Maggie Banks
Te Awa Road
RD 3
HAMILTON

From : NZ College of Midwives (Inc)
P O Box 21-106
Christchurch

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

NATIONAL NEWSLETTER

SEPTEMBER/OCTOBER 1993

Maternity & Related Services Issues Paper

Update on Direct Entry Midwifery Courses

National Midwifery Resource Centre

1st Floor 183 Manchester Street Christchurch Tel/Fax 03-377-2732

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Home Birth Association
Susan Holloway

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

MEMBERSHIP APPLICATION FORM

NATIONAL INFORMATION **REGION** _____

Name _____

Address _____

Telephone _____ Home _____ Work

Workplace _____

Date of Birth _____

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

TYPE OF MEMBERSHIP

Full Membership (Waged)	$155.00) Includes	NEW	
Full Membership (Unwaged/Students)	$ 50.00) Indemnity	RENEWAL	
Associate with Indemnity	$155.00) Insurance	CHANGE	
Associate & Affiliate	$ 30.00		

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)

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

Healthwise July/Aug 93

New mid-wife scheme

By Jenny Baird, Auckland staff reporter

A new "individualised" programme of midwifery care – trialled in the past 18 months with St Helens Clinic – is to be adopted by National Women's Hospital from August 1.

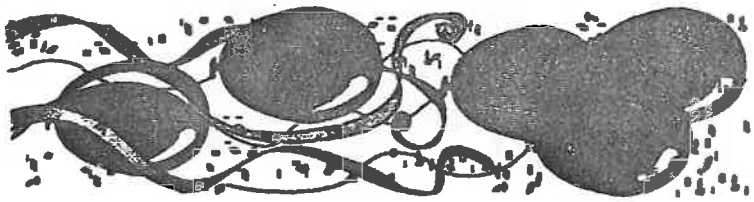
A team of six midwives from Delivery Unit One will provide personalised continuous maternity care to women in defined suburbs of Auckland – a service that is free and offers 24 hour cover, seven days a week.

The scheme, developed by National Women's Midwife Manager, Jan Carew, is designed primarily to improve the continuity of care experienced by women in the course of pregnancy, delivery and during the post natal phase.

The "visiting midwives" programme is community-based and has not previously been available offering new opportunities to build on the excellent birthing facilities already available at the hospital which caters for approximately 9-10,000 births per year.

The new scheme caters for all women, both those with low obstetric risk but also those who may develop complications The midwife team will work in close association with specialist obstetricians once the problem has been identified.

The six midwives known as Pink Team midwives work only in Delivery Unit One, one present on each duty. Before the birth of the baby, women will have the opportunity to meet all the Pink Team midwives to discuss options.



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NZCOMI
NATIONAL NEWSLETTER

REGULAR FEATURES

SPECIAL FEATURES

PUBLISHING DETAILS

Editor
Karen Barnes

Typesetting
M A Stacey

Printing by
MAS Business Services Christchurch

NEXT NATIONAL COMMITTEE MEETING

Friday 26th November 1993
6.00pm
and
Saturday 27th November
1993
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
1st November 1993

Next Newsletter will be due out early December 1993

Editorial

Dear Members,

Welcome to another newsletter. The year races on and it seems that life for midwives in many spheres doesn't slow down.

Once again, a lot has been happening politically and in the media for midwives so read on carefully to catch up on the latest news.

There continues to be increasing amounts of material coming to hand for publishing here, all of it so important. However, we still welcome local contributions so that all regions have an opportunity to be represented.

Please note plans are underway for Conference 1994 to be held on a marae, near Rotorua, and the organisers are now calling for abstracts for papers to be presented.

It has come to our attention that some members have been unhappy about the "expiry of subscription" notice on the address label of their newsletter. We have taken steps to alleviate this and you will only receive a once yearly notification of "subscription now due".

Enjoy your reading.

Karen Barnes

Taranaki Daily News May 5th 1993

Country's midwives to have their day

By JAMES McONIE

MIDWIVES are often the first people we see in this world . . . yet it's hard for us to remember them.

But today is their day. National Midwives Day was created a decade ago to help people become more aware of a midwife's role in women's health.

"It's just a way of promoting midwives, because a lot of people don't know what they do," said New Plymouth midwife Jenny Burnham.

Midwives care for women through pregnancy, labour, childbirth and also support them after the birth.

Most of Taranaki's 40 midwives work in hospitals, but Mrs Burnham is one of the region's six independent midwives.

The midwives at New Plymouth's Taranaki Base Hospital will celebrate their national day by giving a bunch of flowers and a card to each woman in the hospital's maternity unit.

New Plymouth midwife Tricia Thompson said midwives were often confused with nurses.

"Everyone knows what nurses do. A lot of people say, 'The nurses looked after me when I had my baby,' but it was actually the midwives," Mrs Thompson said. "Nearly everybody who's been born has had a midwife look after them — it's just that some of them didn't know what they were called."

You can train to be a midwife without being a nurse, although most New Zealand midwives are also qualified nurses.

New Plymouth mother Karen Whelan has had two births with a midwife and said the service was very personal.

"I found it supportive and encouraging — to give me the confidence during pregnancy, birth and handling the baby afterwards," Mrs Whelan said.

Mrs Burnham said the relationship between a mother and a midwife was close and supportive.

"I think what women like is that they get to know the midwife . . . and that takes a lot of fear out of the birth.

"It makes for a better experience."

THEY DELIVER: New Plymouth midwife Jenny Burnham (centre) pays a visit to Karen Whelan (left) and daughters Ella (left, three months) and Sian (18 months). Photo: ADRIAN MALLOCH

Midwives in the Spotlight

Midwives set up private hospital

By Brad Walker

Five Christchurch midwives have set up a small private hospital which they say is a response to the increasing demand from women for individualised maternity care.

The midwives, all of whom work at Burwood Hospital, have formed a partnership, to run the service, which will be called Avonlea Birthing Centre. It will operate from a house at 746 Gloucester Street.

One of the partners, Catherine Whyte, said the aim was to provide a maternity service with all the safety facilities of a hospital but the atmosphere of a home.

Free

The service would be offered free of charge to women, making it the first private maternity home of its kind in New Zealand, Ms Whyte said.

The five midwives would provide care both before and after birth, with women able to stay at the home for up to 24 hours after delivery.

Mothers would then be sent home with the centre making follow-up home visits for up to 14 days.

Ms Whyte said there was an increasing demand for more personal care for mothers and consistent service from the same midwife. This could not always be provided at large hospitals.

Avonlea would provide total midwifery care from conception right through to the post-natal period of 14 days after delivery. Women would be encouraged to meet a midwife at the centre early in their pregnancies. The same midwife would offer support throughout the whole term.

Ms Whyte said there had been some resistence to the service from the Ministry of Health "because it's new", and it had taken a year to obtain a private hospital licence.

However there had been verbal approval from the Southern Regional Health Authority to consider Avonlea for funding as a pilot scheme.

The centre will claim from the Ministry of Health's maternity services benefit to operate the home and cover salaries, Ms Whyte said.

- Chch Press 30/07/93

Birthing Centre : Four of the five Christchurch midwives who have set up a private maternity service in Gloucester Street (from top left clockwise): Helen Becconsall, Joan van Maanen, Catherine Whyte and Jo-Anne Hale.

National Co-ordinator's Forum

- Karen Guilliland

Another action packed few weeks since the last newsletter! These Health Reforms seem to lead us from one crisis to another as we battle to hang onto a women centered maternity service. The latest submission called for is to the Coopers & Lybrand run review of the Maternity Services. It seems in a matter of weeks these economists feel confident they will be able to

- define requirements for "good" care.
- define quality standards associated with these components of care
- identitify possible options for delivery of care that provides choice for consumers in type of mix of providers, philosophy of care and style of provision.
- determine factors which should be taken into account when purchasing or providing care.

Whilst the College was obliged to respond to their maternity and related services issues paper, it did so with difficulty. Firstly, the timeframe for input was impossible for consensus decision making for organisations such as ours and many consumer groups.

Consequently the project canvases individual opinion rather than consensual agreement by collective discussion.

Secondly, the "instructions" for response contained a confused mixture of messages. On one hand response to the paper was imperative if our comments were to be considered but on the other hand we need not respond to everything.

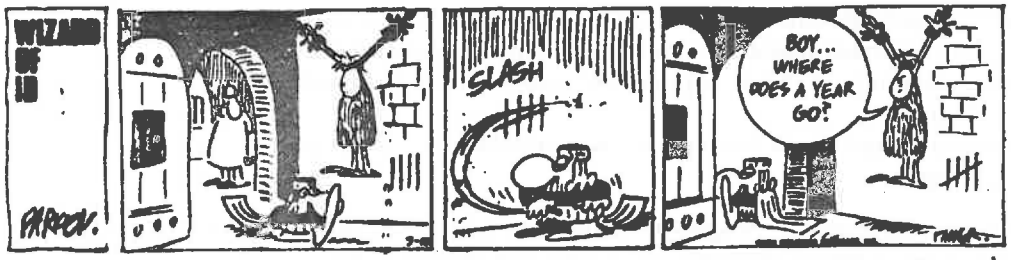
Some members were told to send submissions, others that submissions would not be taken. At some of the arranged meetings the issues paper was ignored and another set of questions posed. Discussion for some groups were limited to those questions rather than the issues the group itself deemed important.

Thirdly the lack of knowledge not only about New Zealand's health and maternity services, but also its culture, that was exhibited by some members of the project team identified the enormous learning curve Coopers & Lybrand were aiming to achieve. That such learning was to take place over such a short time frame did not instill confidence in any of the College members "consulted".

