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



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NEW ZEALAND COLLEGE OF MIDWIVES (INC)


# NATIONAL NEWSLETTER


November/December 1994


*The Six Week Check*

*Polycose Screening Update*

*Independent Practice Organisation*

## NEW ZEALAND COLLEGE OF MIDWIVES (INC)

906-908 Colombo Street P O Box 21-106 Christchurch Tel/Fax 03-377-2732

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|---|---|---|
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## NEW ZEALAND COLLEGE OF MIDWIVES (INC)
MEMBERSHIP APPLICATION FORM

**NATIONAL INFORMATION** 01 May 1994 - 30 April 1995 **REGION** ____________

Name ____________________________

Address ____________________ Area Code __________

Phone __________ Home __________ Work __________ Extn

Workplace ____________________________

Date of Birth ______________ ARE YOU A MEMBER OF NZNO? YES/NO

**TYPE OF MEMBERSHIP**

- ☐ Self Employed $225.00 } Includes
- ☐ Waged $155.00 } Indemnity
- ☐ Unwaged/Students $ 50.00 } Insurance
- ☐ Associate with Indemnity $155.00 } Cover
- ☐ Associate / Affiliate $ 30.00

**FOR NATIONAL USE ONLY**
Date of Joining __________
Membership Number Allocated
__________

**METHOD OF PAYMENT**

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

| NEW | |
|---|---|
| RENEWAL | |
| CHANGE | |

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| NEW | |
|---|---|
| RENEWAL | |
| CHANGE | |

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

## NATIONAL TREASURERS / MEMBERSHIP PERSONS

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56 Glenalmond Crescent
Invercargill

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Hamilton

**OTAGO**
Catherine Lynch
7 Morton Street
NEV Dunedin

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Island Bay

**NELSON**
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P O Box 672
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P O Box 24-403
Royal Oak Auckland

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Flat 1 Hawera Hospital
Hawera

**NORTHLAND**
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c/- Antenatal Clinic
Whangarei Hospital
Whangarei

**CANTERBURY / WC**
Caroline Nye
P O Box 21-106
Christchurch

**EASTERN / CENTRAL**
Mary Mather
27 Shamrock Street
Palmerston North

## SITUATIONS VACANT

### WHANGAREI

The Whangarei area needs more Independent Midwives.

- Plentiful case load
- Home births
- Hospital births

Supportive functioning group of established Midwives.

Locum or permanent basis.

Phone : *Alison Carlin* (09) 436-2519
*Feliz Dean* (09) 438-4793
*Lynley McFarland* (09) 437-6046

### MIDWIFE
**BURWOOD BIRTHING SERVICES**
**BURWOOD HOSPITAL**

We are offering a temporary full time position for 6 months from Jan-Jul 1995. This position would ideally suit a new graduate. A full orientation programme will be provided.

Applications are invited from Registered Midwives who are members of the NZ College of Midwives. Written application to:

*Chris Hendry*
*Practice Manager*
*Burwood Birthing Services*
*Burwood Hospital*
*Private Bag 4708 Christchurch*

Applications close Friday 30 December



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## NATIONAL COMMITTEE MEETING CALENDAR 1995

3rd, 4th, 5th March 1995
19th and 20th May
25th and 26th August (and AGM)
17th and 18th November

## NEXT NATIONAL COMMITTEE MEETING

***Friday 03 March 1995***
***6.00pm***

***Saturday 04 March 1995***
***9.00am - 6.00pm***

**Midwifery Resource Centre Christchurch**

**OBSERVERS WELCOME**

## DEADLINE

for the next Newsletter is
1st February 1995
Posted
20th February 1995

Any contributions to the National Newsletter should be addressed to
Julie Richards
P O Box 21-106
Christchurch


**PUBLISHING DETAILS**

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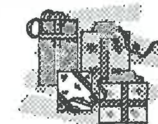
Wishing you all a very Merry Christmas and a Happy and Safe Holiday Season




**DISCLAIMER**

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

# Editorial

*Hello once again and welcome to the last newsletter of 1994. How did it become December so quickly and how do people ever find the time to send Christmas cards?*

*When I reflect on what has happened in Midwifery and the College over 1994, I recall that our professional life is never static and sometimes we forget how much energy this exciting but changing time takes.*

*Enjoy the summer and take some time out to recharge because no doubt there will be plenty more excitement next year!*

*Have a wonderful festive season.*

*Julie Richards*

THE MIDWIFERY RESOURCE CENTRE, CHRISTCHURCH

Every now and then go away
have a little relaxation
for when you come back
to your work
your judgement will be surer;
since to remain constantly at work
will cause you to lose power
of judgement . . .

