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

NATIONAL NEWSLETTER

February / March 1994

Committee Workshop Report

Defining Consultation

Draft Position Statements

Enkin Tour

National Midwifery Resource Centre

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

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

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Workplace _____

Date of Birth _____

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ARE YOU A MEMBER OF NZNO? YES/NO

MEMBERSHIP NUMBER ALLOCATED _____ Office use only

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☐	Full Membership (Self Employed)	$255.00 } Includes
☐	Full Membership (Waged)	$155.00 } Indemnity
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☐	Associate & Affiliate	$ 30.00

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Researchers want more debate on qualifications

- Sunday Times 2/1/94

More research and public debate is needed on the new national qualifications framework, education researcher say.

The Association of Research in Education has written to Education Minister Lockwood Smith criticising the framework and the process by which it is being developed - criticisms that the authority has defended itself against.

Association secretary Lauran Massey listed several concerns identified in papers and discussions at last month's conference. "A group of members, including some leading New Zealand researchers, expressed disquiet with the present situation," he said.

A concern was that unit standards would drive the curriculum. "This is dangerous because it could lead to fragmentation, standardisation and conformity of learning," Massey said.

There was no evidence that the framework had been based on research establishing it would be more beneficial for learners than other systems.

The association also questioned the use of a model which used one form of assessment for all areas of learning. The essence of many subjects could not be captured in "segmented unit standards", and competency based units could "limit learning to mediocrity rather than worthwhile professional excellence".

The association also criticised the process of developing the framework, saying the timeframe for registering unit titles and standards appeared to be "driver politically" and "far too shore for adequate consultation, research and development work".

Advisory groups and others consulted had been "disempowered" b lack of information and changes in definition, and "confused by jargon and use of ill-defined terms".

"Theses people have sometimes been told that they must not question the purposes and underlying philosophy of the framework but rather that they must provide details to help unit writers complete their task," Massey said.

Association members were not satisfied there was enough evidence from overseas to illustrate the framework worked for academic and professional learning. "These issues need to be researched and debated by the education community. This needs to be done before we could give a commitment to the NZQA framework for general professional education." Massey said.

The association challenged the Qualifications Authority's assumption that the framework has been "accepted by New Zealand".

"There has not been, according to our members, enough debate and understanding or even surveying of the public and education groups of the

NATIONAL CO-ORDINATORS FORUM

Welcome to the first newsletter for 1994. This year promises to be just as exciting (or controversial depending on your viewpoint) as last year.

It's always difficult to know where to begin when writing this forum as there is so much change and uncertainty within the health system. The year started on a good note I believe with a very productive meeting with NZNO. The innovation and enthusiasm from Steph Breen and NZNO to work together with the College on joint strategies which unite and inform midwives wherever they work is greatly appreciated. As you know Steph was our Co-advocate at the Maternity Benefits Tribunal Hearing and it was many the time that her professionalism and energy carried the flagging midwifery spirits to greater heights. It was, therefore, personally rewarding working together again to further progress and visibility of midwives. It was also gratifying to have the NZNO recognise our joint statements as applicable to all midwives.

The position statements are printed on pages 21-25. Discussion and comment on these first draft papers is welcomed.

The 27th January was the second meeting with the RHA's and NZMA to negotiate Section 51 (Maternity Benefit Schedule). This meeting started rather unexpectedly with the NZMA attempting to renegotiate the right of midwives to practice independently. Once again they demanded that all pregnant women have at least one visit to a doctor. However agreement was eventually reached by all parties that the right of women to choose midwife only care is a statutory one and not negotiable. Little progress was made on fee's and structure but the group has, I believe, established some ground rules in which negotiation can now take place.

The next move is that the RHA's will present to the doctors and ourselves their first position on the fee structure they wish to see introduced. A further meeting has been arranged for the 21st March to discuss this.

For those of you who are concerned about the future and where your income will actually come from the indications are that the RHA's will look at local initiatives and contracts, but are also "committed to the national section 51 as continuing for the foreseeable future, setting national guidelines for quality care. Local contracts will be a means of encouraging financial competition and efficiency".

However no RHA in practice has shown any interest in contracting with midwife groups either alone or in partnership with consumers. Midland has a particular bent towards "team" health services and therefore appears disinterested in discussing midwifery only services. The team is defined as always having a GP involved along with a range of disciplines. This raises two highly significant issues for midwifery in relation to this new competitive health system which are quite incongruous.

Firstly there seems little understanding by Midland that in the healthy life cycle where pregnancy and childbirth are normal (80-85% of women) a midwife can competently and safely provide the total maternity service without another health professional being involved. Therefore to insist on teams of professionals in a primary health process is a duplication of services and unnecessarily expensive. It also reinstates the medicalisation of birth that the women's health movement has tried so hard to modify. It negates the changes to the Nurses Act which recognised birth as a normal life event and gave women the right to choose the practitioner and their philosophy which best met their needs.

Midwife dispute probed

- Waikato Times 9/2/94

Health Waikato's ultimatum to midwives has been cited in complaints to the Human Rights Commission and Commerce Commission.

The Human Rights Commission has been asked to investigate the Crown Health enterprise's bid to strip hospital midwives of their private caseloads.

The Commerce Commission has also launched an inquiry into allegations some CHE's are denying independent midwives access to public hospital beds. The Health Waikato dispute will be included in that investigation.

Both complaints have been lodged by the New Zealand College of Midwives, in a bid to highlight "misguided" attitudes arising from the health reforms' emphasis on business practice.

College director Karen Guilliland yesterday said from Dunedin Health Waikato was not one of the CHE's denying access to beds, but there was no way of knowing what would happen in the wake of the dispute.

She said the Health Waikato insistence midwives with hospital contracts and private caseloads were "double-dipping", soliciting clients, and setting themselves up in competition had come as a surprise.

"Waikato has always been open and co-operative with the primary health sector," she said.

"We have always held Health Waikato up as an example of institutions that recognise the right of women to childbirth choices.

"I think what's happened is a misapplication of corporate policies on to public health. It doesn't work, and the consequences fall on the customer", said Ms Guilliland - who will address a public meeting in Hamilton on February 23 in a bid to air the midwives' issue.

The complaint of discrimination had been lodged with the Human Rights Commission on two main grounds - that Health Waikato had targeted midwives while other health professionals ran hospital contracts and private practices; and that forcing midwives to give up either hospital work or private caseloads would simply deny pregnant women a choice.

"It seems that like nurses, midwives are easier targets than small groups of doctors who have greater political power. but it's unfair to pick on just one group."

The Commerce Commission complaint was focused on the attempt by some Crown Health enterprises to monopolise midwifery, and Health Waikato - while not directly cited - would be investigated as a result of its ultimatum. ■

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CONTENTS PAGE

Directory - National Committee	FIC
Editorial	2
National Co-ordinator's Forum	3
Nominations for Education & Research Council	8
Current Issues	9
Upcoming Events	20
Draft Position Statements	21
Articles of Interest	26
Media Watch	34
Directory - National Treasurers	44
Membership Application Form	BIC

NEXT NATIONAL COMMITTEE MEETING

To be held in Palmerston North on TUESDAY 17 MAY 1994

AN Education Workshop will be held in Palmerston North on Wednesday 18th to Friday 20th May following the Committee Meeting

VENUE : **Manuwatu Polytechnic**

Any contributions to the National Newsletter should be addressed to:
Karen Barnes
142 Ilam Road Christchurch 4

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DEADLINE
for the next Newsletter is 1st May 1994
Next Newsletter will be due out mid May 1994

PUBLISHING DETAILS
Editor - Karen Barnes
Typesetting by Margaret Stacey
Printing by MAS Business Services Christchurch

EDITORIAL

Dear Members,

Welcome to the first newsletter of 1994.

I hope you have all had a restful break over the Summer and are now busy again with the ongoing work in your regions.

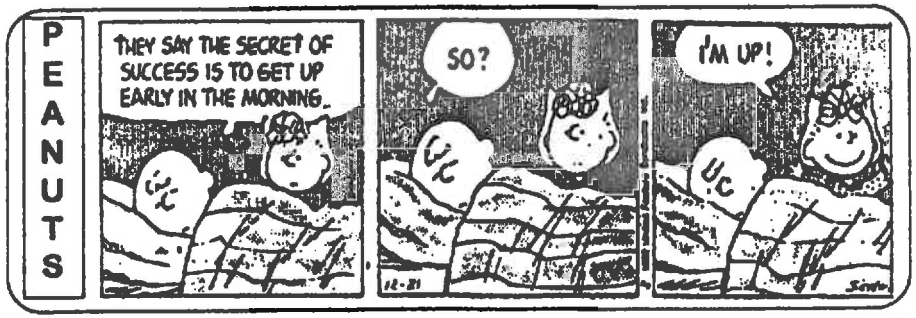
Again, we have a lot of information for you to read. Midwives continue to be under attack as the recent issues in the Waikato have highlighted. We run some of the media releases on this and send our support to those of you personally facing this crisis.