If the "consultations" (45 minutes of standardised formated questions) the College representatives experienced were typical, then it appears the government was prepared to pay over $70,000 to a group of American economists with very little knowledge or understanding of the actual New Zealand experience, to learn how our maternity services run.

The project seems cost focused and profit led rather than women responsive. Comments included "CHEs must be maintained so they can afford to have a full compliment of anaesthetists, obstetricians etc" ... "that RHAs should train staff so they get the sort of doctor they want".

We saw very little understanding of the vision women and their midwives have for their future birthing experiences. It is of great concern that ignorance may cement the status quo into the "new" health reforms. We can only hope that the women, midwives and others equally concerned about birth services convince them otherwise.



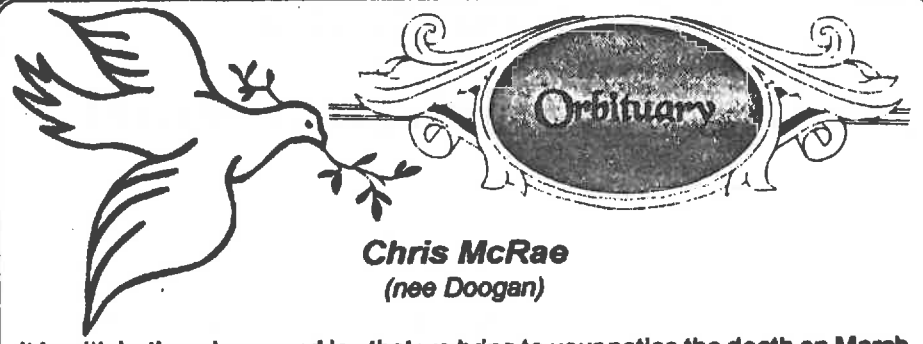
Another AGM has been and gone. The outcome of the proposed remits were as follows.

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

New subscription fees which take effect next year May 1st, 1994.



Chris McRae

(nee Doogan)

It is with both sadness and joy that we bring to your notice the death on March 15th, of our colleague and friend, Chris McRae.

Chris was at the time of her death employed as Community Midwife and Co-ordinator at the Health Centre in Opunake.

The Health Centre and Community Midwife role came about at the time of the closure of the Opunahi Cottage Hospital Maternity Unit : Chris worked tirelessly in establishing the health centre and bringing services tlo the centre, allowing easy access for the people of Opunake.

As a Midwife she established antenatal classes locally and with her friendly manner endeared herself to the women of Opunke, ensuring they were well prepared for the birth of their babies and confident in their ability to breastfeed and mother. In visiting new mums in their early days at home, Chris reassured them and encouraged them, ensuring adequate help was available and giving support to them all regardless of their circumstances.

I say with sadness and joy we mark Chris' death. Joy because she was one very special lady and those of us who worked with her were priviledged to have done so and our lives are more joyful for having known her.

Occasionally you get to work with someone special whose professional skills and judgement you admire, whose friendship you value, who always gives selflessly and is loved and respected by staff and patients alike.

Chris McRae was one special lady. Our lives are the richer for having known her and our careers fuller for the priviledge of having worked with her.

Mary Garlick
- Wanganui/Taranaki Region

- NEWS FLASH -

The Minister of Health has made his final decision on the Maternity Benefits Tribunal Report. He has upheld independence and pay equity for Midwives. This decision also recognises women's choice of care givers as a right. Our congratulations to Mr Birch.

THE OFFICE OF THE
Minister of Health

15 SEP 1993

Karen Guilliland
National Co-ordinator
New Zealand College of Midwives (Inc)

Dear Karen

I am writing to advise you that I have now had the opportunity to consider the further arguments put forward in your submission dated 1 August 1993, together with a letter from the NZMA's lawyers (Mazengarb MacAlister Perry Castle) in a letter dated 28 June 1993, and the NZMA's submission dated 30 July 1993 in relation to my decisions following the Maternity Benefits Tribunal.

As a result of those submissions and the arguments contained in the letter from the NZMA's lawyers I have made the following changes to the maternity benefit schedule which I announced on 31 May 1993:

i) the unit value for epidural pain relief will be increased from 3 to 4;

ii) the requirement that health professionals carrying out obstetric ultrasound be required to be radiologists or hold a Diploma in Diagnostic Ultrasound will be deferred pending further discussions with health professionals working in this area;

iii) to enable better monitoring of ultrasound to occur, a separate fee category will be created for practitioners claiming for obstetric ultrasound scans. The fee will be set at the same rate as the fee for a consultant opinion. If a second scan it required, it will be paid at the lower rate for a consultant opinion. Any scan in excess of two will have to be justified for obstetric reasons. Furthermore, scans will only be paid for if the woman has been referred to the practitioner claiming the fee.

The new schedule will be implemented as soon as practicable following consultation with the respective parties over the interpretation of the schedule.

Yours sincerely

Rt Hon W F Birch
Minister of Health

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.
Passed unanimously.

This will require self employed midwife members to take part in a Midwifery Standards Review process.

Remit : Constitutional

3. OBJECTIVES

3.3 To uphold and promote the New Zealand Midwife model of partnership with women.
3.4 To set, promote and monitor the New Zealand College of Midwives Standards of Midwifery Practice, Service and Education and Code of Ethics.

These are both new amendments and were. ***Passed unanimously.***

Remits : General

From Wellington Region
That the NZCOM lobby the Health Ministry to facilitate the importation or production of oral Vit K for approved useage with newborns. ***Carried unanimously.***

From Domiciliary Midwives Society
That the Domiciliary Midwives Society of NZ be represented at National Committee meetings of the NZCOM. ***Withdrawn.***

From Otago Region
That the NZCOM strongly recommend that the Direct Entry Midwifery courses at Auckland Tertirary Institute and Otago Polytechnic continue on a permanent basis, and that the word "experimental" be removed from the title.
Passed unanimously.

Kathryn O'Regan has officially approved two more intakes. Education Dept has yet to approve funding. See letter to Lockwood Smith on page .....

That Nursing Council notify the midwife of the nature of the complaint against her and the name of the complainant.

Discussion paper to be presented at next National Committee meeting on the whole issue of discipline. ***Remit withdrawn.***

The meeting farewelled Glenda Stimpson from the National Committee and expressed their gratitude for her many years involvement at National level, firstly on the NZNA Midwives Section then the NZ College of Midwives. Bronwyn Pelvin is another long standing member who has also stepped down from National Committee. Bronwyn will continue to provide input on a consultancy basis. These two founder member midwives have contributed greatly to the Midwifery movement and we will continue to benefit from their knowledge and experience.

The Labour Party Policy Document **"Health for All"** clearly identifies two major issues for Midwifery over the next few years. The National Party policy statement has not yet been released.

THE HEALTH PROFESSIONS

An overhaul of many of the statutes governing the health professions is long overdue. The nursing, medical and pharmacy legislation has been subjected to extensive review, but updated legislation has not passed through Parliament. Other professions are also struggling with clearly outdated statutes. Some, like the midwifery and osteopathy, lack adequate recognition in statute. Labour will make a determined effort to clear the legislative roadblocks and present updated statutes to Parliament.

Both the nursing and podiatry professions are preparing for the extension to them of prescribing rights to the level of their competence. Labour will facilitate that change. The new Nursing Act must also enable autonomous nursing practice.

Labour will also move to regulate the practice of osteopathy in the public interest. There are legitimate fears for public safety in this area which is presently ungoverned by statute. This has long concerned fully qualified osteopaths.

EDUCATION AND TRAINING OF HEALTH PROFESSIONALS

Labour is concerned that the continual reviews of clinical training have cast a shadow over its future funding. While in principle there can be no objection to the identification of the costs of clinical training, in practice this could lead under National to the transfer of more of those costs to clinical trainees. Labour is opposed to that.

Two particular areas of education and training are immediately threatened by National:

- National has announced that it will no longer fund the Family Medicine Training Programme of the Royal College of General Practitioners. This programme has been essential for preparing young doctors for general practice.

Labour will work with the Royal College of General Practitioners on funding for a new programme to ensure that new entrants to general practice are adequately trained.

- National has made no commitment to continuing the direct entry course for midwifery.

Labour will ensure that fresh intakes into the current programmes continue without lapsing while the early intakes are evaluated.

CONCLUSION

Labour has a strategy for a public health system which is committed to improving New Zealanders' health and delivering integrated services of high quality.
Labour's model is based on collaboration and cooperation within the health sector.
Labour rejects National's commercial and contracting structures. An open and responsive public health system will replace them.

Maternity costs

Sir,—Doctor Philip Rushmer, whose article about competition for maternity patients appeared in the *Herald*, seems to have missed the point of the economic and health reforms of the last few years.

Gone are the days when "high overheads" could be used as a justification for an increased fee.

Competition is a fact of life and women now have a choice of whom they want to officiate at the birth of their children.

The next step is for all those qualified, and who want to provide the service — that is midwives and doctors — to tender to the Health Department.

Details of the care provided and cost could then be used by the department to compile a list of preferred providers.

Medical benefits could then be based on an average of the lowest tenderers.

The idea of a tribunal setting a fee based on the pleadings of the recipients of that fee seems to me to be a guarantee that costs will stay high.

Now that doctors have some competition in the area of maternity care let us see if it might result in some savings and perhaps help to point the way to the future. 31/7/93

M. Glass.
Mt Roskill. NZ HERALD

Sir,—As a first-time expectant mother who has opted for an independent midwife I would like to let your correspondent Colin Smith in on a few details of what the midwife does for that money.

She is on call to me 24 hours a day, for any questions I have, for some six months of my pregnancy.