Go some distance away
because the work appears smaller
and more of it
can be taken in at a glance,
and a lack of harmony
or proportion
is more readily seen.

LEONARDO DA VINCI

# USEFUL REFERENCES

### *ULTRASOUND SCANNING*

These references are for the papers referred to in the WHO Statement "Routine Ultrasound Scanning During Pregnancy" printed in the NZCOMI September/October 1994 newsletter.


"Effect on Prenatal Ultrasound Screening on Perinatal Outcome", Ewigman, B et al. The New England Journal of Medicine, Volume 329, No. 12, September 16 1993 pp 821-827

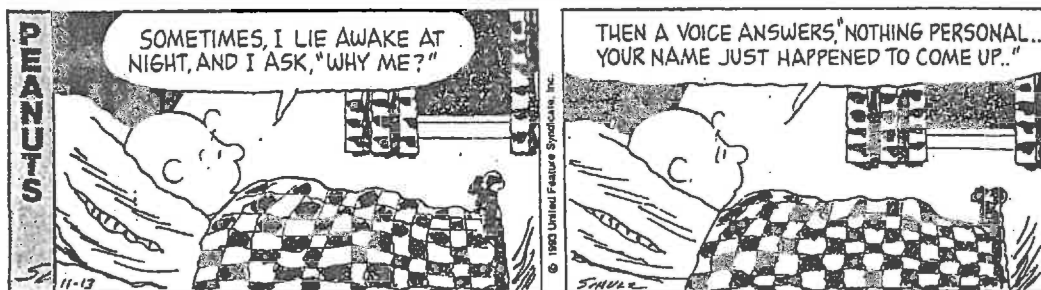
"Effects of Frequent Ultrasound During Pregnancy : A Randomised Controlled Trial"
Newnham, J P et al. The Lancet, Vol 342, October 9, 1993, pp 887-891


### *WATER BIRTHS*


"Is Water Birth Safe? The Facts Behind the Controversy"
Roser, J. MIDIRS Midwifery Digest, March 1994 4:1, pp 4-6

"Water Work" Reid, T. Nursing Times, March 16, Vol 90 No. 11, 1994

"Safety First". Harmsworth, G. Nursing Times, March 16, Vol 90 No. 11, 1994




# *National Co-ordinator's Forum*

Another busy year comes to a close and midwifery continues to grow and flourish. Increasingly employed midwives are taking up the challenge of independent practice and setting up continuity of care schemes. Caseload management rather than team midwifery is gaining support as a more manageable option with higher midwife and women satisfaction. Hospital midwives are working hard at ironing out the inevitable gliches that a new way of working brings and we look forward to the year 2000 where every women birthing in New Zealand will know the midwife who attends her.

Self employed midwifery also continues to increase with approximately 800 (HBL 1994) midwives out of New Zealand's 1707 (MOH 1993) practising midwives now identifying as independent practitioners. Such a remarkable growth in independent practice has of course carried a price for those enduring to provide a midwifery model of care. Individual midwives in self employment and particularly if they provide mainly midwife only care, continue to face hostility and resistance from both medical, midwife and manager colleagues who struggle to accept midwifery autonomy. The health "reform" which requires a competitive model has further inflamed midwives working environments. Too often it is still the organisations needs which are paramount rather than the development of a women centred accessible public health maternity service. We must believe however that this environment is transitory and we must work to make that so. Otherwise midwives (like GP's of years ago) will burn out in their effort to provide continuity of care in a partnership model. For many midwives, this way of working has produced changes within their environment. They provide a role model of what is possible when working in partnership with women and have earned the respect of their colleagues and the women they provide the service for.

The relationship between midwives and general practitioners has also started to settle with some effective working arrangements established between both disciplines as each acknowledges the other respective roles. Many midwives are gaining the confidence to work **with** doctors rather than **for** doctors as they come to understand the power and satisfaction independent practice brings.

The student midwives have also added to the maternity systems understanding of the midwifery model and our future is bright, as these students gain registration. The first class of direct entry students have now graduated from Otago and Auckland Polytechnics and their commitment and unbridled enthusiasm for the partnership model will change our world. Midwifery's congratulations and warm wishes go with them as they start practising. The support of the profession for new practitioners is vital and we look forward to sharing experiences.

Paramount to good practice is the ability to reflect and learn from experiences. The Midwifery Standards Review process is designed to enable midwives to do just that. The College recently had a workshop for the co-ordinators of the ten (and their sub-branches) committees to confirm their direction and compare experiences. It was a fascinating day and the unanimous opinion was that the process is effective and positive for both the midwives and the women they attend.