Along with a selection of interesting articles for midwifery practice, we again have lots of important notices. Read carefully and remember to respond promptly! Note especially that subs will be coming due as of the 1st May. Please note the new amounts that are required to be paid this year. When filling out your membership form for renewal, please ensure you supply us with complete details.

Conference is looming and the Rotorua folks are getting busy with last minute preparations. Remember to get your abstracts into Nita Van Boven soon.

Happy reading!

Karen Barnes



implications of the framework for this to be possible,' Massey said.

Qualifications Authority chief executive David Hood said the authority had consulted long and hard on the principles of the framework, a process that stretched back to October 1990.

About 180 industry and professional groups, representing more than 2000 people, were involved in developing unit standards.

Hood said criticism was an inevitable part of major reform. "What is important is that it plays a constructive part. Overseas experience confirms this." Many overseas countries were following similar paths with their qualifications.

Much of the recent criticism had come from academics who had little to do with the framework, whereas those actively involved were generally highly supportive.

The authority had spent $167,000 on research in the past financial year and had budgeted almost $240,000 for research this year. It was guided by a research committee of prominent educational researchers.

He said there were provisions for extending timelines for registering unit titles and standards if required, and there had been changes to the way advisory groups were informed about the framework to ensure they understood it.

While there was interplay between curriculum and assessment, the framework was not intended to drive curriculum.

The claim that competency standards would limit learning to mediocrity could be "levelled at any system". Standards would be adjusted if students were not achieving the requirements of "worthwhile professional excellence."

LETTERS TO THE EDITOR

Midwives needed

Editor - I agree with Karen Griffith (letters, January 26). As a mother I had never experienced having a midwife at my side. They weren't around during my time of childbirth.

But as a first grandparent, I wish they were. From her first visit our midwife Sue waited for our extended whanau to arrive. The support of everyone being there for our young parent-to-be was encouraging for them. Being able to feel how baby was lying, hearing his heart beating, question and answer time was most rewarding.

Living rurally was no problem. Sue was always there when needed. When our grandchild and nephew was born, the elation in the room was so wonderful. Everyone, even the children, were allowed to witness a beautiful memory. There is a need to have midwives in the community. They form a special bonding with so many young parents and caring and sharing attitude really comes through.

Who is Mrs Adlam? She should tag along on one of those visits, where real people are.

POLLY WILSON
Whitikahu

IMPORTANT NOTICE FOR ALL MEMBERS

Various individuals and organisations have been approaching the College to purchase a one-off supply of our mailing list. After discussion at the National Committee the decision was made to sell one copy of the mailing list to appropriate organisations.

This notice is to give you the opportunity of having your name and address removed from this process. Some examples of requests for the mailing list include:

Ministry of Health - Public Health Notices e.g. Listeria
Regional Health Authorities - Section 51 Notices
Telecom - Special Yellow Pages offer
Medic Corporation - latex gloves, baby scales
Inter Med Medical Ltd - disposable portable vacuum extractor

If you don't wish to receive information from these groups, please contact the Midwifery Resource Centre (03-377-2732) or P O Box 1206 Christchurch within 10 days of receiving this newsletter.

The inter-disciplinary team concept is of course necessary and desirable in the secondary care system where a woman's needs are no longer able to be met by one caregiver. It is not to be confused however with the primary health practitioner who provides a total service including the right to consult at any given point. The normal expectation of co-operation and respect between consultants is of course appropriate for all providers.

Secondly this approach is in effect forcing competitors (Midwives, GPs, Obstetricians) to work in a team and it is a rather ironical (and naive) position to take in this new competitive environment. The purpose of introducing competition according to the corporate idealogues was that contestibility increased innovation and quality as competitors strive to market their particular service. Therefore any RHA which insists on funding one particular way of practising (teams) reduces competition and could well be in breach of the Commerce Act.

There have been a variety of other incidents occurring throughout New Zealand which are also in conflict with the Commerce & Fair Trading Act. Many involve the actions of CHEs as they obstruct access to their facilities for midwives and their clients. Generally this obstruction takes the form of denial of new or renewed contracts for midwives because self employed midwives are seen as in competition. Waikato Health has taken this further and denied their employees the right to also have a self employed practice. We have printed the media coverage of this on pages 35-41. The issue here is blatant discrimination against one set of employees, namely midwives. It is not acceptable and it is particularly important for our newly re-emerging profession to support our Waikato colleagues to resist this discrimination. If Waikato want to pursue a dedicated staff (one that only works for them) they need to apply that to <u>all</u> their employees.

If they can't attract or retain midwives to work for them they must provide more attractive working conditions. That is the rule of the market place! To threaten their staff midwives with dismissal will not solve their problem in the long term and could well increase them.

We must encourage the Waikato midwives to refuse to take part in what is essentially a threat to their autonomy as professional midwives. Nurses and Midwives have too often been bullied and relied on to support the status quo at their own expense. It is how a women dominated workforce has been treated for decades. If midwives are to be strong advocates for women's health and are to effectively empower women to achieve the maternity health care of their choosing they must firstly be able to stand up for themselves.

The College has lodged a complaint with the Human Rights Commission about this discrimination against midwives and the women who choose midwives as their providers.

The College has also laid a further complaint with the Commerce Commission about a variety of incidents by CHEs and RHAs which are anti competitive towards midwives. The Commission has accepted the complaint and has started a rigorous nation-wide investigation. Many midwives and CHE managers have already been interviewed. If you personally have experienced situations where your right to practice has been obstructed (eg denied an access agreement) please contact me.

It is equally important that self employed midwives also do not accept any obstruction or discrimination when applying for access to CHE facilities.

Midwives' jobs not threatened in Taranaki

By DELWYN MASTERS

MIDWIVES running a private practice while employed by Taranaki Base Hospital are not an issue for Taranaki Healthcare.

Health Waikato recently threatened to sack midwives who delivered babies for private clients, saying it was a conflict of interest. But Taranaki Healthcare women's health manager Kathy Glass said the Crown Health Enterprise had no problems with hospital midwives also running a private practice.

"It's not seen as an issue here," said Mrs Glass. "I think many CHEs get a high number of independent midwives working for their services - a considerable number of women coming in to give birth managed by independent midwives.

"But about 10% of births here are by independent midwives, which is probably lower than most places in the country.

"We have a very good relationship between independent midwives and hospital midwives here, and there have been no concerns expressed here."

College of Midwives Taranaki-Wanagnui chairperson, Tricia Thompson said of the eight midwives operating in Taranaki, only two were employed by Taranaki Healthcare.

LETTERS TO THE EDITOR

Better choice

Editor - Add to the list of Health Waikato misdemeanours the "independent midwives" scandal.

How dare the Crown Health Enterprise (CHE) dictate to parents the type of care they can expect pre and post natal, for themselves and their child? Haven't the powers-that-be streamlined - or was that "strangled" - public healthcare within an inch of its life while lining corporate coffers? Nice paint job, Waikato Women's; shame about the service in delivery suite.

Independent midwives provide an outstanding service which, in my experience , is infinitely better than that at Waikato Women's Hospital. I arrived at hospital for the birth of my third child to find room unavailable due to electrical faults over a week old; had a poorly equipped delivery; and a request for an extra pair of hands at critical stage of delivery, was ignored. I then read your article (*Waikato Times*, January 15).

I was incessed. Why does the CHE think independent midwives are in business and so popular? All for the sake of the maternity benefit, the CHE will play the heavy and deny parents the right to choose. The public is ripped off from cradle to grave; at least let those in the womb have the best possible care and a real choice. (Abridged)

MARGARET THOMAS
Hamilton

Midwifery saga a source of concern - WAIKATO TIMES

Editor - It is with great concern I follow the midwifery saga at Waikato Hospital.

Having experienced two midwife-assisted births and about to embark on a third, I find it hard to accept birth without one.

It has taken years for women to finally get a say on how they want to give birth and who they want to assist them and this is about to be taken away by somebody who, at a public meeting declared: "there is no difference been reorganising the forestry industry and the maternity industry". I can assure Mrs Adlam there is a difference between me and a tree.