She comes to my home to visit instead of my having to beat the traffic to the doctor's surgery then sit and wait for the doctor to see me.

When I go into labour, she is there beside me at home until it is time to make the trip to the hospital, should I opt to go into hospital.

A bond is formed so that the person delivering the baby is not some stranger. As I have been a taxpaying citizen of this country for the past 17 years, I feel I deserve this so-called expense and so do a lot of other women. Therefore, a vote of thanks to the Government.

A. Roberts.
Mt Wellington.

Midwives best

Sir,—Midwives can do without GPs, but can GPs do without midwives? At present a GP visits a labouring woman on average once every four hours. He relies totally on midwives to care for his "patient," the midwife is trained to spot any abnormal signs.

Midwives give holistic care, particularly the independent midwife, who visits the home antenatally and postnatally, and stays with the woman throughout the labour.

She advises when the mother's breasts are engorged, she assists the mother to breast or bottle-feed her baby. She works in partnership with the whole family. How many GPs have the slightest notion of their patient's home and social conditions?

I write as a recently retired midwife who has worked in hospitals and out in the community. I have four children, two born in hospital and two born at home.

Pat Cook (Mrs).
Devonport.
NZ HERALD
27/7/93

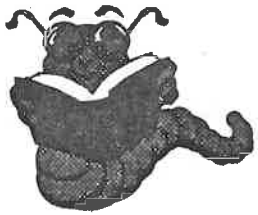
A Midwife's Quality Care

After reading your article, "Midwives out on their own" (Issue 37), I would like to share my experience with you. I am a 27-year-old mother of three, I have a 7-year-old girl and a 5-year-old boy to a previous marriage, and now we have a 7-week-old girl. With the first two it was the usual antenatal care and delivery from whatever doctor was on duty. After the 5 year break I knew there would be some changes and it was my husband's first, so everything was new to him. We heard about Domino Midwives late in my pregnancy, and after talking with Rachel Taylor, one of the three Domino Midwives we have at our hospital, we decided we would like her to look after us. She came over one evening to see us all, which was great because Dad and the kids could listen to baby's heartbeat and they felt a lot more involved. We were expecting a quick labour as my last one was 1½ hours, so I knew I wanted everything sorted out before baby came. Rachel helped us do that. We decided on shared care with my G.P. and Midwife as we had only about 6 weeks to go. By the time she left that evening I felt confident that I could handle the labour and not worry if my doctor would get there in time or just have the midwife who happened to be on duty.

I had had a troubled pregnancy this time round with a bad car crash and a lot of sickness, pain and discomfort — I did not enjoy the pregnancy at all. The last 6 weeks were no exception and more than once I phoned Rachel for help. She was only too happy to come around or meet me at the hospital, no matter what time, day or night.

When the day finally arrived I phoned Rachel, she came to my home and travelled with me to the hospital, and after a 3-hour labour she delivered our healthy baby girl. She came to see me every day in the hospital and then at home until Tori was 10-days-old and thriving. She became a trusted friend over that time and I only wish we had contacted her sooner.

Trudy Jones
Wanganui



Midwife cost

Sir,—Obviously the answer to the birthing question is to privatise midwives. Would the long-suffering public be prepared to pay $5000 in private for each birth now caught by midwives and paid for by the state? I think not.

Although I am a man, I would not mind my back being rubbed and my holistic needs being met by the state — $5000 a rub.

I am a house husband with two teenage children. As my old professors (Green and Bonham) used to say:
Making the baby was easiest;
Popping it out easy;
Actually raising a family the hardest.

I am sure every mother in New Zealand deserves $5000.

Dr D. I. McDonald.
Glenfield.

NZ HERALD 23/7/93

This review mirrors the New Zealand environment and provides further evidence that New Zealand Midwifery is on the right track.

Britain's Review of Maternity Services - territorial disputes by professionals "not a pretty sight"

In February 1992 the British House of Commons' Health Committee produced its second report on the country's maternity services. The report, which has been described as "pro-midwife", supports rather a much more social model of health care - for example, it sees maternity leave as a matter of public health.

The most common controversial aspect of the report has been the conclusion that "the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety." This reverses a recommendation of the first maternity services report (1980), and government policy of the last 20 years.

Much emphasis was given to what women want, and the report looked for evidence to back up the thrust of current practices and government policy decisions. The Committee, chaired by MP Nicholas Winterton, received evidence from women and professionals, and reported "that there is a large measure of consensus among women about what they want from maternity services - emotional support, continuity of care, a confident and confidence-inspiring birth attendant, choice and control over their own bodies - the evidence from the professionals about what they believe women both want and need is less clear cut. Much of what we heard appeared to be concerned with which group should have control over the maternity services."

Indeed, the *British Medical Journal* commented that "waiting until the professions sort it out for themselves" was "not a pretty sight", and provided governments with an excuse for failing to act on the recommendations.

However pressure from those in support of the report, coupled with increasing pressure to contain health costs, may push the return to a maternity service where midwives provide most of the care for women with normal pregnancies and births.

Problems identified in the report included:

- territorial disputes between professionals - medical, midwifery and management.
- poor evaluation of programs, including postnatal care and "linkworker" schemes (health workers who work with minority ethnic groups)
- lack of research into accepted practices, such as the frequency of antenatal visits
- the routine use of some forms of intervention which are unproven scientifically.
- failure to look at the social needs of pregnant women, such as providing adequate living allowances to pregnant women under 18 years of age.
- failure to include the cost to consumers when evaluating the costs of services including the closure of small rural maternity units.
- the failure of the complaints system to adequately deal with the concerns raised by women, which in turn, the Committee contends, possibly leads to increased litigation.

Some of the particular concerns raised by women included the denial of access to information and to medical records, and unsympathetic treatment when given bad news. As well as stating the need to address these issues, the Committee advised that there was a need to improve the skills of professionals in some areas including : the resuscitation skills of GPs, midwives and paramedics; and upgrading the teaching of breastfeeding skills by midwives, and their ability to adequately assess newborn babies.

In addition, the report recommends that the guidelines drawn up by SANDS (Stillbirth and Neonatal Death Support) "should form the basis for training of all professionals and managers involved in maternity care for dealing with bereavement." It was recommended that every hospital acquire the SANDS publication, *A Dignified Ending*.

In line with the report's stress for the need for a sound research basis when providing care, it recommends that every obstetrician, paediatrician, general practitioner and midwife be supplied with a copy of *Effective Care in Pregnancy and Childbirth* (edited by Chalmers, Enkin and Keirse).

The report concluded that "to achieve a proper balance between the goals and objective set and the resources which are available to meet them" requires above all "an affirmation that the needs of mothers and babies are placed at the centre, from which it follows that maternity services must be fashioned around them and not the other way round."

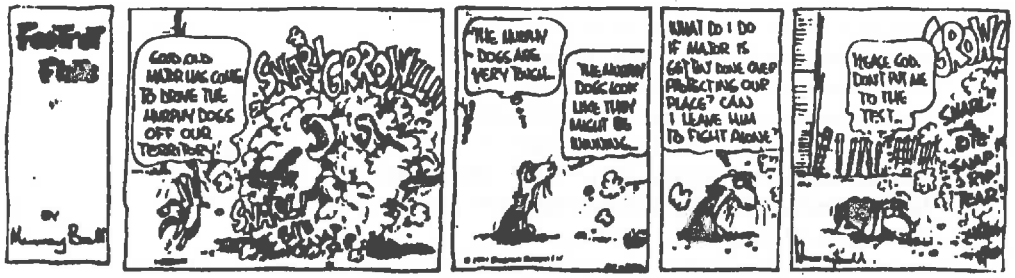
Dell Horey

References

House of Commons Health Committee (1992).
Maternity Services, Second Report, Vol 1 Her Majesty's Stationery Office, Feb

Warden J (1992). Maternity landmark. *British Medical Journal*, 14 March, Vol 304: 662

Day in the life of the National Co-ordinator?!



Use of drugs in births growing

SYDNEY MORNING HERALD 27/7/93

The NSW Department of Health and leading doctors are to investigate a dramatic rise in the number of women whose labours are being shortened with the use of drugs, or by doctors artificially "breaking the waters".

Between 1987 and 1991, the rate of births which followed augmentation — rupturing the membrane or using oxytocic drugs to stimulate the uterus — rose from 17.4 to 26.1 per cent.

The NSW Midwives Data Collection reports for 1990 and 1991 were released yesterday. The latest snapshots of childbirth across the State also show the number of caesareans rose by 1 per cent between 1987 and 1991.

The rate of perinatal deaths, deaths during the pregnancy or soon after birth, previously put at 10.5 per 1,000, is 12.2 per 1,000.

In 1991, 16.9 per cent of births were by caesarean, one of the highest rates in the world. The United States has a rate of 25 per cent, Canada 19 per cent; New Zealand and England 10 per cent.

However, the number of spontaneous vaginal deliveries rose from 67.7 per cent in 1987 to 70 per cent in 1991.

There were 86,917 babies born in NSW in 1991, down on 1990, when 87,532 babies were born.

The chairman of the NSW branch of the Royal Australian College of Obstetricians and Gynaecologists, Dr David Woodhouse, believes the rise in augmentations and caesareans is linked to doctors' fears of being sued.

"What we've got overall is an increasing trend to operative delivery that's almost directly related to litigation rates," Dr Woodhouse said.

Medical insurance for NSW obstetricians had risen from $175 a year in 1982 to $20,000 this year. Next year it is expected to be $30,000.

While obstetricians accounted for only 3 to 4 per cent of the medical workforce, they accounted for 30 to 40 per cent of the litigation settlements.