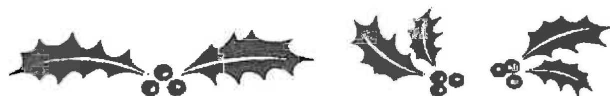
A summary of the day included recognition and affirmation of the following:-

1. The Reviews philosophy is accountability and partnership between women and midwives.
2. The actual process is primarily for the education and support of the individual midwife and her practice. The indirect goal is to improve maternity-midwifery services and empower women.
3. The committee has no power to discipline. This lack of authority is viewed as necessary if the process is to remain user friendly and educative. The MSRC will **not** initiate complaints to the Nursing Council of NZ.
4. The midwife's practice is examined against the NZCOM Standards and Code of Ethics. These standards are to be broken down into principle statements which make the process more explicit to the midwife. There is to be an appeal/second opinion process available to the midwife if she disagrees with the Committee's viewpoint.
5. The committees need ongoing training and support. A manual for committee members will be produced - its framework will include:-
   - Mentoring
   - Communication skills
   - Group work
   - Conflict resolution
6. Consumer input needs to be encouraged. More publicity and explanations about the MSRC to be initiated.
7. Client evaluation forms are shared with the midwife when the client has indicated permission. Consumer members collate client responses.
8. Complaints committee is separate from the review process and ideally has different members. Each committee consists of two members preferably one midwife and one consumer. The committee's primary function is to provide a forum for the discussion of concerns and facilitate resolution. Failing resolution the complainant must be given all the options available which would allow them to progress the complaint further.
9. Committee members and midwives being reviewed must be members of the NZCOMI.

Another major decision by the College this year was to go ahead and set up Independent Practice Organisations (IPOs) to contract for midwifery services. We have applied for funding to help establish the structures as without financial assistance we remain disadvantaged in the competitive world where other maternity providers have enjoyed subsidies for a number of decades.

The College will employ a consultant to help with the contractual/business side of IPOs and a study day on December 15th for a small contracts team will plan the process and the timeframe. We are confident and excited that we will enter the competitive market on an equal footing. Your local chairpersons will keep you in touch with progress.

A very warm and peaceful Xmas to you all and I look forward to a wonderful new year.





# Uncertainty lingers about vitamin K use

NZ Doctor '94

BY CHARLES ESSEX

Two years after a major change in the neonatal vitamin K protocol, New Zealand neonatal units are still unsure what is safe.

A questionable study published in 1992 by the *British Medical Journal*, which linked Vitamin K injections to childhood cancer, prompted many countries to change their administration regimes.

Last year the Plunket Society found that vitamin K regimes varied widely.

To eliminate the confusion, the government may have to rewrite the neonatal vitamin K protocol it changed just two years ago.

According to a new study reported this year in the *BMJ*, the vitamin K preparation currently used for intra muscular injection, Konakion, is not licensed for oral use.

Many mothers in the UK study (which showed that less than 40 per cent received the third oral dose) reported that the GP or community midwife was reluctant to prescribe and give Konakion orally because of the lack of manufacturer backing for its use in this way.

Auckland Medical School biostatistician John Thompson believes "the whole vitamin K saga highlights the danger of changing policies and protocols on the results of a single study".

Mr Thompson told paediatricians at the Starship Children's Hospital in Auckland that subsequent papers from the US and Sweden (the latter containing data on virtually all Swedish children born over a 16 year period) do not support an increase in childhood cancer following neonatal IM vitamin K.

"Following the original paper, different countries adopted different neonatal vitamin K policies," he said.

- Sweden and the US continued to recommend a single dose of IM vitamin K.
- Holland recommended daily oral vitamin K for breastfed babies.
- New Zealand, postnatal units were shown last year to be at odds with each other. A Plunket Society survey found some units give 3 doses of oral vitamin K ranging from 0.5mg to 2mg per dose at birth, five days and six weeks of age. It is uncertain how many infants actually received the third oral dose.

Mr Thompson said while this three dose regimen seems to prevent classic haemorrhagic disease of the newborn (HDN), there are concerns about its effectiveness in preventing late HDN.

That the original study has significant amounts of missing data, particularly on children who developed cancer, is cause for concern.

Dr Ralph Pinnock, clinical director of acute paediatrics at the Starship, said that the Paediatric Society should have taken a more proactive role and given more guidance to both the profession and the public over the neonatal vitamin K controversy.

While the manufacturer is close to licensing a mixed micelle oral vitamin K preparation, this may not end the problems.

# Family planning holds key to women's status

- NZ Doctor '94

Health and family planning are key determinants in the improvement of the status of women around the world, according to United Nations Population Fund spokesperson Charlotte Gardiner.

Dr Gardiner, speaking at the conference of the International Federation of Gynaecology and Obstetrics (FIGO) in Montreal recently, said it is a fundamental right of women to be freely able to decide on the number and spacing of children that they have.