Do people know the amount of time a midwife gives to her expectant mother? Apart from the usual ante-natal visits, she's on call 24 hours each day after for at least 10 days. Does a GP or specialist do this? I don't believe so.

I am also curious to know the difference between an obstetrician or GP attending a birth at Waikato Hospital and having private patients and midwives doing the same. After all, they are all professionals.

Perhaps Mrs Adlam would like to talk to mothers who have experience with midwives and get a different viewpoint to the almighty dollar.

KAREN GRIFFIN
Hamilton

Don't sign, lawyer tells midwives

WAIKATO TIMES 7/2/94

By BILL ROBSON
Health Reporter

Arrested criminals have greater rights than midwives targeted by a Health Waikato "moonlighting" purge, a Hamilton lawyer has said.

In an opinion sought by independent midwives, lawyer Gerald Bailey said the Employment Tribunal would regard the dismissal of midwives on grounds that they handled private caseloads as "unjustified".

Part-time midwives with Health Waikato have been told to choose between their hospital work and their private caseloads. The latest ultimatum from children's and women's health general manager Bev Adlam was Saturday.

A public meeting is scheduled for February 23, to be addressed by College of Midwives and Nurses Organisation representatives, in a bid to gauge public support.

Independent midwives sought a legal opinion from Evans Bailey and Co., and a written opinion signed by lawyer Gerald Bailey was released to the *Waikato Times* today.

The firm says its advice to midwives required to sign a declaration choosing between Health Waikato contracts and private work was that "none of them should sign".

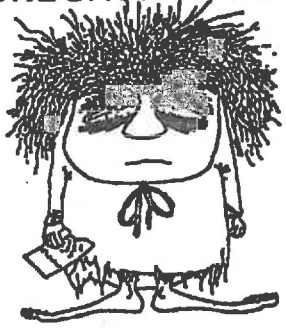
Mr Bailey's legal opinion describes a letter sent to midwives by Ms Adlam as "remarkable". Health Waikato seemed willing to implement a policy regardless of whether the midwives approached agreed with it: "Criminals arrested in this country have greater rights than that."

The opinion also said: "We believe that the Employment Tribunal would regard termination of employment in circumstances such as those as being quite unjustified," - emphasising that an "aggrieved applicant" could be entitled to substantial damages.

Mr Bailey says his clients are willing to take part in discussions, but are not prepared "to lend their support to the draconian measures which you have sought to introduce unilateraly, without reasonable dialogue, an in a particularly objectionable way." ■

Your midwifery registration grants you the right to practice, not a CHE. Do not accept the CHE's definition of how, when, where and with whom you practice without question. Take the NZCOM Handbook for Practice and quote the professional Standards and Code of Ethics by which a midwife is expected to practice within New Zealand. Take part in the annual Midwifery Standards Review to evaluate and monitor your performance. Constantly reflect on your practice and be willing to learn from constructive critique. To do so is the protection you and your clients can rely on.

I try to take JUST ONE DAY AT A TIME



but lately several days have attacked me at once

VACCINATION AGAINST PREGNANCY

- Fed of Women's Health Councils Nov/Dec 1993

A new contraceptive is currently being researched. It works through immunisation of women against pregnancy. Women in developing countries are the main target for this vaccination. Tests have been carried out on women in India, Finland, the Dominican Republic, Chile and Brazil and are soon to commence in Sweden. Researchers estimate that a product will be ready for marketing in 5-10 years.

The main conclusion of a Health Action International (HAI) study on research into contraceptive 'vaccines' is that it should stop because it entails serious risks to women's health and rights.

cont'd on page 31

SUBSCRIPTIONS COMING DUE!

Subscriptions will be due for payment from 1st May 1994. This is your reminder to get in early. Fill in **both** portions of the form at the back of this newsletter and post it to your local treasurer. **Please** include your postcode with your address as this helps with sending out newsletters and other mailouts.

NOMINATIONS

NZCOM EDUCATION & RESEARCH COUNCIL

This standing committee requires nominations from interested women and midwives. There are three midwife practitioner positions and two consumer positions coming up for re-election at the AGM in August 1994.

Committee's Terms of Reference :

1] To represent the views of the NZCOM on Education and Research policy and development.
2] To provide a forum for discussion and information sharing on issues relating to Midwifery Education and Research.
3] To report and make recommendations to National Committee on issues relating to Midwifery Education and Research.
4] To monitor courses, developments and initiatives in midwifery Education and Research.
5] To develop and implement the NZCOM official policy relating to Education and Research.
6] To host a forum at National Conference to inform members about issues relating to Midwifery Education and Research.
7] To facilitate and promote ethical and research based Midwifery practice.

The Committee meets twice yearly and has teleconference discussions two monthly.

Nominations with curriculum vitae to:
Midwifery Resource Centre
P O Box 21-106 Christchurch

Closing date 01 July 1994

Risk of miscarriage increases when either the man or woman smokes. New finding : Nicotine can cause abnormally shaped sperm. (MR) Health Watch

Private vs public - the debate begins

WAIKATO TIMES 24/1/94

Bev Adlam, in charge of children's and women's health at Health Waikato, has brought into the open a philosophical debate finally beginning to escalate. Prompted by the health reforms and presumably stemming from her review of maternity services, she has written to hospital midwives, presenting them with them an ultimatum - give up private practice or no longer work at the hospital. Unless Ms Adlam changes her mind - she's gone mum since lobbing her letter into the midwives' Christmas break - the women concerned must, by the end of the month, decide which way they'll jump. Upset, the midwives are threatening through their union! - the College of Midwives - to use the Fair Trading Act to stop Health Waikato's plans.

The issue of private v public health care - an issue that can find protagonists on either side in some hopelessly comprising positions - has dominated holiday headlines. It's an issue that deserves airing. But by making only midwives choose between their public and private patients, Ms Adlam and Health Waikato are leaving themselves open to some pretty fundamental questioning. Why are they the sole maternity professionals being targeted? If they must choose between their public and private careers, why, too, shouldn't specialists who've apparently been told it's OK to double-dip? Are midwives simply easier to find than consultants who, practising in often more esoteric specialties of medicine, can be harder to replace and, given the public esteem in which they're held, can create a bigger stink when they walk out in high dudgeon when their empires are challenged?

Health Waikato is apparently bidding to retain public health dollars for the childbirth business from Midland Health, the regional health authority which decides how to spend millions of taxpayers' dollars improving the health of those in its central North Island bailiwick. Shouldn't the RHA actually try to encourage all midwives to move into independent practice in the community where many women argue they belong, anyway? Their view - it has a certain logic - is that, generally, pregnancy and childbirth are not illness that must be managed by hospitals, unless something goes wrong. That's an argument women have made with increasing force for years.

Health Waikato is the obvious provider of high tech services like the neo-natal unit, for example. but It's questionable whether is should, in ordinary cases be doing more than making beds and other facilities available if the mother-to-be opts for a hospital birth? That them becomes a service for which the CHE charges the independent midwife and GP team managing the birth, who would be paid a set sum by the RHA for the entire pregnancy.

If Ms Adlam has gone quiet, however, so has Midland Health. It surely is vitally interested in where and how the birthing business is managed in the Waikato. Where does it want its dollars to go? To the CHE? To an independent midwifery service? It has an obligation to enter this debate and make clear to its constituents - all 683,000 of them - what kind of service it believes will best cater for mothers' needs, within - of course - sensible and capped spending parameters.

Midwives stand firm on services

By BILL ROBSON Health reporter

Health Waikato is planning a second letter to midwives who are standing by their right to run private practices while working for public hospitals.

Meetings over the past two days failed to resolve the impasse, despite a requirement that midwives decide by the end of January whether to continue with private caseloads or retain Health Waikato contracts.

Bev Adlam, general manager of children's and women's health, could not be reached to confirm this today. But New Zealand Nurses Organisation organiser James Ritchie said Health Waikato had refused to reconsider its ultimatum. As fare as he knew, no midwives had signed a declaration to give up private practice. Health Waikato was planning a second letter similar to that sent at Christmas.

Meanwhile, a Hamilton women's health collective today described Health Waikato's ultimatum as "blatant discrimination". Women's Health Information Support And Education Services (WHISE), called on Health Waikato to reconsider its move and to open up the debate on maternity services.

WHISE spokesperson Martha Simms said the ruling was "blatantly discriminatory", would reduce birth options and was a "clear injustice" for one health group to be told private caseloads raise a conflict of interest.

"If the ruling is made for one group, it should be made for all, including obstetricians, radiololgists, and all other specialists in maternity services. Clearly, this would not be possible or prudent. Justice and fairness demand that midwives employed by the hospital should continue to have their right to private practices as long as that right exists for other health specialists," she said.