Other factors in the trend to more intervention included a rise in the average age of women having their first child. There had also been an increase in the number of women over 35 having a child, Dr Woodhouse said.

The 18-member NSW Maternal and Perinatal Committee, which includes obstetricians, midwives, Health Department officers and general practitioners, will meet on August 18 to investigate the findings of the report.

☐ ALICIA LARRIERA

WAIKATO TIMES - 23/4/93

New rules need care

Editor — I would like to comment on your article "surgeon urges new birth-care standards" (*Waikato Times*, April 20).

General practitioners receive training concerning childbirth, which is comparable to that received by midwives during their training. Not all doctors agree if and when a specialist obstetrical intervention is needed, or on which intervention is appropriate.

If any "specific rules" were to be introduced as to "when midwives faced by birth complications should call in a doctor," I believe they should similarly apply to when general practitioners faced by birth complications should call in another doctor. In both cases the doctor called in should be a specialist.

Personally, I think that women have the right to determine their own childbirth experience. I recently gave birth at home, attended by two midwives. No doctors were involved in the birth or antenatal care. I am more than happy with the treatment I received, as well as the treatment I would have received had there been any complications. I would not welcome any rules that could interfere with this experience, and affect my right to determine my health, and that of my child.

DR ANNA WHITEHEAD
Hamilton

Midwives 'totally maligned' in row

PA Wellington

THE midwives' professional organisation yesterday defended members who were being "totally maligned" in a row over provision of birthing services.

The national co-ordinator of the College of Midwives, Mrs Karen Guilliland, accused doctors of a "deliberate campaign to protect their own interests", which were threatened with competition for the first time.

She was commenting on reports that said a further review of birthing services would be conducted jointly by the four regional health authorities.

The latest study will follow work already done by a special tribunal set up by the former Health Minister, Mr Upton, and a Government review of that tribunal's report.

Doctors were unhappy with the earlier recommendations, saying they would reduce most GPs' incomes, and give no incentive to integrate birthing services while allowing continued "over-servicing" at birth.

In the meantime, media reports have suggested that spending on birthing services has swelled from $50 million to $90 million over the last three years.

Central RHA's project spokeswoman, Ms Gillian Bishop, said the new project aimed to give women choice "while ensuring effective management of public money". Mrs Guilliland said, however, that the latest review was re-creating work that had already been done. Also, "it is doing it in a timeframe which means it can't possibly be a consensus document, which is what you require for any protocol or guideline to work".

The first phase of the project, to draw up a protocol for good maternity care, is due for completion by mid-September.

The chairman of the Medical Association, Dr Alister Scott, said earlier that doctors looked forward to the review providing a sensible and realistic solution to an untenable situation.

"It's clearly in the interests of women that there have been both midwives and GPs in maternity care but there comes a point when we have to say that's more than is needed," Dr Scott said.

Mrs Guilliland, however, said she was infuriated at the way the services provided by midwives had been portrayed since they were allowed to take the lead in caring for women in childbirth.

She said the reported burgeoning costs could be explained partly by the addition of ultrasound scanning to the Government benefit, at $76 a time, and back-payments to doctors, rather than by increased payments to midwives.

The Press 27/8/93

Baby born in front seat

PA Auckland

Doctors who warned Mrs Jin Soon the birth of her child would be difficult could scarcely have imagined how dramatic the delivery would be.

Mrs Soon gave birth to 3370gm Chloe at 2.35am yesterday, in the front seat of a small car on the way to North Shore Hospital.

"I was crouched on the front seat," Mrs Soon said.

"One scream and a leg came out. Two screams and the other came out. Four screams and she was here. I could not believe it."

Mrs Soon, the proud mother of her second child, thrust the newborn babe toward her husband, Peter, who was driving at speed toward the hospital.

"'Here is your baby,' I told him."

The Whenuapai couple had been expecting problems — but not drama.

Mrs Soon had been scheduled for a caesarian section days before Chloe was due on September 8 because doctors believed it would be safer.

Hospital staff rushed out when Mr Soon pulled up outside sounding the horn. The umbilical cord was cut and mother and daughter were admitted.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

25 August 1993

Update on the Direct Entry Midwifery Courses

Mr Lockwood Smith
Minister of Education
Parliament Buildings
WELLINGTON

Dear Lockwood Smith,

The College of Midwives was delighted to hear that the Associate Minister of Health, Katherine O'Regan, has responded to the wishes of an enormous number of New Zealand women and given approval for two further intakes of Direct Entry Midwifery students in 1994 and 1995. These intakes are to continue at Otago Polytechnic and the Auckland Institute of Technology.

We understand that you are now required to endorse this decision by approving the funding for these two courses.

We urge you to do this.

Direct Entry Midwifery became possible with the 1990 amendment to the Nurses Act and follows many years of discussion and research by women's groups and Midwives throughout New Zealand. It is not a new model, being a widely accepted method of educating Midwives in Britain, the Netherlands and elsewhere in Europe.

You may be aware that three provinces in Canada have recently legalised Midwifery and after extensive consultation overseas, all have endorsed the Direct Entry model to educate their Midwives. Ontario begins its first course in September 1993 and already close links have been established between its three year degree programme and the three year programme offered at Otago Polytechnic.

At the recent International Confederation of Midwives Conference in Vancouver, May 1993, New Zealand was applauded for the advances it has made in reinstating Midwifery as a profession to meet the needs of women during childbirth. The rest of the world is watching New Zealand progress with interest.

/....page 2

First Floor 183 Manchester Street Christchurch New Zealand Tel/Fax 03-377-2732

Whilst New Zealand has achieved much in the last three years we still have a desperate shortage of midwives. Many CHEs are now attempting to recruit Midwives from overseas as there is still insufficient numbers of Midwives being educated in New Zealand.

One difficulty with employing Midwives from overseas is their lack of understanding of the culture in which they will be working. At this highly significant time in a woman's life and for her family, it is essential that all midwives understand the way New Zealand women and their families function.

In addition, Midwives are changing the way in which they practise. Many Midwives work independently providing total care or shared care and many CHEs have also established Midwifery services to provide this type of care. It is vital that Midwives are appropriately prepared for this type of practise. Direct Entry Midwifery education is focused on ensuring specialised knowledge which allows the Midwife to be independent and highly competent. A Midwife so prepared is confident in providing a total maternity service in the normal birth environment. Midwifery only care is not only cost effective but ensures safe and satisfying outcomes.

All western governments and New Zealand's health reforms are currently developing health policies focused on effective community based, primary care and the reduction of highly expensive, institutional forms of technological medicine. If Midwives are to effectively respond to the opportunities created by this intention and the increasingly popular request for Midwifery managed birth, attention must be given to the crucial relationship between education, effective autonomous practice and professional status.

Midwives require and have developed in their Direct Entry Midwifery programme new forms of educational opportunities to gain the knowledge and abilities necessary to obtain independent professional status. This means a decisive shift away from the nursing dominated courses of the past.

The direct entry programmes are part of an extensive evaluation being co-ordinated by the Health Department and involving NZQA, the Nursing Council of New Zealand, the Education Department and the New Zealand College of Midwives. This evaluation is ongoing and reports each year with the final report expected towards the end of 1995, early 1996 when the first group of graduates have been in employment for a year.

As well, the NZQA and the Nursing Council carry out their own evaluations annually and the polytechnics are continuously monitoring their courses responding to evaluation.

/....3

7] The English Midwifery training is not considered by world standards to be "better" than the NZ system. New Zealand enjoys considerable respect within the International Midwifery arena and is regarded by many countries as having one of the most appropriate education curriculars for independent practice. Canada recently imported New Zealand Midwife experts as consultants for their new curriculum. The International Confederation of Midwives recently re-elected New Zealand to represent Midwifery at United Nations level.

8] Doctors, Midwives and the Department of Health have never "failed to agree on a new schedule " for fees. We have never even met to discuss it because the Medical Association has always refused to come to any negotiation process where the College of Midwives is present. As long as they refuse to negotiate and hold the government to ransom the present outdated schedule remains.

9] Because the present schedule does not reflect today's maternity service provider possibilities midwives were instructed by the Department of Health to claim the same $140 labour fee given to doctors as the appropriate one, until it was renegotiated to reflect new practices. The College has always accepted that this situation, along with many other aspects of the schedule, would change. That this has not happened is entirely the responsibility of the NZMA. Both the Minister and the Tribunal hearing the case for the College, the NZMA and the Department accepted the maternity service midwives offer is equal to that of GPs. For Midwives to give up their right to equal pay for that service would be an unacceptable submission on behalf of working women.

10] Independent Midwives are the only providers who are costed on the complete maternity service they offer and as such are vulnerable to false cost comparisons with doctors whose total service is provided and paid from several different sources. The Maternity Benefit only pays a fraction of the true cost of a doctor-attended birth. For antenatal visits and "catching" the baby a GP can claim between $800-$1200. The hospital staff and services the GP requires in order to "catch" the baby costs anywhere between $1800-$2247 (depending on which CHE provides the figures)

The practice nurse subsidy of 75% provided by vote health, any community postnatal care provided by district midwives and any antenatal education provided by CHE's have not been included and must be added to this figure. In the absence of reliable data a reasonable estimate of true costs to the taxpayer is somewhere between $3-4000 for a doctor attended normal birth. Even if one accepts the midwife average claim of $2000 as valid the independent midwifery service is half the price of a medical one.

Not only is the midwifery service cheaper to the taxpayer, it is also a service women want and appreciate. Of the 200 submissions received by the Maternity Benefits Tribunal the overwhelming majority came from women supporting midwifery care and their right to equal pay for work of equal value.