Within the past 20 years, she said, the increased uptake of family planning has resulted in a fall in fertility rates in developing countries from 5.7 to 3.6 children.

Dr Gardiner said to maintain this trend planners must ensure that adequate resources are allocated to the provision of freely available contraception.

# Extra water caused seizures

nz Doctor 13/10/94

Parents who feed their infants water to supplement formula may be putting their babies' health at risk, according to a report from Wisconsin doctors.

Two babies who had been given bottled water along with formula were hospitalised for seizures, the doctors reported in the Centers for Disease Control and Prevention's weekly health report.

Too much water in a baby's diet can cause water intoxication and hyponatremia which leads to seizures, according to the report.

Human milk and formula provide infants with sufficient water for growth, and to replace normal bodily losses. Parents do not need to give their infants extra water before the babies start to eat solid foods, although formula-fed infants may need some water if the weather is exceptionally hot, they added.

The risk of water-related seizures may be highest in infants from poor families, because the parents may be tempted to supplement a more expensive formula with what they believe to be harmless water, according to the researchers from the Medical College of Wisconsin.

# Pregnant pause is healthy

nz Doctor '94

Women who wait at least a year after beginning sexual relations with a partner before they become pregnant, and who stick with the same man to father all their babies, are less likely to develop pre-eclampsia, according to a study reported in the *Lancet*.

The complication affects about one in 10 pregnant women on average but is relatively rare among women having their second or third baby by the same man - only about 5 per cent of such women develop it. But nearly 25 per cent of women having a second baby with another man develop pre-eclampsia.

While women who have sex with the same man for at least one year before getting pregnant have only a 3 per cent risk of the complication, those who get pregnant after less than four months have a 32 per cent risk.

The study did not rule out psychological or social causes for the differences, although it was controlled for the effects of age, race, marital status and education level.

Instead, the researchers focused on the theory that semen works on a woman's immune system like a vaccine against the man's genes. Given in doses for a long enough period of time, the woman builds up tolerance so that when she conceives a fetus, her body does not try to reject it as foreign tissue.

# Buds are battering rams

nz Doctor 13/10/94

Parents should not use cotton tipped swabs to clean their children's ears, according to a recent study.

Rather than cleaning the ears, the swabs are more likely to push the wax deeper into the ear, causing it to accumulate, said lead researcher Dr Michael Macknin, an associate professor of paediatrics at Ohio State University.

"The cotton-tipped swab most likely acts like a battering ram, jamming the wax in further," said Dr Macknin.

Over 650 young people aged two weeks to 20 years were studied. Of those, 62 per cent had used cotton-tipped swabs during the two months before the study. Those who had used cotton swabs were significantly more likely to have ears that were mostly or completely blocked.



# Upcoming Events

**HEART POLITICS GATHERING**
10th - 14th January 1995 Tauhara Centre, Taupo

Heart Politics Gatherings explore the ways that many people are slowly changing the world with political, social and economic action. The gatherings focus on potential for personal action within the major issues confronting our society today.

Keynote Speakers : Philida Bunkle, Tony Simpson, Katrina Shields

Cost : $275.00 - $315.00

Contact : Lynn 09-815-3622
Rex 09-817-9067

**Midwifery Today Pacific Rim International Conference**
2nd - 5th February 1995
Pacific Beach Hotel
Waikiki
Honolulu, Hawaii

Theme: *Weaving a Global Future*

Includes:

- Traditional Midwifery
- Cultural approaches to breastfeeding
- Natural remedies from around the world
- Lessons to be learned from the developing world
- Midwifery education for a global future

Speakers Include:
Suzanne Arms, Elizabeth Davis, Nicky Leap, Marsden Wagner, Michel Odent, Maggie Lecky-Thompson, Joan Donley

For Enquiries and Registration details, contact:
Midwifery Resource Centre
P O Box 21-106
Christchurch

## Supporting Breastfeeding by Excellence in Practice

17th - 19th March 1995
Waipuna Lodge
Auckland

Key note speaker: Chloe Fisher [Midwife and Lactation clinical specialist]

## Infant Massage Instructor Certification Training

| | |
|---|---|
| 18th - 21st February 1995 | Christchurch |
| 03rd - 06th March 1995 | Auckland |
| 23rd - 26th March 1995 | Wellington |

Training will include videos, overheads and hands-on training, and effective methods of working with :

- Well Babies - Pre-term Babies - Teen Parents - Drug-exposed Babies - - Special Need Babies -

Cost : $550.00

Contact : Peggy Dawson Phone 09-489-8796
P O Box 33-997
Takapuna

## International Conference on Water Births

1st and 2nd April, 1995
Wembley Conference Centre
London, England

Aim of the conference is to increase knowledge and understanding of water birth.