The move could run down maternity services in rural areas, with midwives having to choose between private practice and local hospitals. ■

WAIKATO TIMES Jan 1994

"Nothing is impossible; there are ways that lead to everything, and if we have sufficient will, we should always have sufficient means. It is often merely for an excuse that we say things are impossible."

- Francois de La Rochefoucauld

CURRENT ISSUES

Report from Committee Workshop - 06 March 1994

- Sally Pairman, President

Each quarterly National Committee meeting is followed by a workshop which enables members to work on some of the larger issues facing the College. The most recent workshop involved review of the management structure of the College, development of an exciting vision for our future role and discussion of the kind of management structure the College needs to enable us to reach our goals.

The workshop was led by Gill Down, an accountant with specific expertise in contracting and small business development. Gill has a number of midwife clients and very generously gave her time to prepare and lead the workshop.

Influences

Gill prepared a written review of the College business and the market in which we operate as a starting point. She identified a number of factors which impact on the present management structure of the College.

1. Rapid development in four years to a nationally and internationally recognised professional midwifery organisation with clear statements of philosophy, standards, ethics and practice guidelines.

2. Recognition by RHAs and CHEs that College members are the major providers of maternity services.

3. Midwife responsibility for 20% of all births in New Zealand in 1993. Expectation that this market share will continue to increase.

Present Structure

The present structure of the College involves 10 regions whose chairpersons make up the National Committee along with 3 Consumer representatives, a Maori representative, a President and the Board of Management (National Co-ordinator, Treasurer and Secretary). There are two standing committees who report to the National Committee - the Education & Research Council and the Section 51 Negotiating Committee.

The National Committee is responsible for policy decisions but there are no clear job descriptions for regional chairpersons, the president or the national co-ordinator and no appraisal process to make people accountable. We have global objectives but do not set annual goals and plan strategies to meet these goals. There are no clear lines of responsibility or decision making, and this can constrain our ability to act quickly and be proactive. The role of the National Co-ordinator is enormous and requires specialised knowledge about a wide range of areas. The lynch pin of the College is the National Co-ordinator and the College is vulnerable because of her indispensability. In short, the College management structure was developed to enable change. This has been achieved and if we are to continue to be effective in the long term, we need to look at a structure which will enable this to happen.

Threats

Gill reviewed the health industry and identified the major threats facing midwives in their practice.

1. **Collective Contracts.** The present maternity benefit system is under threat and the RHAs are showing a clear preference for large collective contracts. Midwives will have to form very large practices in which to contract with the RHAs or the College will have to contract regionally or nationally on their behalf. The alternative is to sub-contract to GPs or Obstetricians for significantly less money and much less autonomy of practice.

2. **Continuity of Care.** RHAs are interested in contracting with groups of professionals who will provide a system which identifies a "lead professional" for each woman. This person is likely to be the person who diagnoses the pregnancy and who will then sub-contract to other providers in order to provide the complete service (GPs) or will provide the complete services themselves (Midwives). The issue of whether there will be different contracts for primary and secondary services is still unknown.

3. **Other Maternity Service Providers.** The main competition facing Midwives is GPs. They will need to sub-contract midwives as well as establish referral links to obstetricians, but midwives do not need GPs and need only to establish links with Obstetricians.

Midwives warned of dismissal

WAIKATO TIMES 15/1/94

❑ Legal advice sought after Che imposes ban on private practice in Waikato

Health Waikato midwives have been warned they face dismissal if they continue with private practices.

Be Adlam, general manager of children's and women's health, told midwives in a Christmas Eve letter the Crown health enterprise was in competition with private midwives and it was no longer acceptable for its midwives to also work privately.

"If any employee does have private clients it will mean the disciplinary policy will apply. As a conflict of interest is considered serious misconduct, termination of your employment could be the result," the letter says.

It is understood 50 midwives employed by Health Waikato have private caseloads.

Ms Adlam has refused to comment on the letter, which tells midwives they must decide their future with Health Waikato by the end of the month.

She said the issue was a personal matter between her and the midwives.

But midwives contracted by the Waikato Times say some are seeking legal advice.

Homebirth midwife Maggie Banks said she was concerned the ban on private work might be the forerunner to closure of outlying hospitals.

"If the majority of midwives choose to go out on their own, it might be Health Waikato which says it hasn't got enough midwives to staff theses rural hospitals, and closes them,"I

Health Waikato figures show births cost the CHE most in maternity hospitals at outlying towns such as Huntly and Waihi.

New Zealand College of Midwives Waikato branch chairperson Raewyn Park described the letter as "intimidatory" and an open declaration of war on independent midwives.

The midwives' union, the New Zealand Nurses Organisation, wants the January deadline deferred until March.

NZNO organiser James Ritchie said he could understand Health Waikato "wanting its employees not to engage in conflicting employment". But the timeframe was too short and midwives were being asked to make decisions without all the information before them.

Mr Ritchie said he had been told the restriction imposed on midwives would be applied throughout Health Waikato.

But Health Waikato obstetrician Amelia Hart said she and her colleagues were told before Christmas they would not be asked to drop their private caseloads.

The times understands six of the seven obstetricians employed by Health Waikato have private clients.

Obstetricians working privately are, like midwives and GP's, eligible for public funding under the Maternity Benefit Scheme. The scheme, administered by Midland Health, covers care of women during pregnancy, childbirth and a few weeks after birth.

"To most of us the future seems unsure, but then it always has been, and we who have seen great changes must have great hopes".

MEDIA WATCH

STATE POLITICS

Western Australia 11/11/93

DOCTORS OUT TO GET ME: MINISTER

Health Minister Peter Foss hit out yesterday at his critics in the Australian Medical Association, accusing them of trying to batter him into kowtowing to their agenda.

He said the doctors were angry because he was the first Minister to tackle them head-on.

The AMA called this week for Mr Foss to be sacked if he continued to ignore advice and based his decisions on personal views and experiences.

It claimed Mr Foss was dangerously promoting home births while hiding the extra risks.

But Mr Foss said the AMA was using home births as an excuse to get at him because he would not be their lap dog.

He said the AMA was arrogant and had complained over his head to Premier Richard Court because it wrongly believed it was owed something.

The Federal AMA backed the Liberal Party at the last Federal election.

Mr Court said he was happy with Mr Foss's handling of the health portfolio.

He said Mr Foss had brought a refreshing approach to the job.

AMA state president Keith Woollard said he was worried Mr Foss was not coping with the pressure of his three portfolios - health, arts and fair trading.

He said Mr Foss was not spending enough time on health issues.

The AMA and other doctor groups denied earlier that their comments were motivated by possible loss of income.

Australian College of Midwives WA president Carol Thorogood said it was sad that mothers and babies were being used as a political football.

She defended Mr Foss, saying he was prepared to discuss matter with family and health groups rather than just doctors.

Health Commissioner Peter Brennan denied that Mr Foss was ignoring Health Department advice.

He said the department had no argument with more babies being born at home as long as there was support from a doctor if needed.

About 30 women and their home-born babies rallied in support of Mr Foss yesterday in front of the Federal Health Department offices. ■

Our Vision

We discussed our vision for the College. We see a College which is recognised as the authoritative voice on Midwifery and childbirth matters by midwives and the public alike. An effective and efficient process of reviewing all registered midwives standards of practice and ongoing competency would develop. The College would provide up to date information to members on Midwifery practice and related issues and would be involved in development of new knowledge through co-ordination of midwifery research. The College would have a major role in education, pre and post registration, through approval of curricula and providers of midwifery education. The provision of an education role would expand. The College would promote midwifery through marketing strategies and public relations. The College would negotiate contracts with RHAs on behalf of members and increase its industrial role. The College would work towards a separate Midwives Council to ensure midwife and consumer control over registration and discipline of midwives. The College would have a secure financial base and all midwives in New Zealand will wish to be members.

Restructuring

We felt very excited by these possibilities and there was a strong belief that these were attainable if we could develop an administrative and managerial structure which would enable action on all fronts.

We identified the key areas as :

1] Marketing and public relations
2] Quality Assurance
3] Professional development
4] Membership
5] Industrial

The National Committee members have divided into groups to address these areas and to develop job descriptions and terms of reference for the people who might be employed in these positions in the future.

Clearly there is a need to employ more people to spread the load and responsibility currently carried by the National Co-ordinator, and to enable adequate time to be devoted to key areas to really make substantial progress. The positions need not necessarily be full-time and possibly one person could fulfil two roles initially.