Yours faithfully,
Karen Guilliland
NATIONAL CO-ORDINATOR

Media Watch

INTRODUCTION

For those of you who read the North & South article in July, you may have wondered about the authenticity of statements attributed to Karen Guilliland. The Editors chose, as yet, not to publish Karen's letter in response to the article so we publish it here.

15 July 1993

The Editor
North & South
Private Bag
Wellesley Street
AUCKLAND

Dear Editor,

Since I have only ever had a 40 minute telephone conversation with David McLoughlin, it was with considerable surprise I read his "Politics in Childbirth" article to find myself a main contributor. However in the main, he has attempted to address the issues associated with such a complex socio-political subject. Unfortunately he (and others he quotes) have also made some inferences and assumptions which are false and need rebuttal.

1] Neither I nor the College of Midwives believe and have never stated that the family doctor should be made redundant in childbirth. Midwifery advocates for the woman and her family to be the ones able to choose the provider present at the birth; ie informed choices should be "in the hands" of women, not the doctor or the midwife. Neither is independent midwifery about home birth as such. It is about women being in control of their own birth processes and having enough knowledge and confidence to give birth where they want and with whom they choose.

2] It was the Obstetrician Professor John Hutton who stated at a recent Health Research Council Seminar that 50% of O&G Specialists are under investigation. I had no reason to doubt him. Could it be that since no figures were available for 1992, Professor Hutton may still be right?

3] I do not believe "that four hours in second stage of labour is normal." I believe it could be if you are defining normal on an individual basis. The point being that there is a range of normal which is denied by strict protocol setting.

4] I do not "accept" the need for obstetricians - I support them as absolutely necessary.

5] The College recommends a caseload of between 50-70 when providing total midwifery care. (not 40-60).

There is no evidence from any area that there is any concern about these courses and no reason to think they will not eventually become part of mainstream education. The first evaluation report raises no concern .

As two Polytechnics have now invested considerable energy and resources into setting up the programmes, it would seem a waste of resources to have no further intakes. The Polytechnics may then have to begin again if the decision is made that direct entry becomes part of usual Midwifery education. In the meantime considerable experience could be lost.

Clearly there is huge consumer demand for the courses. The College and both Polytechnics receive requests on a daily basis.

New Zealand desperately needs New Zealand educated Midwives to meet the changing needs of maternity services in New Zealand. We urge you to approve the funding for two further intakes and allow the courses and students to demonstrate that they are prepared to meet the needs of women in New Zealand.

Yours sincerely,
Sally Pairman
PRESIDENT

copy to : Katherine O'Regan

A very famous Obstetrician was vacationing on a tropical island. Walking along a beautiful beach, he found a lamp half buried in the sand. He picked it up and started rubbing off the dirt, when a Genie appeared to grant him three wishes.

After some careful though, the Obstetrician said, "I want to have the best outcomes, the lowest Caesarean section rate in the country and I want all women to be able to afford my care." The Genie said, "Done. You are now a Midwife".

"NO! Wait!" shouted the Obstetrician as the trail of smoke drifted back into the lamp. But it was too late.

Jody McLaughlin
North Dakota USA
THE COMPLEAT MOTHER

RESEARCH

Safety of Depo Provera

IN 1991 and 1992, a number of studies were published which provide reassuring multicentre data that the injectable contraceptive Depo Provera (DMPA) does not increase the risk of breast, ovarian, endometrial or cervical cancer in long-term users.[1] Although it was found that the risk of breast cancer did increase very slightly in short-term users (less than four years) under age 35, DMPA cannot be considered the cause. Since breast cancer takes a long time to develop in most cases, the increased risk would also have appeared among long-term users if the method was the cause. At most, the progestogen could act to stimulate pre-existing tumours, but even so, the association is weak. Thus, longstanding concerns about these medical aspects of the safety of DMPA have finally and happily been put to rest, to the great relief of many in the field. DMPA is now considered to be as safe as oral contraceptives for the great majority of women.[2] The US Food & Drug Administration (USFDA) approved DMPA as a contraceptive method in October 1992, a decision that also allows the US to fund its use in family planning programmes in other countries. Countries which approve drugs only if they are USFDA-approved may follow suit.

One outstanding safety issue is currently the subject of research. A study published in 1991 indicated that in women who had used DMPA for over five years, there is evidence of a loss in bone density (which did not change with duration of use) due to suppression of natural oestrogen. Unless the bone loss is reversed upon discontinuation, the risk of osteoporosis may be increased[3], especially after menopause. If further research were to confirm this, there would be implications not only for DMPA use but also for other progestogen-only methods. There has been a rapid response among researchers to find out if this is indeed a problem.

Since these studies were published, medical professionals have been urging women's health advocates who are critical of this method to separate medical safety aspects from problems in service delivery, where abuses regarding information and choice of methods remain.

1. The WHO Collaborative Study of Neoplasia and Steroidal Contraceptives have published the following studies:
   - Breast cancer and DMPA: a multinational study. *Lancet*. 1991; 338(5 Oct):833-38.
   - DMPA and risk of epithelial ovarian cancer. *International Journal of Cancer*. 1991; 49:191-95.
   - DMPA and risk of endometrial cancer. *Ibid* 186-90.
   - DMPA and risk of invasive squamous cell cervical cancer. *Contraception*. 1992; 45:299-312.
2. For an up-to-date packet of information about DMPA, US FDA approval, and abstracts and summaries of most of the major papers on its safety published in 1991 and 1992, see 'Injectable contraceptives: safe, effective but neglected' Population Action International, Washington DC, November 1992.
3. Cundy, Tim et al. 1991. Bone density in women receiving DMPA for contraception. *British Medical Journal*. 303(6 July):13-16.

TABLE 1

1 Unit = 10gms absolute alcohol (Murry-Lyons 1989)

= 7.9gms " " (Plant 1990)

Measures

1 Unit = 1/2 pint of beer

1/2 pint strong beer

1 single whisky

1 glass wine

1 glass sherry

Alexander J, Levy V, Roch S: Antenatal Care A Research approach **Macmillan**, 1990, pp 73-75

Brooke O G, Anderson M R, Bland J M, et al: Effects on Birthweight, of Smoking, Alcohol, Caffein - Social Economic Factors and Psychological Stress **British Medical Journal**, vol 298, no 6676, 25 3 89, pp 795-801

Diggory P: Alcohol and the Unborn Child Fetal Alcohol Syndrome **The National Council for Women**, Working Party 1980

Lumley J, Corry J F, Newman N M: Cigarette Smoking, Alcohol Consumption and Fetal Outcome in Tasmania. **M.I.D.I.R.S.** Information Database, 1991.

Marles K: Bottling Up the Problem of Pregnancy. **M.I.D.I.R.S.**, (Pregnancy/Antenatal Health Teratogens and Environment). August 1989

Mills J, Graubard B: Is Moderate drinking in Pregnancy Associated with an Increased Risk of Malformations? **Paediatrics** vol.80 no.3, September 1987, pp 309-314

Murry-Lyons: Alcohol in Pregnancy **Maternal and Child Health**, vol 14, no.6, June 1989, pp 165-169.

Plant M. Drinking in Pregnancy and Fetal Harm. **Midwifery** vol.2 no.2, June 1986, pp 81-85

Plant M: Advising on Alcohol. **Midwives Journal, In Nursing Times**, vol.86 no 12, 21 3.90, pp 64-65

Sterling K, Clarren K, Smith D W: The Fetal Alcohol Syndrome. **New England Journal of Medicine**, 298:1063, 11 May 1978.

Streissguth A P, Clarren K, Jones K L: Natural History of Fetal Alcohol Syndrome - Ten-Year Follow Up of Eleven Children, Seattle, USA **Lancet**, vol.11 no 8446, 13 July 1985, ppu 85-91

Suleiman N D, Fiory C D U V: Alcohol Consumption in Dundee Primigravidae and its Effect on Pregnancy Outcome. **British Medical Journal**, vol 296 no 6635, 28 May 1988, pp 1500-1503

Walpole I, Zubrick S, Pontre J: Is There a Fetal Effect with Low-to-Moderate Alcohol Use Before or During Pregnancy? **Journal of Epidemiology and Community Health**, vol.44 no 4, December 1990, pp297-301

Wallerson J: Alcohol and Pregnancy. **Nursing Times**, vol 81 no 35, 28 August 1985, pp 38-40

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GPO Box 9848, CANBERRA ACT 2601

Contact for this correspondence

Name :
Phone :
Fax :

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL

Commonwealth of Australia

The Director
New Zealand College of Midwives Inc
Fax 0011 64 3 365 -146

Dear Sir/Madam

I am writing on behalf of the Infant Nutrition Panel of the National Health and Medical Research Council, to request your permission to reproduce the Consent to supplement of compliment new-born babies' form developed by your organisation (attached).

The Infant Nutrition Panel is currently developing guidelines for health workers based on the World Health Organisation International Code of Marketing of Breast Milk Substitutes. In its development of these guidelines, the Panel considered that informed consent by mothers on the use of complimentary feeds in hospitals was a priority. A copy of the consent form developed by NZCOMI was sent to the Panel during a public consultation process and the Panel felt that, with some minor alterations in content and layout, this would provide a good example of how to develop such a form it included in the guidelines.

Would you please be able to advise me on your decision on the above matter as soon as possible. We would of course be willing to acknowledge the permission of NZCOMI to reproduce the form and send you a copy of the guidelines when they have been developed. I can be contacted on ph (61-6) 289-7712 or fax 289-8420.

Thank you for your assistance in this matter.