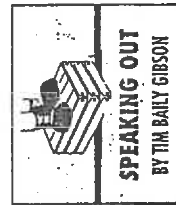
Cost : Ƶ180 for waged
Ƶ 90 for students/unwaged

Contact : International Conference on Water Birth
Administrator
Parkside Communications Ltd
St Charles Hospital
Exmoor Street
London W10 6D2, England



NEW ZEALAND DOCTOR PRACTICE

# Maternity fundholding: work more, earn less



SPEAKING OUT
BY TIM BAILY GIBSON

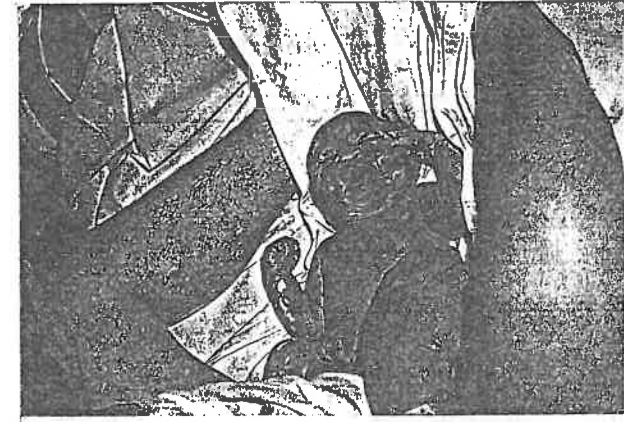
The second draft of the proposed new Maternity Benefit Schedule has been released and it contains considerable material to strike real fear into most sensible doctors.

It introduces true budget holding for the first time for most doctors and midwives. It is not optional. The only option, if you don't like it, is to get out of obstetrics.

When budget holding is introduced to professionals who have been used to fee-for-service, some rather surprising messages are generated.

They have been used to a situation which rewards hard work. If they do more, they get more. Budget holding introduces the idea that they get less if they do a better job.

Where systems like this are introduced, the controlling authority has to introduce quality controls to effectively force the budget holders not to save too much of their budgets by simply not providing the service. This idea is rather alien to the way medical practice is conducted at present.



*New contracts will see GPs leaving maternity care*

If I am going to be cynical (or perhaps realistic), I must ask how practitioners will maximise their incomes.

- They will only keep the easy obstetrics - there is an amount in there to allow for swings and roundabouts
- They won't do scans - or only if they absolutely have to
- They will do the minimum antenatal care they can get away with
- They will refer late - or not at all.

This is most unlikely to produce much job satisfaction.

What is the likely result of the new maternity schedule?

I believe there will be a mass exodus of GPs from maternity care and of specialists from private obstetric care.

This will increase in maternal morbidity and mortality and perinatal mortality.

In summary then, it is to be budget or nothing. There is no other non contract option and no fall back position.

This situation has arisen by the perceived need to cap maternity spending.

The maternity budget grew out of control as a direct result of doctors and midwives accessing the same payment schedule, because Helen Clark, then Labour's Minister of Health, stated that they do the same job. That is clearly absurd and I do not believe that either doctors or midwives truly believe it.

Hence, it is necessary to recognise midwives and doctors are different, do different jobs and should be covered by different schedules.

Once someone is brave enough to stand up and say that, then all the current attempts to reinvent the wheel become unnecessary.

On a personal note, I used to find my obstetric practice the most satisfying part of my job. In the last year or two it has become less and less so. The revised schedule, under which we currently work, ceases to value hard work.

For example, this revised schedule removed the "Trial of Labour" fee.

This was a payment equal to the delivery fee that recognised that a large amount of work went into a complex case that ended in a caesarean.

To illustrate this, recently I was involved in a case with a prolapsed cord, requiring an urgent caesarean. It took over two hours on a Saturday, but, because the decision to go to caesarean was made early on, my claim was $22.70. I cannot make any claim for the time I spent in theatre assisting at the delivery.

Neither the RHAs (through Health Benefits Ltd) nor the CHEs want to know about that. Indeed, I have just had a letter from HBL quibbling about the $22.70!

The message that I get from all this is that I am not valued when I have gone the extra mile. No one appears to give a damn. So why should any of us bother?

I have great respect for the maternity benefits negotiating committee, but it, the midwives and the RHAs are hamstrung by the fact that they are all negotiating in the wrong direction.

The system has ceased to be fair and the proposed new system is going to be worse.

It will be compulsory budget holding - for the first time with risks attached, and with no chance to recoup losses from the patient or any third party.

