980s and later, scattered the recognised patterns of the four winds.

The guidelines were adopted by the insurers with the agreement of GPs and midwives, and despite obstetricians' objections.

When a pregnant woman first approaches a GP or midwife, the professional uses a flow chart (see box) to decide whether he or she should care for her or whether a specialist is needed.

Other criteria show whether a hospital birth is indicated, or a woman can be left to choose where she gives birth.

There are four criteria, against which every medical indication the woman presents with, are measured.

They show clearly where the birth should take place and who should be the responsible caregiver.

Where primary obstetric care (A) is indicated, a woman remains under the care of the midwife or GP and it is considered safe for her and her baby to give birth at home.

Where consultation is required (B) a specialist is asked to examine the pregnant woman and give advice. Then the GP or midwife makes a decision on further obstetric policy and is held responsible for this decision.

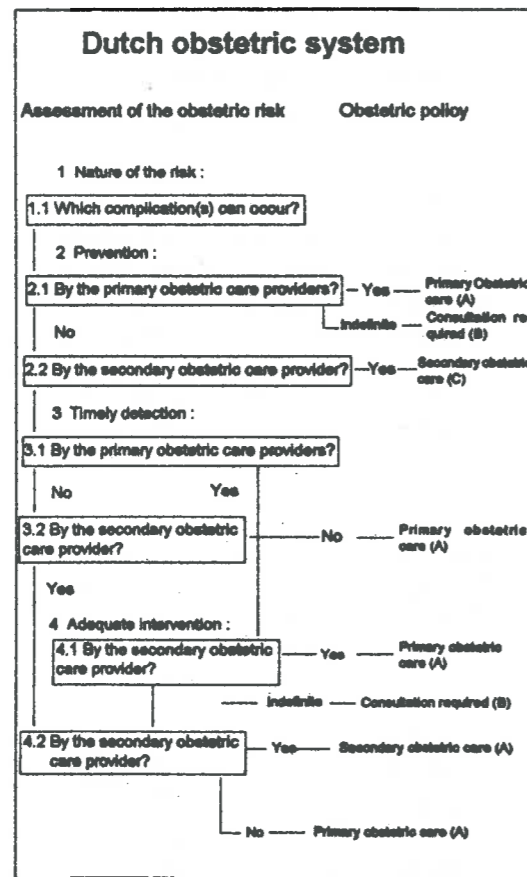
Where secondary obstetric care (C) is indicated, the woman is referred to the secondary caregiver for any further prenatal care and delivery. The delivery has to take place in hospital.

In a number of situations the obstetric risk for either mother or baby may be such that a hospital delivery is necessary

but the care is within the competence of the GP or midwife.

This "medium risk" situation always involves consultation with the specialist but the primary caregiver is fully responsible for the birth in hospital.

Using the system about 18 per cent of pregnant women are referred to an obstetrician during pregnancy and a further 13-15 percent are referred during labour.



Premature rupture to be studied worldwide

- NZ Doctor - 1993

Canadian researchers are spear-heading an international study of how best to manage premature rupture of membranes (PROM) at term.

The study will include 5000 women at centre in Canada, New Zealand, Scotland, Sweden and Norway.

It is expected to settle "once and for all" whether active or expectant management of PROM at term is the best strategy for the baby, according to Dr Mary Hannah, associate professor of obstetrics and gynaecology at the University of Toronto, and principal investigator of the study.

The study will also determine the risk of caesarean section associated with each management approach, and will assess material outcomes and how women feel about their management.

The question is important in obstetrics because PROM at term is estimated to occur in 10 per cent of otherwise low risk pregnancies.

Management across Canada is variable.

Historically, women with premature rupture at term have been induced because of fears of infection.

But more recently, a strategy of waiting for labour to begin on its own has been found to result in a lower C-section rate with no increase in material, fetal or neonatal infections.

There are currently 25 to 30 centres participating, with an additional 20 to 25 centres including National Women's Hospital in Auckland expected to join over the next several months.

Canada's Medical Research Council has provided \$Can1.3 million in funding for the first three years of the study (from July 1991 to June 1994).

Enrolment is expected to be completed by mid-1995, with the results available by early 1996, said Dr Hannah.

Women in the study will be randomised to one of four groups: induction with IV oxytocin, induction with vaginal prostaglandin E2 gel, or expectant management over four days.

If women in the expectant group need to be induced, they will be further randomised to receive oxytocin or prostaglandin.