Yours sincerely,

Sue Jeffreson
Secretary/Convenor
Infant Nutrition Panel
26 July 1994

***Editor's Note**: It's of interest to note that the consent form being considered by the Australian National Health and Medical Research Council is the same one Charles Essex, Paediatrician, was so highly critical of when reviewing the NZCOM Breastfeeding Handbook.*

Editor's Note : The NZMA continue their orchestrated campaign against Midwifery. Some doctors statements are almost humerous they are so bigoted eg *"Don't go to her - did you know she's a witch"* - Chch GP
"Don't go to a midwife - they make you eat the placenta" - Nelson GP

Such statements in 1993 make one realise how thin the veneer of sophistication is when "women's business" can still attract the superstitions and witch hunts of centuries ago.

However, when medicine's professional body defames the profession it actually cannot provide a service without, these tactics are no longer humerous or acceptable.

"Disappointed, incredulous, cynical"

The fax from NZMA requesting my comments on the new maternity benefits schedule ended: "I imagine you'll be feeling strongly about the Ministerial decisions".

Yes, I dare say along with other members of the Maternity Benefits Negotiating Committee, I do have strong feelings.... of? anger, certainly disappointment, incredulity and ultimately, cynicism that a Minister of the Crown could so abuse the report of a tribunal appointed by a previous minister - albeit a more professional one.

The MBNC and associates worked hard to present your case and were superbly led by the then chairman, Dr Philip Rushmer. Our case was considered by a well balanced tribunal of two health professionals and three ministerial lay persons, who allayed our misgivings the first day by their obvious professionalism.

This faith was further borne out by the quality of their findings contained in a report which was capable of setting a high tone of obstetric conduct in New Zealand we could all have accepted and respected.

It should have been seen as a gift from heaven to a minister so badly needing to establish good rapport with both the nursing and medical professions to foster the necessary co-operation to ease in his policies.

As well, the findings had the power to establish after years of suspicion, accord between midwives and doctors. Certainly no party got everything they asked for by any means but at least both professions could accept the same document and were prepared to work together on its contents.

And then came the incredible ... once again, the Minister of Think Big turned his back on informed professional advice. He missed all the points relating to quality and standard of service and appeared to pass the document unread back to his department.

(His young inexperienced advocates had already demonstrated during the hearings how little they knew about obstetrics per se and I could only surmise they knew more about economics.)

CONTINUED ON PAGE 15

who consumed 400 mls or more of wine or beer daily during pregnancy had significantly higher rates of perinatal deaths, fetal growth retardation and low placental weight, even when other variables were taken into account.

The current interest in alcohol harmful effects on the fetus stems mostly from the work done at the Dysmorphology Unit of the University of Washington, Seattle, USA. One notable professor of paediatrics is Dr D Smith, who with his colleagues described the features of FAS and confirmed Lemoine's findings. (Sterling, Clarren and Smith 1978).

The current and general consensus is that FAS occurs with excessive intake of alcohol. Murry-Lyons (1989) gives some guideline as to what constitutes excessive This is defined as an intake of 80 to 100 grams of absolute alcohol daily. (table 1). Plant (1990) also gives some guidance However, it is also important to realise that not all alcoholic women produce children with FAS, although FAS has been reported in one case after a single binge (Alexander et al 1990, Streissguth 1979)

Features of Fetal Alcohol Syndrome

- Intra-uterine growth retardation
- Retarded growth during the early developing years
- Impaired motor and mental function
- Characteristic facial appearance (fig 1 & 2).

Mental deficiency is the most handicapping feature Streissguth et al (1985) followed up 11 children with FAS for teen years These children's mothers were severe chronic alcoholics Two of the children have since died and the remainder never caught up with their peers in development, mentally or physically

A few examples of the incidence, which varies from country to country are as follows.

Northern France	1 100
Sweden	1 600
Seattle	1 2000
London	1 30002

(Murry-Lyon 1989)

FETAL ALCOHOL EFFECTS

There is conflicting evidence as to whether alcohol in moderation is harmful to the fetus. Most research produced to date seem to indicate that alcohol in moderation is unlikely to harm the fetus. (Mills et al 1987, Walpole et al 1990; Plant 1986). Lumley et al (1985) even suggest that less than 2 glasses of wine daily could even be beneficial

Waterson (1985) reports that some research studies have suggested a link between consumption of two drinks daily in the early stages of pregnancy and an increased risk of mid-trimester abortion. Lumley et al (1985) in their analysis of smoking and alcohol consumption in a group of Tasmanian women, did not find harmful effects of alcohol at less than two units per day. Walpole et al (1990), studied 2002 women in Western Australia who admitted to low to moderate alcohol consumption, and their study failed to show any significant relationship between low to moderate alcohol intake and neonatal morbidity. Sulaiman, Flory (1988) studied 952 primigravidae, and concluded that at less then 100 grams alcohol per week, there are no detectable harmful effects on pregnancy

Other researchers however suggest that there is evidence to link moderate alcohol in early pregnancy with low birth weight, decreased length and head circumference. (Little et al 1986, Day et al 1989) Brooke et al (1989) do not support this view, they found that smoking was the commonest cause of low birthweight

The nature and mechanism of damage.

Alcohol is a teratogenic agent It affects the fetus at any stage during pregnancy. (Rossett, Weiner 1985) Emhart et al (1987) suggest that alcohol teratogenicity is greatest around the time of conception, and also during the first trimester when tissue organisation is taking place, as stated also by Murry-Lyons (1989) Alcohol crosses the placenta and affects the fetus It has been found in amniotic fluid many hours after maternal consumption, causing prolonged exposure to the fetus (Diggory 1980)

DISCUSSION

Current campaigns to increase women's awareness of the dangers of alcohol tend to be sensationalised and arouse anxiety in those women, already pregnant, who consume low to moderate alcohol Many women may experience stress during the early weeks for various reasons, including an unplanned pregnancy, which may lead to an increase in alcohol intake and smoking Walpole et al (1990) suggest that warning women that ANY alcohol intake is potentially harmful to the fetus is inaccurate and probably counter-productive. Caution is therefore needed when health professionals counsel women on the dangers of alcohol.

Some Health Education Authority Guidelines for Midwives

- The midwife must remember that in the antenatal clinic, the woman's anxiety levels are raised There fore avoid exaggeration and sensationalising
- The midwife's role is to provide information based on current evidence The choice is always up to the woman.
- Preconception care based on public education and campaigns is probably more effective Cases such as that of the woman in Seattle, USA, who sued a whisky company, claiming damages for her multiply-handicapped child, may be due to lack of health education. (Marles K 1989)
- Problem drinkers should, if possible, be identified antenatally and helped as soon as possible.
- Moderate drinkers should be advised in the light of current evidence, that the less they drink the better for the baby. Limiting alcohol reduces the risk to the baby, and cutting it out completely eliminates the risk completely. (HEC 1983)

Lois Bowman, October 1992

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ALCOHOL IN PREGNANCY -

ILLUMINATING CURRENT EVIDENCE

MIDIRS Midwifery Digest (June 1993) 3:2 165

The damaging effects of alcohol on the fetus have been documented since ancient times. There is reference to this in the Bible. (Judges 13.7). "Behold thou shalt conceive and bear a son; and now drink no wine or strong drink". In ancient Carthage there were laws prohibiting newly married couples from drinking alcohol to prevent conception during moments of drunkenness. Aristotle is quoted, "Foolish drunken harebrained women, for the most part bring forth children like unto themselves, morosos et languidos". (Diggory 1980. Alexander 1990)

In 18th century British doctors made observations which seemed to suggest a link between the sale of cheap gin and the high rates of infant mortality and morbidity. They concluded that female insobriety was to blame, but continued to use alcohol in their medical practice for pain relief in the surgery as well as for labouring women. (Waterson 1985)

There were no further inquiries on the subject until 1899 when William Sullivan, a physician to a Liverpool prison, studied 600 children of mothers in prison. 120 were children of alcoholic women. He found that the infant mortality, morbidity and stillbirth rates were 21/2 times higher in the alcoholic group. He also noted that if these women were denied alcohol during pregnancy they produced healthy babies. (Diggory 1980)

Interest in the harmful effects of alcohol was largely ignored by 18th and 19th century physicians, the general feeling was that the problem was in danger of getting out of perspective.

Renewed interest occurred in the last 15-20 years, resulting in extensive literature and research being produced on the subject, which centres on two types of alcohol damage features, Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). (Murry-Lyons 1989).

FETAL ALCOHOL SYNDROME (FAS)

A French doctor, Pierre Lemoine and fellow researchers first recognised the features of what has now come to be known as Fetal Alcohol Syndrome. (Diggory 1980)

Lemoine studied 9,000 alcoholic women between 1963 and 1969. This French paper was first translated into English in 1976, and part of it published in the British Medical Journal in 1978. Diggory, (1980), states that the French researchers had found that mothers

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5 August 1993

The New Zealand Medical Association
P O Box
WELLINGTON

ATTENTION : Chairperson

Dear Sir,

RE : NEW ZEALAND MEDICAL ASSOCIATION NEWSLETTER

We act for the New Zealand College of Midwives who have handed to us an article by Heather Thomson described as the chairman of the MBNC published in a recent edition of the NZMA newsletter. This article states at page 9:

> "It is ironic that now fewer and fewer GPs will want to practice obstetrics, and will leave the apparently normal birth in the hands of midwives, thus in actual proven fact increasing danger levels ..."

Not only is that statement manifestly incorrect but it is an attempt to undermine the practice of midwifery by seeking to link that profession with unsafe procedures.

The circulation of defamatory material by your association is of much concern to our client. The reason for this letter is to advise you that if this approach continues then our client will take the appropriate action to ensure that the public are not misinformed and misguided as to the service midwives provide. Further, we believe such defamatory statements published by the NZMA in the course of its business are misleading and therefore actionable under the Fair Trading Act 1986.