It illustrates the dangers of not having a long term national agreement for any segment of primary health care.

*Dr Tim Baily Gibson is a GP in Masterton*

MATERNITY FUNDHOLDING

### Summary of new schedule

Without going through the document point by point, it can be summarised as:

- Fixed fees and no right to charge patients
- Lists of commandments, ie, less carrot, more stick
- Encouraging mediocrity
- Financial disincentive to practise good obstetrics, eg, a financial penalty for extra services and later for specialist referral
- Incentives for specialists to give up private practice and only be available via roster at hospital
- Loss of choice for patients.

# Pregnancy-care options

Daily News Taranaki 25/11/94

WE would like to express our concern at the negative nature of the feature article on Page 9 (November 22).

We are saddened that a three-year-old Wellington case is again dragged through the media, which may affect that family's ability to grieve, and carry on with their life.

Rather than indulge in slanging matches in the media, we would encourage any woman seeking options for care of pregnancy, to ask questions of any potential care giver.

These questions may include such issues as:

- Do you belong to your professional body (eg. the College of Midwives)?
- Do you undergo regular peer and consumer review, and what is the outcome of such review?
- What consumer feedback process, and system for complaint, do you use?
- What are your statistical outcomes?
- What ongoing education and professional development have you undergone?

We believe that when caregivers adhere to the standards set by their professional bodies, the care provided will be of a high standard.

**TRICIA THOMPSON**
Chairperson
College of Midwives
Taranaki/Wanganui region
New Plymouth

# Wrong egg for British woman

The Press 22/11/94

Test-tube fertility procedures have been tightened at a top British hospital after the wrong egg was implanted in a woman, it was revealed yesterday.

The error at St Bartholomew's in London was spotted and dealt with immediately, the hospital said. The Human Fertilisation and Embryology Authority insisted there was no evidence other errors had gone unnoticed, causing patients to have other women's babies. —PA

THE PRESS, Christchurch

GARFIELD by Jim Davis



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AUSTRALIAN COLLEGE OF MIDWIVES INCORPORATED

KNOWLEDGE
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*The* KEYS
TO SAFE
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**CALL FOR ABSTRACTS**
for
**Australian College of Midwives Inc.**
**9TH BIENNIAL CONFERENCE**

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***Abstracts due 28th February 1995***

***Completed papers will be required by 30th June 1995***

Abstracts must be submitted on official abstract forms.
Forms available from:

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PO Box 787, Potts Point NSW 2011 Australia
Telephone (02) 357 2600
Facsimile (02) 357 2950

## PAEDIATRIC CONFERENCE

27 - 29 September 1995 Sheraton Hotel, Auckland

Contact : Organising Committee
1995 Paediatric Conference
P O Box 12736
Penrose, Auckland



# Collection for Henry Murray

For those of you who have not caught up with the news Henry has transferred to Sydney and in order to raise funds for the transfer of his household has sold a story worthy of Mills and Boon to the ever gullible James Hollings(of Grace Neill-gate fame) The NZCOM feel that it would be kinder and more charitable to run a cake stall for Henry with the aim of raising sufficient cash to buy him a one way ticket to outer Mongolia. contributions to Eds

Wellington Region Newsletter 11/94

# Local birthing mishaps investigated

By JAMES HOLLINGS
Health reporter.

COVER STORY
BIRTHING
WARS
SEE PAGE 7

Two births which went wrong involving Wellington GPs are being investigated by ACC.

ACC client services manager Fred Cockram said two cases of medical misadventure resulting from births involving Wellington health professionals were presently under consideration.

He would not give further details but said the rate of cases was if anything slightly less than the rest of the country for cases of that type. One of the cases is understood to have resulted in a complaint to the Medical Practitioners Disciplinary Committee.

However, the quality of maternity care by some Wellington GPs and midwives has been questioned by a former Wellington Hospital obstetrician, Henry Murray.

He said some Wellington women are getting "less than competent" care from some GPs and independent midwives.

Some women are not being told perhaps they should be referred to specialists because the GPs or midwives would lose hundreds of dollars in birth fees.

"I don't believe some Wellington women are getting an ideal level of obstetric care. I worked on call at nights and almost every night there would be some form of near or absolute obstetric disaster. I don't believe that modern care allows for such a constant level of near disaster."

Doctors and midwives have been at loggerheads over control of the lucrative birthing trade since midwives were allowed to claim maternity benefits in 1989, but so far obstetricians have largely refrained from questioning the competence of GPs.

Dr Murray's comments signify the frustration felt by specialists that they are being left to carry the can when things go wrong.

Dr Murray said he believes more explicit standards must be set and published which GPs and midwives are required to meet if they wish to do hospital deliveries.