An efficient and enlarged secretarial role will be necessary. The National Co-ordinator could take on more of a supervisory, co-ordinating role and have responsibility for ensuring that objectives were met. The National Co-ordinator would continue to liaise directly with the National Committee who would continue to direct policy. A new structure has not yet been clearly defined and there is much work to do. An obvious difficulty is finance and members will need to consider what they want from their professional organisation and what they are prepared to pay for. Borrowing money is also a possibility which needs to be investigated. It has the benefit of shifting some of the financial burden on to future members as well as present ones.

Where to from here?

Regional chair people will be reporting back to you and the National Committee will be continuing to develop a possible structure at the next meeting in May. meantime, specific members have the responsibility for working on identified areas and reporting back at the next National Committee meeting. If you wish to contribute to any of these areas, please contact the individuals directly. We will be most grateful for your input.

Public Relations/Marketing	-	Jo Coco	09-426-7049
		Sally Pairman	03-477-3014 extn 8149
		Rea Daellenbach	03-332-5739
Professional/Education	-	Paulette Whitford	07-856-0130
		Chris Hendry	03-348-9347
Industrial	-	Karen Guilliland	03-377-2732
		Bronwen Pelvin	03-528-6762
		Carey Virtue	04-384-7261
		Jo Mawdsley	03-442-6023
Membership	-	Julie Richards	03-377-2481
		Sue Lyttle	03-355-6289
		Karen Barnes	03-351-9984

Quality Assurance. It was decided to wait until after the May education workshop to identify specific people to look at the further development of this role for the College. We are already working hard on standards review but have not yet tackled competencies and need a structure which combine both aspects. Perhaps annual standards review with a smaller committee than at present and five yearly assessment of competency which is linked to the practising certificates?

"It has a very important task and that is rationing health care, and it should not be disguised as anything else. "Then we can assist them in this and the public can continue to be involved."

EDITORS NOTE: *It seems the College of GPs Chairperson can see the problems associated with guidelines and have a much broader view than her Maternity Benefit negotiating colleagues. Why do they believe pregnant women to be the only group of health consumers who need to have protocols attached to their caregivers? GP negotiator Lyn Coleman says,*

"If the RHAs are only worried about medical-legal issues in the sense of legality, then they're going to let midwives do their thing and it won't be until the auditing process when they see high levels of complications that they say, maybe we should've had a doctor involved in this case. That's why we're stressing the importance of scopes of practice and guidelines for referral whereas the midwives don't believe them to be as necessary. But I can't see how you can make a system work without them for the safety of the patients."

Apart from the obvious libel attached to such statements this rationale very clearly identifies the midwife competition to be the issue not patient safety. The chairperson of the NZMA negotiating committee Heather Thompson openly admits "members want to stop this threat from midwives" While the NZMA keep seeing midwives as the threat the RHAs/CHEs and health reforms dismantle women's choices within the maternity service.

CVS RISKS TO BABIES

Fed of Women's Health Councils
Nov/Dec 1993

CVs is used to collect cells from the developing placenta which, when analysed, can reveal whether a fetus carried one of a number of genetic or chromosomal abnormalities. A woman who gave birth to a child with a deformed limb after having a chorionic villus sampling (CVS) was so convinced there was a link that her persistence prompted geneticist Helen Firth to conduct a study that forced the medical profession to think again. In December 1992, a small group of eminent obstetricians, geneticists and epidemiologists met to take stock of research findings since Frith's study. The evidence, they concluded, strongly suggests that CVS carried out in the first nine weeks of pregnancy can cause limb defects. The groups made the following recommendations:

1. CVS should not be carried out before nine and a half weeks' gestation
2. More research is needed into the damage done to the placenta

(From New Scientist, April 1993)

COLLEGE REJECTS CORE COMMITTEE GUIDELINES

- NEW ZEALAND DOCTOR *NEWS* -
09/12/93 -

RHAs should not write Core Services Committee guidelines into GP contracts, according to RNZCGP chairperson Tessa Turnbull. Dr Turnbull said the consensus guidelines have been included in agreements between the Crown and the RHAs and they may feel obliged to pass them on. "This is clearly not appropriate, considering the way they have been developed so far," she said

Dr Turnbull said the consensus guidelines may have had some GP input, but they have largely failed to take the special needs and complexities of general practice into account.

"They have generally gone along the lines of traditional, hospital-specific protocols and don't fit comfortably into general practice," she said.

There is a wealth of evidence to show that savings made by sticking to strict protocols are small and that training, continuing education, peer review and audit are much better ways to change doctors' behaviour.

Dr Turnbull said protocols for use in general practice must be based on general research and not imposed from on-high.

"There needs to be a perceived need, such as a problem like glue ear or asthma, and local input is of absolute importance." Having identified a problem, a general practice team can sit down together and discuss ways to improve care in that area.

"It is best if this is based on some sort of audit. The practice can look for appropriate outcomes such as use of an asthma educator or peak flow use or cutting down hospital admissions."

Dr Turnbull said the direction of the Core Services Committee should be re-examined.

We are only at the beginning of a possible change in management structure for the College and there is much to discuss and think through. The structure is not yet clear and we hope to have something more for you to see after the next meeting. The possibilities are exciting but will require commitment from members. Tell us what you want!

☐ **Changes in bone density with lactation** by M Sowers, G Corton, B Shapiro et al J Am Med Assoc 1993:269-3130-35

Results of research on the relationship between bone loss and lactation have been mixed and confusing. Bone loss during lactation is present in many animal species including dogs, cows, sheep, pigs and rats: thus bone loss may be considered a normal physiological process during this period. Following lactation, however, bone mass density rapidly returns to baseline levels.

The purpose of this prospective study was to test the hypothesis that significant bone loss occurs in lactation of greater than 5 months duration and that bone mass returned to baseline levels when breastfeeding ceased. Participants were 98 healthy women residing in the midwest United States. Bone mineral density (BMD) of the proximal femur was measured at two weeks (baseline), two months, four months, six months and 12 months following parturition. BMD of the lumbar spine was measured at baseline, six months and 12 months after parturition.

Women who breastfed for a month or less following birth lost no BMD at either bone site. Women who lactated six months or longer had mean BMD losses of 5.1 percent and 4.8 percent at the lumbar spine and femoral neck, respectively, compared to baseline values. This bone loss was not explained by differences in age, diet, body size or physical activity. Women who breastfed six months or longer returned to baseline levels of the lumbar spine at 12 months after parturition. Women who continued breastfeeding for more than nine months had increased the BMD from its lowest point during lactation, but had not yet returned to their baseline level at the conclusion of the study. Follow-up ended at 12 months.

The authors conclude that while extended lactation is associated with bone loss, there is evidence that baseline bone mineral level return to normal by 12 months after parturition. Transient bone loss and recovery that occurs with long term lactation offers "little evidence to justify the therapeutic intervention" according to the authors. This study suggests that, in the presence of adequate maternal nutrition, maternal bone mineral loss during lactation appears to be a normal, temporary phenomenon.

- Breastfeeding ABSTRACTS Nov 1993 Vol 13 No 2

(see subscription on page 43)

Informed Consent -
ICEA - Teaching Ideas Sheet #15

Informed consent is the process by which people receiving health care make decisions about their care. To have informed consent you need:

Enough information to be able to make decisions about your care and then the opportunity to make those decisions.

The information should include:

* What the proposed treatment is.
* What the benefits of the treatment are.
* What the risks of the treatment are.
* What the alternatives are to the treatment proposed and their risks and benefits.
* What would happen if you did nothing.

Informed consent is not simply signing a form. Informed consent is knowledge - given in your language, in a way in which you can understand. And informed consent includes your opportunity to decide what care or treatment will be given based on this knowledge. There should be no penalties imposed if you do not agree to the recommended treatment.

Obviously, there may be emergency situations where you will choose not to make decisions or where you are physically unable to make decisions, but in most cases, you should be able to do so. Learn during pregnancy about your alternatives in procedures, treatment or drugs for labour. Then you will have time to decide what's best for you. Don't wait until labour begins.

Obstetrics, like other medical specialists, is not an exact science. Tests, procedures, and medications are sometimes given out of habit and custom, rather than because of scientific proof that they are safe or helpful. You can avoid problems and share in the decision-making about obstetrical practices if you have the information to do so.

Written by Mickey Gilmor, CNM

Many women are eager to try to conceive again right away after being treated for miscarriage. However, some clinical psychologists, concerned with the woman's emotional health, feel it is wise to put off the attempt for a few months. This allows her time to love the next child for itself and not as a "replacement baby". Doctors agree that women should wait until they feel psychologically ready to try again. Once they pass their prior point of miscarriage, they can feel more secure knowing that the treatment worked and the pregnancy will progress.