Yours faithfully,
MACFARLANES

pp G M ABBOT
Partner

The next ministerial document was a production only a Minister of Labour could fee good about - a complete hatchet job. Services were annihilated in value with a stroke of the pen (no logic required when you are a minister demonstrating complete power) and when the wise findings lay in tatters, he resorted to the long established adage of previous ministers: "Don't concern yourselfe with relative values 0- just resort to a neat percentage - the lowest you think you can justify by using a smoke screen of an irrelevant outdated CPI statistic as an excuse. Grind the fee down as low as possible - medical professionalism can always be relied on - engrained regard for patient's welfare and fear of the Medical Council will force them into line. After all, there are few votes to be gained by being reasonable to doctors. The public couldn't care less how a free service is funded. They just expect the best service to be there regardless."

And so does the minister.

But let's be more positive. We may have lost the battle, but we need not lose the war. Consider:

1. It has been a sad but maybe salutary lesson in the "nature of the beast" - a working profile of the man who now rules the Health portfolio. Can we trust him in the future?

When you consider your position in the contract scene, you will perhaps be better prepared to read the fine print and listen to informed advice. Look at all the clasues, eg arbitration, appeal, release, etc. If it seems at all like a pot of glittering gold, beware of Greeks bearing gifts.

2. Read the maternity schedule when you finally see it - it is independent of other contracts - and read between the lines.

The Minister says, in effect, that we will feel the warm glow of success when, like any other business, we "increase productivity". He could come to regret this modern turn of phrase as he explains that we should put more time and effort into our work. If this is so, then we are entitled to charge for it.

Perhaps he has designed the Conduct of Labour fee for this very reason? Is it, for example, intended to replace the recognition of a "premature labour hopefully not resulting in delivery?"fee? Consider how the schedule might be used in the most appropriate way. Think on ...

We may be resigned to an inadequate antenatal fee and a woefully dangerous poverty of antenatal consultations, but we are invited to annotate. use this service - but keep good records explaining why. The Christchurch office is always very fair.

3. Consider again your working liaison with midwives. You and I both know there are excellent independent mid wives - we have worked with them. But can we aford to work with them now and still survive the hours and renumeration?

Midwives are regulated into the system by Act of Parliament to 'give woman a choice'. It is ironic that now fewer and fewer GPs will want to practice obstetrics and will leave the apparently normal birth in the hands of midwives, thus in actual proven fact increasing danger levels, and incurring the use of more expensive specialist intervention. This will result in a loss of choice to women.

Is this really what the women of New Zealand want? I doubt it.

Heather Thomson
Chairman, MBNC

Department of Health estimates:
Cost of implementing recommendations
Tribunal $10.9 - 15.3 million
Department $ 4.8 - 5.9 million

costs (building, maintenance, furnishing etc). At that time indirect costs added another 51% to this cost. (A report on the development of maternity services - Ak. Area Health Board - May 1991).

Before midwifery independence hospital births in Auckland therefore cost about $3,000 plus the average $800-900 claimed by doctors from the Maternity Benefit. Recently hospital births which have involved full midwifery continuity of care have cost an average of $2,500 more. Savings are made when women have midwife only care and in true DOMINO births (Women are discharged directly from delivery suite saving the approx. $500-600 per day cost of in-hospital postnatal care) Also as more women engage the services of independent midwives for hospital birth, delivery suite midwifery staffing levels will be able to be reduced.

New Zealanders have been well socialised by the medical philosophy of childbirth which sees every pregnancy and birth as unpredictable, potentially dangerous and only able to be judged as normal in retrospect. This lack of confidence in the normalcy of childbirth has led to some "double dipping". Many women have enjoyed the continuity of care offered by an independent midwife have continued to see a medical practitioner, have spent long hours in delivery suite and several days in postnatal wards. However increasing numbers of midwives and women are becoming confident and comfortable with midwifery care and more women would happily opt for homebirth or discharge from delivery suite if some subsidised homehelp services were available.

The recently announced restructuring of the Maternity Benefit schedule will result in a marked decrease in the cost of independent midwifery services (The attendance in labour fee has dropped from $139.60 to $90.80 per hour and mileage rates have dropped form $1.60 to $1.00 per km).

The passing of the Nurses' Amendment Act greatly increased the options for and the quality of maternity care available to NZ women. Whilst the cost of maternity services may have increased slightly in the short-term, independent midwifery care has introduced the potential for cost savings as care moves out of the institutions and into the community. Huge cost savings could be made if more practitioners offered their clients the homebirth option.

B.H.

EDITORIAL

CAN WE AFFORD MIDWIFERY CARE?

Birthing issue have been in the news again as the Medical Association pursues its campaign to try to persuade the minister and the tax paying public that independent midwives cost too much.

Apparently the Maternity Benefit, from which doctors and midwives are reimbursed for providing maternity services, pays doctors too little (they have longer training and higher overheads) and midwives too much (they "loiter" at births to bump their fee up). Both groups of practitioners are paid from the same schedule of fees. Midwives end up earning more because they spend more time with women in labour, make more postnatal visits and clock up much greater mileages because they drive to their clients' homes for most of the antenatal and/or postnatal visits.

The massive blow out in the Maternity Benefit budget is not the result of independent midwives being paid too much. The Maternity Benefit budget was not increased to take into account the huge increase in the number of practitioners who would be claiming this benefit following the passage of the Nurses Admendment Act in September 1990. Neither was the schedule adjusted to take into account the different ways in which midwives and doctors provide Maternity Services. The schedule only allowed for a birth fee and a prolonged attendance fee. In the absence of a "conduct of labour" fee midwives had to claim their hours of attendance in labour from the latter. Both these factors have led to a huge increase in the amount paid out via the Maternity Benefit. The Medical Association, supported by some sections of the media, have sought to persuade the minister and the general public (in an election year) that NZ cannot afford this apparent increase in the cost of maternity services. In fact Helen Clarke, during her time as Minister of Health, guided the Nurses' Amendment Bill through the legislative process because she could see the potential cost savings midwifery independence could achieve.

Up until 1 July 1993 the cost of maternity services came out of two different budgets. (1) The Health Department Maternity Benefit budget paid to independent practitioners. (2) Area Health Board budgets paid for hospital based maternity services.

Figures released in April 1993 by the Health Dept. put the average cost of independent practitioners for shared care (midwife & doctor or midwife & midwife) at $2,500 - $3,000 per birth. This represents the total cost of a homebirth as all other costs (except up to $50 for the cost of equipment sterilization and linen packs provided free by many hospitals to homebirthers) are met by the parents or the midwife. Hospital births cost about the same. Earlier this year National Women's Hospital was charging foreign nationals $3442 for care during labour and birth and 3 days postnatal care (NZ Herald 11 March 1993) In 1990/91 National Women's Hospital budgeted approx. $2195 for each birth - this sum did not include neonatal services or indirect costs related to administrative and support services (cleaning, meals, security, laundry etc) or capital expenditure

Editor's Note : Given the recent media sensationalisised reporting of the need for the cultural safety components in Nursing and Midwifery, this article may interest the doubters and encourage the educators.

Midwifery (1993) 9, 1-2
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Midwifery

EDITORIAL

The use of stereotypes in the provision of midwifery care

In this issue of the journal there is an article describing some research that found that midwives used stereotypes when providing care to women of Asian descent living in the UK (Bowler, 1993). The research has shown that these stereotypes reduced the quality of care the women received and in some cases they even received inappropriate care.

We all use stereotypes in our every day lives but in the context of health care they can be dangerous. A previous areticle in this journal (Green et al, 1990) showed that the often held negative aspects of the stereotype of the "well educated, middle class NCT type" did not hold in practice. Although these women were more knowledgeable about childbirth and pain relief they did not have unrealistic expectations about the course of labour. What was most concerning was that women with minimal education were less likely to have enough information to make a decision, but it was women who did not have enough information to make a choice who were more likely to have had "a shave, an enema, a glucose drip or continuous fetal monitoring (Green et al, 1990). In Bowler's (1993) study Asian women did not receive appropriate care with regard to pain relief in labour, breast feeding and contraception. There may be other areas which were not identified by the research.

I do not wish to use these articles to start a "midwife battering" campaign as that would be counter productive. What I would like to do is turn this issue around and ask what we should be doing so that we do not rely on stereotypes and run the risk of providing suboptimal care. One of the major problems in the Bowler (1993) study was that the midwives could not communicate with women. Situations were described where the midwives did not speak the woman's language and where the woman did not speak the midwife's language. It takes time to learn another language so in the meantime we have to use interpreters. We have to take steps to find out what interpretation facilities are avialble and we have to use those interpreters who are available. Where there are deficiencies, we have to demand of our employers that facilities are provided so that interpreters can eb available whenever necessary. In the context of childbirth that may mean 24 hours a day. We have to assess the level of understanding of those women who do understand a little of our language. We have to consider that the colloquialisms we use may be inhibiting communication and perhaps consider using more "professional" language with women. We should also consider whether we should be at the forefront of the campaign to fight for language classes for women.

We have to find out and understand the nature of customs and practices which are important to individuals, because it is only when we have these understandings that we can tailor care to individual needs. However, we must appreciate that the customs and practices of one area of Asia will not necessary be relevant to all women of Asian descent.

In the Green et al (1990) study it was women with least education who were least prepared for labour but 71% of them wanted to know as much as possible about what might happen in labour. However, it is women with the lowest levels of education who are least likely to attend antenatal classes which address these issues. Instead of saying "it's no use trying to get her to come to parentcraft classes" we should be trying to see if there are other ways in which we can provide this information.