The natural history of PROM at term is that 70-80 per cent of women go into labour within 24 hours of membrane rupture, and 90 per cent within 48 hours, she said.

Although a large number of trials have examined the issue, "most of the trials haven't been very well done".

The results tend to suggest that active management carries a high C-section

risk, but a lower risk of neonatal infection - but there is now much less confidence about that result.

"Because of those concerns and others, we're very uncomfortable with drawing a specific conclusion that IV oxytocin early on is better for the baby.

"And in the face of this fairly strong evidence that it increases the C-section rate, we felt that we should find out once and for all what was best as far as the baby was concerned," said Dr Hannah.



The O&G Society recently published and widely distributed their referral guidelines which some CHEs have adopted without question. While there are certainly areas of agreement, midwives have criticised the guidelines as too restrictive with many of the indicators identified as non research based. The College argues strongly for a more consensual approach to guidelines which can then be owned and adhered to by obstetricians, GPs and Midwives.

NZ DOCTOR - NEWS - 11.11.93

GPs question obstetric referral guidelines

Referral guidelines developed by the Royal New Zealand College of Obstetricians and Gynaecologists extend the role of specialists too far, according to North Shore GP/obstetrician Phillip Railton.

He said in other countries such as Holland (see story below) it is considered to be a waste of resources to tie up specialists with normal births.

Dr Railton said the guidelines are pitched at the lowest level of GP obstetric ability and do not take a team approach.

They have been developed without discussion with other interested groups and do not take individual practitioner's level of skill into account.

"What is needed in New Zealand is a discussion on guidelines involving all the interested parties.

"Primary caregivers should be consulted in the development of referral lists when these could be used as evidence in disciplinary proceedings against them," said Dr Railton.

The RNZCOG Council has compiled a list of indications for consultation with a specialist obstetrician.

Copies of these guidelines have been sent to Government, CHE and RHA managers, and colleges and societies representing other practitioners.

The guidelines state: "A general practitioner is trained to manage medical conditions but must recognise the additional potential problem caused by pregnancy and the need for specialist consultation.

"A midwife is trained to provide midwifery care for women in pregnancy, labour and the puerperium but she is not qualified to manage medical conditions."

They stress the importance of differentiating between a consultation with, and referral to, a specialist.

Accordingly, once any contact has been made, the specialist must: "provide a clear management plan

"decide who provides subsequent care
"state clearly the indications for further specialist consultation for those women who are returned to a primary care giver.

The College has listed medical conditions, which in its view necessitate a consultation with an obstetric specialist either before pregnancy or before 12 weeks of pregnancy have elapsed.

These include neoplasia and psychiatric conditions. GP/obstetrician say pregnant women presenting with these conditions may benefit more from a consultation with an oncologist or psychiatrist, respectively, than with an obstetrician.

Early consultation with an obstetric specialist is also suggested for women with a history of more than two terminations of pregnancy because of the risk of preterm labour.

"This is something a caregiver should be aware of, but cannot do anything about until labour," said Dr Railton.

There are many conditions in the list of indications for specialist referral which GPs say are well within their scope to monitor or refer on if necessary.

These include the presence of meconium, high head at term, maternal anaemia, low maternal weight or short stature, and uncertain dates in the last trimester.

According to Dr Railton, the Dutch system, in contrast, takes into account each doctor's ability and scope of practice.

The system was outlined at the 1993 WONCA Conference in the Hague which Dr Railton attended.



NZ DOCTOR NEWS - 11 Nov 1993

Dutch obstetric scheme offers clear direction

In 1992 only one in 50 New Zealand births took place at home, while in Holland that figure was close to one in three.

At the same time Holland has one of the lowest caesarean birth rates in the world.

The Dutch obstetric system has been operating since 1987 under a set of national guidelines for determining the obstetric caregiver and the site of the birth.

Primary obstetric care is given by midwives (42 per cent in 1991) or by GPs (12 per cent) and is primarily home based (31 per cent of total births).

Secondary obstetric care is given by obstetricians (44 per cent) and is hospital based (26 per cent).

GPs and midwives can also be the responsible caregivers in hospital and 43 per cent of births occur on a short hospital stay basis.

In order to have secondary care covered on her medical insurance plan, a pregnant woman in Holland must have a "medical indication" for specialist involvement.

The guide to indications for secondary care was drawn up by a health insurers' medical advisory board in consultation with obstetricians, GPs and midwives.