Mcaedale, L. 1993. Miscarriage:The silent loss. Child 6:85-92.

CAPERS

CHILDBIRTH & PARENTING EDUCATION RESOURCES & SERVICES

CALL FOR ABSTRACTS

Birth Issues
International Conference

Melbourne
25 - 27 November 1994

The focus will be on

* midwifery practice
* research
* birth centres
* consumer advocacy
* childbirth education
* support for childbearing families

International speakers have been invited. Abstracts or an expression of interests in presenting a paper should be sent to:

Jan Cornfoot - CAPERS
P O Box 567 NUNDAH QLD 4012
Fax 07 260 5009 Tel 07 266 9573

cont'd from page 7.....

Judith Richter, author of Vaccination against Pregnancy, *describes the methods as working in a totally new way by tricking the body into attacking a natural part of reproduction in the same way it would attack a germ. This type of reaction would normally be considered an auto-immune disorder. The long term health risks for women, and for children accidentally exposed before birth are unknown.*

The book Vaccination Against Pregnancy: Miracle or Menace? *is available from Health Action International - Europe, Jacob van Lennepkade 334T, 1053 NJ Amsterdam. The Netherlands.*

New Research Into The Causes Of Miscarriage

- IJCE Vol. 8 No. 4

New research into the causes of miscarriage has finally given women answers, hope and a plan of action. In the past, miscarriage was often surrounded by secrecy and passed over by the medical profession and well-meaning family and friends. Until recently, doctors often didn't know what caused miscarriage and so they avoided dealing with and helping women deal with it. The attitude about miscarriage was to minimize the loss, but this makes it harder for the woman to mourn and then move on.

One in four women experience miscarriage. No matter when a miscarriage happens, a woman will want to know why. About 40% of first-time miscarriages that occur in the first trimester are due to chromosomal abnormalities, for which there is no treatment. Ninety percent of the time, the woman will have a successful subsequent pregnancy. When miscarriage happens two or more times in a row, it's time to look beyond chromosomes or lifestyle factors and suspect that a chronic physical problem may be preventing a full-term pregnancy. The doctor will take a medical history and ask relevant questions about the father's medical history too. The doctor may then discuss the various possible causes of the problem and plan a series of tests, usually beginning with the simplest procedures.

A general checkup and pelvic exam is usually the first step. The following conditions are known causes of miscarriage: medical disorders such as endometriosis, lupus and diabetes, hormonal problems such as low levels of progesterone, thyroid gland disorders and high levels of prolactin and anatomical factors such as abnormalities of uterine structure, a weak or "incompetent cervix" or blocked Fallopian tubes. To check for such anatomical abnormalities, the doctor can perform a hysterosalpingogram, in which dye is injected into the uterus and Fallopian tubes and an x-ray is taken or laparoscopy, in which a thin, flexible instrument, inserted near the umbilicus, is used to inspect the uterus and Fallopian tubes visually. A small or irregularly shaped uterus can be corrected through surgery and an incompetent cervix can be corrected with a simple stitch placed on the cervix early in pregnancy. The stitch will then be removed when the woman is close to delivery.

Sexually transmitted diseases, often without symptoms, can cause miscarriage by interfering with either the fertilization or implantation process. Extreme cases of these infections can cause infertility. A course of antibiotics can often alleviate the infection. Other exciting break-throughs involve a new understanding of how problems with the immune system affect the ability to get pregnant. It is now thought that immunological disorders may account for more than half of recurrent miscarriages. In approximately 5% of all recurrent miscarriages, a couple may not be able to create a viable embryo because one or both parents carries chronically defective genetic material. A genetic cause should be suspected if the couple has produced a previous child with a congenital abnormality or if either partner is over age thirty-five. In these cases, both partners will be interviewed by a genetic counsellor. Blood will be drawn for chromosome testing. At the present time, there is no way to alter the body's chromosomal makeup if there is a problem. If pregnancy occurs, amniocentesis or chorionic villus sampling can detect the absence of chromosomal disorders in the fetus.

DEFINING CONSULTATION

Greetings Kia Ora Malo el lelei Talofa Kia orann Ni sa Bula

In a recent High Court case in relation to a Resource Management matter, Mr Justice McGechan used the following definition of consultation:

"Consulting involves the statement of a proposal not yet finally decided upon, listening to what others have to say, considering their responses and then deciding what will be done."

Mr Justice McGechan noted that consultation should be a reality, not a charade. Although there were no universal legal requirements as to form, he found that essential elements of genuine consultation should include:

- sufficient information provided to the consulted party, so that they can make intelligent and informed decisions;
- sufficient time for both the participation of the consulted party and the consideration of the advice given;
- genuine consideration of that advice, including an open mind and a willingness to change.

The Ministry for the Environment in their September 1991 document - Consultations with Tangata Whenua - described the following as the essential ingredients of good consultation:-

- honesty
- clarity of information
- and provision of resources
- certainty of purpose
- statement of what is required

Consultation does not just encompass the gathering of information. One must also consider why the information is being gathered, how the information will be used and the status that information will have in the decision making process.

Community Services Councils should consider making use of these legal definitions of consultations when proposals to/from Local or District Councils, RHAs/CHEs, CFA and NZ Income Support Service, and any other SOE or quasi-government body, are being considered and actioned.

Obituary

In Memory

AGNES MASOE

RN, RM, BAppSc, MEds

A wonderful young woman and midwife I had the privileged to meet and know died suddenly on September 20th, 1993.

Agnes was an international person whose beliefs in the healing capacity of love arose from her strong Samoan heritage, her New Zealand education and midwifery experiences in Australia and Fiji. She had a deep commitment to improving the life and birthing situations for indigenous women. She had a special commitment to Aboriginal and Fijian women and her ability to "open doors" will be sorely missed.

Our deepest sympathy is extended to her family in New Zealand and to her many friends and colleagues around the world.

Agnes' family have established a memorial fund for research studies in Fiji. If you wish to contribute, donations may be sent to:

Agnes Masoe Memorial Fund
c/- Mary O'Kello
Tropical Health Program
University of Queensland Medical School
Herston
Queensland 4006
Australia

Valley Diagnostics pathologist John McCafferty said the service at a charge of $260 was started as a result of public demand.

He said Valley Diagnostics takes the sample and sends it to a US laboratory which sends back an assessment of risk level.

"I simply offer an established test by a US laboratory which meets the requirement of the American College and that is the extent of my involvement.

"I always personally point out to every woman this is a screening test which suggests a probability of Downs syndrome and we are certainly not touting it as a diagnostic test."

Dr McCafferty said he would also like to see a national screening programme but believes the chances of getting one up and running are slight.

"Our health system is in such a mess we have destroyed any chance of that happening."

Dr McCafferty said patients are paying the full cost of the test and if women want the test, it should be available.

Wellington Hospital obstetrician Peter Stone said, "At best the test picks up 60 per cent of Downs syndrome babies which means you can more or less flip a coin to decide on its accuracy."

He also points out women who get a false positive and go on to have amniocentesis run a risk of miscarriage.

New test could halve Down's syndrome births

A working party of the Royal College of Obstetricians and Gynaecologists - UK, have concluded that serum biochemical screening identifies a group of women with a sufficiently high risk of having a Down's syndrome affected child to justify the offer of a diagnostic amniocentesis and if this proves positive the opportunity to terminate the pregnancy. The advantages of biochemical screening are that overall it will allow the detection of twice as many pregnancies with Down's syndrome and under most circumstances it is a financially more cost effective policy than screening by amniocentesis based on maternal age. The biochemical testing method depends on the ratios of various markers such as serum alpha-feto protein; human chronionic gonadotrophic; unconjugated oestriol and free sub-unit of human chronionic gonadotrophic.

Press release, July 1993
Royal College of Obstetricians and Gynaecologists, London

suffered stress in the process. It is probably this latter factor which has contributed to the obstetricians' decision to withdraw their back-up services from independent practising midwives.

Judith L M Mair LLB RN CM DNE (NSW Coll Nurs) is currently Pro-Dean of the Faculty of Health Sciences, University of Sydney. Judith is an author and regular conference speaker on issues related to pregnancy, childbirth and the law.