In my clinical practice throughout the UK, I have heard many midwives complain about having to look after women who are teachers. The complaints have been about the fact that the teachers "know it all". In the context of Green et al's (1990) findings it is just as well that some do "know it all"; otherwise many more women would have unnecessary shaves, enemas, drips and continuous fetal monitoring.

The way forward here is to recognise the need for individual care and care can only be individualised when we have assessed an individual woman's requir-

ements. The requirements should be identified jointly between the woman and the midwife, and in identifying the requirements we as health professionals have to remember that postnatally even well prepared women still felt there were unfilled gaps in their knowledge (Green et al, 1990). Green et al (1990) suggest that this is because the women were unable to formulate the questions in order to correct the omissions. We must help women to formulate the questions. Having identified the requirements steps can then be taken to fulfil them. It may be that one of the steps that the midwife will have to take is to learn another language in order to break the language barrier so that hopefully the use of dangerous stereotypes can be overcome.

ANN THOMSON

REFERENCES

Bowler, I 1993 Stereotypes of women in Asian descent in midwifery. Midwifery 9 (1):

Green, J M, Kitzinger, J V, Coupland, V A 1990 Stereotypes of childbearing women : a look at some evidence. Midwifery 6(3): 125-132

Subjects - 15935 pregnancies (7992 in which routine ultrasound scanning was used and 7943 controls with selective scanning) from four randomised controlled trials.

Main outcome measures - Perinatal mortality, live birth rate,m rate of miscarriage, Apgar score < 7 at 1 minute, and number of induced labours.

Results - The live birth rate was identical in both screening and control groups (odds ration = 0.99; 95% confidence interval 0.88 to 1.12) although the perinatal mortality was significantly lower in the group who had routine ultrasonography (0.64, 0.43 to 0.97). Differences in perinatal morbidity between the two groups as measured by the proportion of newborn babies with Apgar score < 7 at 1 miniute were not significant (1.05; 0.93 to 1.19).

Conclusion - Routine ultrasound scanning does not improve the outcome of pregnancy in terms of an increased number of live births or of reduced perinatal morbidity. Routine ultrasound scanning may be effective and useful as a screening for malformation. Its use for this purpose, however, should be made explicit and take into account the risk of false positive diagnosis in addition to ethical issues.

MANAGEMENT OF PREMATURE RUPTURE OF MEMBRANES AT OR NEAR TERM

- Vanessa A Marshall, CNM, ScD - Journal of Nurse Midwifery Vol 38 No. 3 May/Jun 1993

Abstract

The purpose of this retrospective cohort study was to explore the safety and cost-effectiveness of conservatively managed premature rupture of the membranes (PROM) in term and near-term pregnancy. The records of 909 women with PROM at or near term were reviewed. Outcomes of those women and infants who were managed conservatively were compared with those who were managed aggressively. Those who were managed conservatively experienced one-third the rate of cesarean sections, with no increase in intrauterine or neonatal infections, and were hospitalized a half-day longer than those managed aggressively. These findings are consistent with previously published studies and support the position that conservative management can be safe for both mother and infant. The findings also confirm that, with minor adjustments in institutional protocols, conservative management can be cost-effective.

Articles of Interest

Administration of vitamin K to newborn infants and childhood cancer

- British Medical Journal Vol 307, 10 July 1993

Hans Ekelund, Orvar Finnstrom, Jan Gunnarskog, Bengt Kallen, Yngve Larsson

Abstract

Objectives - To investigate whether childhood cancer is associated with intramuscular administration of vitamin K to newborn infants.

Design - Routines for administration of vitamin K to infants born after normal deliveries during 1973-89 were obtained from maternity hospitals. Occurance of cancer up to the end of 1991 was identified by comparing these records with the national cancer registry. Adherence to the routine method of administering vitamin K was checked with the medical records of a sample of 396 infants (196 who had developed childhood cancer and 200 controls).

Setting - All materenity hospitals in Sweden.

Subjects - 1384424 full term infants born after non-instrumental deliveries, 1085654 whom were born in units where vitamin K was routinely given by intramuscular injection and 272080 of whom were born where it was given orally.
Main outcome measures - Odds ratios for cancer after intramuscular administration of vitamin K versus oral administration after stratification for year of birth.

Results - Adherence to routine method of administering vitamin K was 92% in the 235 cases where individual information could be found. The risk of cancer after intramuscular administration of vitamin K was not elevated compared with that after oral administration: odds ratios of 1.01 (95% confidence interval 0.88 to 1.17) for all childhood cancers and 0.90 (0.70 to 1.16) for childhood leukaemia.

Conclusions - The alleged association between intramuscular vitamin K prophylaxis to newborn infants and childhood cancer could not be verified in the present study of full term infants born after non-instrumental delivery.

Does routine ultrasound scanning improve outcome in pregnancy? Meta-analysis of various outcome measures

- British Medical Journal, Vol 307, 3 July 1993

Heiner C Bucher, Johannes G Schmidt

Abstract

Objective - To evaluate the effectiveness of routine ultrasound scanning in pregnancy by a meta-analysis of various outcome measures.

Design - Meta-analysis of randomised controlled trials evaluating the effect of routine ultrasound scanning on perinatal mortality and morbidity. Live birth rate (that is, live births per pregnancy) is included as a measure of pregnancy outcome in addition to the conventional perinatal mortality.

Upcoming Events

a] **CONFERENCE 1994**

"The Culture of Midwifery : Celebrating Women & Family"

13th, 14th, 15th August 1994

Te Papaiouru, Ohinemutu, Rotorua

Plans are underway for this exciting conference, so mark these dates in your next diary.

Calling for Papers. Forward details and abstracts of papers for presentation at Conference to: Nita Van Boven, c/- Post Office, Lake Okareka, Rotorua.
Phone 07-362-8083 (a/h)

b] **KATHLEEN AUERBACH SEMINARS**

Auckland - 3 October 1993 Christchurch - 5 October 1993

New Zealand Lactation Consultants Association (NZLCA) is delighted to be able to host Dr Kathleen Auerbach, PhD, IBCLC, in New Zealand for two seminars in co-operation with the Australian Lactation Consultants Association (ALCA)
Dr Auerbach is an internationally known lecturer, symposium and conference presenter, author of nearly 50 scientific articles, book chapters and monographs and numerous other publications. She has also taught in and is consultant to a number of academic and proprietary organisations and institutions.

Since 1985 Dr Auerbach has been Editor-in-Chief of the **Journal of Human Lactation** and was the editor of the **Lactation Consultant Series** from 1985-1991. An International Board Certified Lactation Consultant (IBCLC) since 1985,, Dr Auerbach has a PhD from her thesis on "Behaviour During Pregnancy: A Sociological Analysis". her most recent work is as co-author of **Breastfeeding and Human Lactation** an extensively referenced 700-page book; an essential resource for those interested in lactation and breastfeeding.

At the seminars Dr Auerbach will present a number of topics including lactation, failure to thrive, lactation research, breastfeeding devices and the baby-Friendly Hospital Initiative.

FOR FURTHER INFORMATION CONTACT

Auckland
Barbara Hamilton
Ph 09-524-5155

Christchurch
Marcia Annandale
Ph/Fax 03-323-7124

c] **BIOETHICS SEMINAR**
Knox College Dunedin
22-26 November 1993
Topics include : Carma, dying, death, genetic research, assisted reproductive technology, STDs and AIDS and more.

For further information, contact : International Seminar on Bioethics
Bioethics Research Centre
P O Box 913 Dunedin
Phone 03-474-7678 Fax 03-474-7601

d] **HERBAL THERAPIES FOR THE CHILDBEARING YEAR**
1-day Seminar Chanel Park, Hamilton 09.30am to 5.00pm
12 November 1993 $75 (includes lunch)

Susan Weed - "Green Witch and Wise Woman"
Author of "Wise Woman Herbal for the Childbearing Year" and "Healing Wise"

For programme and registration, contact: J Cohen 25 Glenview Terrace, Hamilton
or J Hoyle 57 Plunket Terrace, Hamilton

e] **PETER NATHANIELSZ**
Author and researcher for 30 years in the mysteries of fetal development. Author of the book "Life before Birth" and "A time to be Born".

Christchurch	**Wellington**	**Palmerston North**
Wednesday 3/11/93	Tuesday 2/11/93	Tuesday 2/11/93
7.30-9.30pm	7.30 - 9.30pm	1 - 2.30pm
Stringleman Room	Venue yet to be	Education Centre
Public Library	advised.	P/North Hospital

Books & Videos

a] ***"Post Partum Depression and Anxiety"***
- A Self Help Guide for Mothers
by Pacific Post Partum Support Society. Available from PPP Support Society, Suite 104, 1416 Commercial Drive Vancouver BC V5L 3X9. Phone 604-255-7999

b] ***"Women Together"***
Edited by Anne Else
Published by Historical Branch of Dept of Internal Affairs

A unique, lively account of New Zealand's voluntary women's organisations. From the earliest formal welfare organisation of 1863 to the newest, including a mention of the New Zealand College of Midwives.

Enquiries to : Daphne Brasell, Associates Press, P O Box 12-214, Thorndon, Wellington. Phone 04-471-0601 or Fax 04- 471-0489

c] *Elizabeth Noble*

Videos - ***"Channel for a New Life"*** (37 mins)
A spectacular outdoor water birth
- ***"Baby Joy"*** (68 mins)
Exercises, activities, massage for parents and infants

Books - ***"Exercises for Mother-to-Be"***
- ***"Exercises for Mothers and Babies"***

Contact : Sally Hopton, 27 Hyland Terrace, Rosslyn Park, SA 5071, Australia.