Wellington Obstetrics and Gynecology Society president Dr Chris Kalderimis said he could not comment on whether Wellington GPs were being questioned over birthing mishaps.

But he said Dr Murray's views were not the consensus view of other specialists. Although there had been problems in the past of inadequate management of birth, a lot of the care had been excellent.

# Letter to the Editor

## MIDWIVES & EPIDURALS

The questions raised by Mike Millar in your June 1994 Newsletter are also of interest to the midwifery profession. The guidelines on epidural anaesthesia in obstetrics may reflect the Australian maternity service, however the New Zealand situation is different. The 1990 Nurses Amendment Act enabled midwives to take responsibility for the care of a woman throughout the normal physiological process of childbirth and post partum period.

This legislative change provides women with two choices of caregiver, the midwife and the medical practitioner. GPs and midwives are considered equivalent practitioners in normal birth, requiring equivalent training and professional standards to provide a maternity service. Both professions attract the same level of accountability.

It is inappropriate therefore in the New Zealand context to require a midwife to refer for epidural pain relief via a medical practitioner. The referral criteria for epidural pain relief must be the same for general practitioners and midwives. The use of epidural pain relief does not necessarily indicate that labour progress is abnormal but is generally considered a valid choice of pain relief for some women. If however an epidural is required for obstetric reasons, eg, surgical intervention, both midwives and GPs would transfer care to the obstetrician.

This does not remove the capacity for individual assessment and clinical judgement and in practice a GP or midwife may choose to transfer care for epidural analgesia regardless of the indication for the procedure. This should be the health professional's decision based on the clinical indicators and their level of expertise as is the case in any practice situation. To be required to do so is not consistent with professional practice.

Karen Guilliland
NATIONAL CO-ORDINATOR
NEW ZEALAND COLLEGE OF MIDWIVES



## FOURTH UNITED NATIONS WORLD CONFERENCE ON WOMEN

September 1995 Beijing, China

Attendance by invitation only

The Conference will be attended by government delegations and by non-governmental organisations which have official status within the United Nations. The Conference will be approving a Platform of Action to remove obstacles to women's full and equal participation in all spheres of life.

## 24th Triennial Congress of the International Confederation of Midwives

May 26th - 31 st 1996 Oslo, Norway

Theme : *The Art & Science of Midwifery gives Birth to a Better Future*

CALL FOR ABSTRACTS

Deadline 31st March 1995
Completed papers due 40th June 1995

For more information, contact : MIDWIFERY RESOURCE CENTRE
P O Box 21-106
Christchurch Ph 03-377-2732

## JO HOYLE

Jo passed away from this world on 26th September 1994, but we would like to share some of our memories of her indomitable spirit as a midwife and colleague.

As a true pioneer, Jo fought for midwives to be recognised as the expert in normal birthing, and the right for women to make informed decisions about themselves. There are countless women who valued her loyal and strong support during their labour and the endless energy and humour that she brought to these occasions. She said "Birth is a celebration!" Jo was a champion for those who chose to give birth at home (the 'high risk list was just too long to read!'); she proved she was a safe practitioner and clearly defined the limits of her expertise.

For new graduate midwives, she was a teacher and an inspiration. For her colleagues she was a helper and gave endless support as a listening ear. She is sorely missed.

from the *"Birthwise" Midwives Group*

# Current Issues

## POLYCOSE SCREENING & GESTATIONAL DIABETES

Do you recall Sharron Cole's letter to Lakeland Health CHE printed on page 20 of the September/October 1994 newsletter?

The following are extracts from the response to that letter, written by P J Dunn, Endercinologist. He also states that he is "somewhat lukewarm about testing for diabetes in pregnancy."

*Question 5 : What is the incidence of macrosomic babies born to non-diabtetic mothers?*

"...Within western countries only five percent of macrosomic babies, that is babies greater than 4.1 kilograms, are thought to have gestational diabetic mothers. Other factors such as size of the parents are much more important in determining the size of the child."

*Question 10: What is the reliability and scientific validity supporting routine polycose as an effective screening tool, i.e. what is its reproductibility?*

"This Question is confused but the meaning is quite clear, that is 'How can one interpret a test?' All of our tests have built in variability and the glucose tolerance tests are particularly bad in this regard. To answer it, I need to explain that if a sample is tested repeatedly then it is possible to get a range of values, the average of which is the closest to what is probably the true value. The range of values around the average is commonly expressed as standard deviations where something like 97 percent of values fall between two standard deviations above and below the average. A test that is highly reproducible has a very tight scatter of values and the standards deviation narrow. In the case of the glucose tolerance test, the values vary quite considerably, of the order of 20 to 30 percent of the original value. This of course means that a woman who on one day may be categorised as normal could on another subsequent test be categorised as abnormal and vice versa. The formal oral glucose tolerance test has got the same problems. In recognition of that variability the criteria for these tests are set somewhat high and an attempt is made then to validate the categorisation in terms of clinical outcome.