ACKNOWLEDGEMENT
Reprinted "Birth Issues" Vol 2 No 4/5 Sept-Dec 1993 published by CAPERS P O Box 567, Mundah, Qld 4012 Australia

TRIPLE TESTING NEEDS NATIONAL APPROACH

- NEW ZEALAND DOCTOR *NEWS - 20 January 1994*

Wellington Hospital specialists are refusing to interpret results for obstetricians using the new antenatal triple test and are calling for a national screening programme.

At present only one private laboratory near Wellington and another in Auckland are carrying out the screening test which assesses the risk of a woman having a Downs syndrome baby.

National Women's Hospital is also planning to offer the test but Wellington Women's considers it "inappropriate" to offer it at this stage.

Medical geneticist Joanne Dixon, who is the only geneticist currently working in New Zealand, has been asked by obstetricians for interpretation of results since Valley Diagnostics started doing the test.

However, she is refusing to do so, saying the results cannot be interpreted because the analysis is done using US data which bears no relation to the New Zealand population.

"The laboratory only provides a number representing a risk and the GP or obstetrician is expected to interpret the results. The reality is they don't know how to interpret these results and invariably we end up picking up the pieces with these women."

However, she said many women still want the test because there is nothing else available. She is calling for a Ministry of Health funded national screening programme to be introduced.

Such a programme would mean designated laboratories all use the same methods and provide nationally coordinated computer analysis.

"You've got to do thousands of tests to get the normal range needed for this sort of testing. In a small country like ours that can only mean a national programme and a central place where the calculations are done."

CAMPAIGN FOR PARENTAL LEAVE DURING THE UNITED NATIONS INTERNATIONAL YEAR OF THE FAMILY

- Fed of Women's Health Councils (Nov/Dec 1993 Issue p4)

The Wellington Working Women's Resource Centre is organising collective action on parental leave to coincide with the 1994 International Year of the Family. There is no statutory entitlement in New Zealand to paid parental leave. In this regard New Zealand lags behind most of the world where some form of paid leave is now taken for granted.

The Centre also identifies another good reason for launching a campaign for parental leave. The Department of Labour is about to embark on a review of the Parental Leave and Employment Protection Act. The report is due out in the middle of the year so there is a need to highlight the importance of this issue as soon as possible.

There is a need for groups to provide what financial assistance they can for the campaign.

For further information contact : Marian Wood Ph (04) 384-8117 or Martin Coleman Ph (04) 385-8596

BRITAIN'S HEALTH CHANGES DISASTER

- Fed of Women's Health Councils (Nov/Dec 1993 issue p14)

UK Doctors are claiming that changes to the British health system are not working and are harming patients. Reports from Britain (which sound rather familiar!) show that:

1. the cost of restructuring there is currently running at 800 million pounds (about NZ$2.3 billion)
2. the British people believe money could have been better spent on health services
3. people are worried that trust hospitals will fragment the national health system by concentrating on a limited range of 'profitable' services, while being reluctant to accept contracts for 'uneconomic' services.
4. people fear that patients can no longer be certain that clinical decisions will be based on clinical, and not budgetary, considerations.
5. There is deep disillusionment among medical professionals. A survey in an issue of Doctor magazine showed that more than two-thirds (65%) of the 3500 GPs who responded would get out of medicine if they could, because of the pressure created by the changes. 3% said the stress of being a doctor now was so great they had contemplated suicide.

EDITOR'S NOTE :

NZ's changes are more extensive than those in the UK and have been implemented far more quickly. Concern is mounting about the viability of our health system. The Maternity Services are really struggling with the competition concept and the RHAs would appear to be abdicating responsibility for service and quality to CHEs and individual providers under the guise of "budget holding". The Coalition of Public Health is holding a public forum in Wellington to debate these concerns. Midwives will need to keep informed and understand the principles behind the changes initiated within their own areas and also at a National level if we are not to lose the impetus gained by the Nurses Amendment Act to enhance Maternity Services.

compensation will be payable. Costs will usually be awarded against the plaintiff.

(ii) Should the court find that the obstetrician's care was negligent, then the obstetrician will be liable to pay full compensation to the plaintiff. If the obstetrician believes s/he was not entirely responsible for the harm that was caused, s/he may seek to have the midwife joined as co-defendant. This latter process may lead to difficult outcomes:

(a) The court finds that neither were negligent in which case the action will fail.

(b) The court finds both were negligent and apportions liability according to the extent to which each was considered responsible for the harm.

(c) The court finds that there was no evidence of negligence on the part of the midwife but the obstetrician was negligent leaving the obstetrician fully liable to compensate the plaintiff.

(d) The court finds there was no evidence of negligence on the part of the obstetrician but that the midwife was negligent in which case the midwife will be held liable to compensate the plaintiff fully.

An alternative would be for an obstetrician, who is found negligent and required to compensate the plaintiff in fully, to seek to be indemnified by the midwife in a separate action to the extent that s/he believes the midwife to be responsible for the event. However, the obstetrician would only be successful in such an action by proving that the midwife was negligent and partly responsible for the plaintiff's harm.

Vice versa, a midwife who is found liable to compensate a plaintiff for negligent harm could seek to be indemnified by an obstetrician whom the midwife believes was partly responsible for what happened. Again, this action would only succeed if the midwife could prove that the obstetrician was negligent.

When a plaintiff sues both doctor and midwife jointly, the same principles apply as when the midwife has been joined in the action by the obstetrician. What is clear is that neither will be required to compensate a plaintiff where the facts either do not disclose a cause of action or do not prove negligence on behalf of either.

The fact that an obstetrician may be joined as a defendant in an action against a midwife does not mean that the obstetrician will have to compensate an injured plaintiff. If there is no evidence of negligence on the part of the obstetrician, s/he will not be required to pay any compensation to the plaintiff. Likewise, it would only be on proof of negligence by a midwife that the midwife would be liable to pay compensation to an injured plaintiff. The onus is on the plaintiff to prove that negligence caused the injuries complained of..

However, an obstetrician who is innocent of wrongdoing could be held liable for the negligent act or omissions of a midwife where s/he employs that midwife in an employer/employee relationship.

One problem which arises in negligence cases where several persons have been involved in the care of a patient is that the plaintiff may be inclined to join all parties as defendants in the action in the hope of finding at least one who can be proven to have been negligent. A defendant who is exonerated from liability has nevertheless incurred financial costs with respect to his/her defence, spent time in working with defence lawyers and has most likely

ARTICLES OF INTEREST

SHARED CARE
Shared Legal Liability?

Judith Mair

The recent withdrawal of medical services by three obstetricians providing obstetric back-up for an independent midwifery practice in Queensland has raised the question as to who is liable for injuries suffered by a mother and/or child, either prenatally or during the birth, when both an obstetrician and a midwife were involved in caring for the mother in pregnancy and labour.

To answer this question it is necessary to identify the ways in which the law accords liability to compensate a plaintiff for harm caused by a negligent act. Personal liability is the liability each person has to compensate other for tortiously inflicted harm. Vicarious liability is the responsibility a person or institution has for the negligent acts or omissions of others. This latter liability is found, inter alia, in employment relationships. An employer will be held liable for the negligent acts or omissions of employees which occur during the course of employment.

The question of liability in conjoint care arrangement in child care has not been a major issue in the past and only arises now because of the development of independent midwifery practice and the alleged increase in obstetric litigation. When obstetricians work with midwives in a hospital-based setting, they have little need for concern regarding the possibility that they will be sued because of a midwife's negligence causing harm to a mother and/or newborn. When the midwife is employed by the hospital, the hospital is vicariously liable for the midwife's's acts or omissions whilst the midwife is operating in the course of employment. However, a private obstetrician has always been, and still is, vicariously liable for the acts or omissions of any midwife, or any person (including receptionists), who is directly employed by him/her in the course of his/her practice. This is not new.

For the purposes of this particular discussion, I will consider the different ways in which joint care of a pregnant woman can operate:

A. The pregnant woman contracts with the midwife solely. Should the midwife detect a complication, the client is referred to a specialist obstetrician for a consultation. In addition, arrangement may be made with an obstetrician for the midwife's client to be seen at particular times during the pregnancy. The specialist may continue to manage a complication, eg diabetes, leaving the routine care of the woman to the midwife. A complicated delivery would be carried out by the obstetrician.

B. The pregnant woman contracts with both an obstetrician and midwife to provide conjoint care. The midwife and the obstetrician both see the client on a regular basis.

Where a woman or her child allege that negligence caused harm to either, there are several possible outcomes:

(i) The obstetrician is sued solely. If the court finds no negligence on the part of the obstetrician, the case will fail and no

UPCOMING EVENTS

NZCOMI CONFERENCE 1994

"The Culture of Midwifery : Celebrating Women & Family"
13, 14 and 15 August 1994
Te Papaiouru, Ohinemutu, Rotorua

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

MURRAY ENKIN TOUR

Professor Murray Enkin - Obstetrician, Epidemiologist, Researcher and Director of the Cochrane Centre (Pregnancy & Childbirth Database) will be visiting on the following dates.

May 18 1994	Auckland	May 21 1994	Palmerston North
May 24 1994	Wellington	May 26 1994	Christchurch
May 28 1994	Dunedin		

Venues still to be arranged. Please contact your local chairperson for details.

(d) **Conflict of Interest**

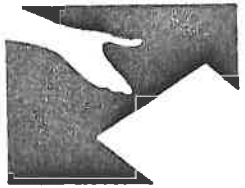
- Conflict of interest only exists if there is competition for the same funds.
- Those involved need to define/explore if any conflict of interest actually exists.
- NZNO/COM position is that a conflict of interest exists where public employment is undermined in favour of self employed practice. Since doctors/obstetricians are the main gatekeepers to maternity services it is unacceptable to view midwives as having conflicting interests without also applying that to doctors.

(e) **Guidelines and Protocols**

NZNO and COM do not support protocols which deny clinical judgement and/or women's choice. Professional judgement and informed choice and consent for women is fundamental to midwifery practice.

Protocols can deny women's individual needs and undermine midwifery education, registration and therefore practice.

However guidelines which facilitate professional judgement are supported. These guidelines should be written by the profession, ie NZNO and COM, with consumer input to ensure practice reflects needs of women. It is not the role of the founder or other disciplines to write midwifery's guidelines for practice. The funders role is to identify the outcomes required from the contracted service.



Comments to

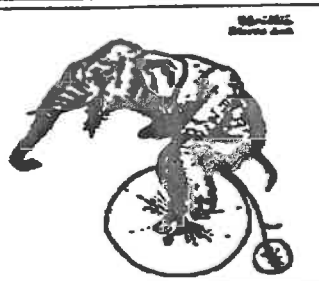
Karen Guilliland
PO Box 21106
Christchurch

or

Steph Breen
NZ Nurses Organisation
PO Box 2128
Wellington

No matter how much I exercise my body,

It refuses to go away and leave me alone.



- Midwifery education in NZ is now providing greater number of midwives who actively practice midwifery under the WHO definition and legislation.

- Maternity Managers in CHEs should make it more attractive when recruiting midwife employees eg
  - enable flexibility in work practice
  - encourage independent practice
  - provide fair remuneration and working conditions which reflect increased responsibility

  Women want continuity of midwifery care and New Zealand needs its midwives able to meet this need.

(b) **Retention of Midwives**

- To retain midwives we need to provide orientation back to the profession in polytechnics as approved by NZNO and COM.

- Fair remuneration and working conditions which reflect increased responsibility

- Effective communication between hospital and community midwives that is open, co-operative and receptive.

(c) **Funding of Midwifery Care**

Both NZNO and COM have policy positions supporting the integration of primary and secondary care services.

For 75-85% of women the maternity service is a primary health service as birth is a normal life process and the women are well irrespective of the place of birth and how the midwife was paid for the service.

The remaining 15-25% of women may require the services of the secondary care system. It is vital that these two services are integrated and work in co-operation with each other.

BOTH ARE FULLY PUBLICLY FUNDED SERVICES AND AN INTRINSIC PART OF THE PUBLIC HEALTH SYSTEM, IE IT IS NOT PRIVATE ENTERPRISE, WOMEN DO NOT PAY FOR MIDWIFERY CARE. SIMILARLY TO PLUNKET, IT IS FREE OF CHARGE TO WOMEN.

Midwifery care (especially when autonomous) is cost effective both for women and babies short term and long term wellbeing. The midwife is the primary practitioner in maternity care as she provides the majority of care, eg, all labour and postnatal care. GP Services often duplicate the midwife service.

continued

NZ College of Midwives and NZ Nurses Organisation
DRAFT Position Statements

CONTINUITY OF CARE

"Pregnancy is a long and very special journey for a woman. It is a journey of dramatic physical, psychological and social change; of becoming a mother, of redefining family relationships and taking on the long-term responsibility for caring and cherishing a new born child. Generations of women have travelled the same route, but each journey is unique."

Maternity services should support the mother, her baby and her family during this journey with a view to their short-term safety but also their long-term wellbeing."

UK NHS "Changing Childbirth"

NZCOM and NZNO see the midwife as having a special and specific role in the maternity services. Continuity of care is the cornerstone of midwifery practice and means that midwifery care is provided in a continuous manner. It is primarily community based. The woman needs to have the opportunity to meet and develop a relationship with the midwife who will care for her throughout her pregnancy labour birth and post natal period.

Ideally this would be the same midwife.

NZNO and NZCOM recognise that the majority of CHEs are not presently structured in a way which facilitates continuity. It is also recognised that some self-employed midwives do not provide continuity of care.

NZCOM and NZNO are working towards strategies which develop a supportive environment for midwives to provide continuity of midwifery care.

Surveys of women who have experienced the maternity services have consistently identified continuity of care as their top priority.

As the health reforms progress midwives need to be given the opportunity to update their skills and knowledge base to meet the challenge of providing total care.

Studies have shown that continuity of midwifery care results in :-

- increased satisfaction
- increased breastfeeding rates
- less low birth weight babies
- fewer premature babies
- less unnecessary intervention
- less analgesic usage during labour
- shorter length of stay in hospital

continued

Continuity of midwifery care also improves the outcome for

* teenage mothers
* lower socio economic groups
* ethnic minority groups
* women classified as "high risk"

Continuity of care also improves the job satisfaction levels of the midwife providing the care.

Teams of midwives provide a modified form of midwifery continuity. NZCOM and NZNO recommend the following when considering team midwifery.

* The team should be a partnership between two midwives with a backup of another one or at the most two teams for annual leave or sickness.
* A caseload for a team of two midwives should not exceed 40 women each per annum when providing total care and enabling leave requirements.

MIDWIFERY PRACTICE

The NZNO and NZCOM support and promote the World Health Organisation definition of the Midwife and her scope of practice.

> *The Midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant.*
>
> *This care includes preventative measures, detecting complications in mother and child, accessing medical assistance when necessary and carrying out emergency measures. She has an important task in health counselling and education, not only for women, but also within the family and the community. The work should involve preconceptual and antenatal education and preparation for parenthood, and extends to certain areas of women's health, family planning and child care. She may practice in any setting, including the home, hospital and community.*
>
> Based on World Health Organisation Definition

There are four levels of midwifery involvement. THESE LEVELS ARE EQUALLY APPLICABLE TO EMPLOYED AND SELF EMPLOYED MIDWIVES

(1) Midwives as primary care givers for normal births

(2) Midwives consult with an obstetrician/physician and remain as primary care givers when appropriate

(3) Midwives refer clients with high risk pregnancies to obstetricians and continue to provide supportive care.

continued

(4) Shared care with GP and shared responsibility.

INDEPENDENT MIDWIFERY IS ABOUT HOW A MIDWIFE PRACTICES, NOT WHERE A MIDWIFE PRACTICES.

Those midwives who choose to provide some components of a women's care, eg post-natal care only, labour care only, have different responsibilities to the midwife who assumes responsibility for total care.

The midwife who provides only a component of care is not the lead professional and responsibility is shared.

A lead professional is

"The professional who will give the substantial part of the care personally and who is responsible for ensuring that the woman has access to care from other professionals as appropriate."

The difference in responsibility is generally reflected in the remuneration provisions. Both organisations are working towards equalising remuneration for the level of responsibility taken.

The NZCOM and NZNO acknowledge that midwives may choose either form of practice while the maternity services evolve to incorporate the midwifery model of care.

MISCELLANEOUS POSITIONS

(a) **Overseas Recruitment**

- Active recruitment is not supported as it is not necessary. We acknowledge however that New Zealand can benefit from the input of other cultures.
- There are enough midwives in New Zealand. The focus should be assistance with orientation back to the profession. Orientation programmes should be approved by NZNO and COM through Polytechnics.
- It is important to encourage a New Zealand midwifery model rather than reinforce the medical model of maternity services provision as is the predominant western world model. Overseas midwives may be "culturally" inappropriate as NZ midwifery is a world leader in developing the midwifery/women partnership model in a bicultural country. This model is women centred with the emphasis on women's choice, continuity of care, and midwives practising in all settings, ie home/hospital/birthing unit. It also affirms New Zealand's responsibilities under the Treaty of Waitangi.

continued