No. 41,157 Dunedin — Monday December 5 1994

(ODT)

### Jubilant graduates make historic ceremony a lively affair

PHOTO: SAM HENDERSON

Enjoying the hairstyle of Otago Polytechnic bachelor of midwifery graduate Justine de la Cour (right) are polytechnic director Dr Nirwan Idrus (left), polytechnic council chairman Peter Wixon and head of nursing and midwifery Alison Dixon.

### Standards of dress, decorum extended

By Lee Harris

Saturday's historic first graduation of degree-holding nursing and midwifery students from Otago Polytechnic was an emotional time for staff and students alike.

The usual standards of dress and decorum were stretched by graduating students, including one woman in a pink tutu and another with pink hair.

Others receiving certificates and diplomas on Saturday included graduates in commerce subjects, community studies, engineering, occupational therapy and tourism.

About 3000 people packed the Dunedin Town Hall as graduating midwifery students gave whoops of delight, one sporting a hairstyle complete with roses that resembled ovaries, and another turned cartwheels across the stage.

Associate Minister of Health Katherine O'Regan addressed her speech to those receiving bachelors of nursing and midwifery.

Women would have real choice in maternity and childbirth services through the expertise of the midwifery graduates, she said.

Graduates of both courses would find themselves well received overseas, where there was a shortage of nurses.

"While we lose out in the short term from New Zealand-trained nurses who choose to work elsewhere, we reap the benefit of their overseas experience when they return to New Zealand to resume nursing here," Mrs O'Regan said.

While there had been an oversupply of nursing graduates, the prospects of gaining employment in New Zealand were improving.

Proposed changes to the Nurses Act would include competency-based practising certificates, more open, consumer-focused disciplinary procedures and the development of a code of practice.

Mrs O'Regan suggested a multi-skilled community nursing workforce might be the face of the future if there was no longer a need for separate identification of positions as public health nurses, practice nurses, district nurses and independent nurse practitioners.

The Ministry of Health was looking at a project on the future work roles of nurses in primary care, and the question of nurses being given prescribing rights was also being examined.

Mrs O'Regan stressed the importance of cultural safety.

"Cultural safety is about health professionals acquiring an approach to people that incorporates humility, sensitivity and respect for difference, whether this difference be due to culture, gender, age, sexual orientation or any other factor that distinguishes one from another."

Teaching of cultural protocols was not the same as cultural safety issues.

"Schools of nursing and the Nursing Council should take note of this as I believe much of the angst is caused by this lack of differentiation," she said.

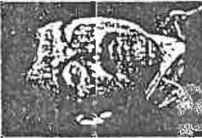
The Otago Polytechnic School of Nursing had an excellent cultural safety programme, Mrs O'Regan added.

After her address, the Otago Polytechnic's director, Dr Nirwan Idrus, thanked retiring polytechnic council chairman Peter Wixon for his service on the council for 20 years.

# Debate rages over midwives' post-natal role

Taranaki Daily News 8/11/94

By DELWYN MASTERS
Health Reporter


TIM SPROTT

THE SIX-WEEK check of mothers and their new babies should be done by a qualified doctor, says North Taranaki General Practitioners Society spokesman Tim Sprott.

But independent midwife Tricia Thompson said midwives were specialists in their own right and could provide thoroughly professional checks.

The national General Practitoners Association has approached the Children's Commissioner for help in its campaign to get the requirement for post-natal medical checks by a qualified doctor reinstated under the changes to the maternity system.

Until 1990, the check done after the babies were six weeks old could only be done by a qualified doctor but an amendment to the Nurses Act increased the number of professions which could do the checks.

Dr Sprott said it was important that health problems and congenital defects were diagnosed early as some conditions could cause problems later in life.

"Even for highly trained health professionals, some of the congenital defects early in life can be very difficult (to diagnose), they are very subtle and things can be missed," he said.

"If you're not doing it often you can easily miss a child with displaced hip."

Women should have a wide choice of health providers when it came to obstetric care but the six-week check should only be done by a qualified doctor, he said.

But Ms Thompson said women and children were not in any more danger from receiving a misdiagnosis from a midwife than from another health professional: "We're trained to know what's normal or not and if there's any abnormality, we refer it on."

Taranaki Base Hospital paediatrician John Doran said he had no reports of a child's condition being missed by a midwife and there was good communication between Taranaki health professionals.

"But my personal belief is that the principle of the six-week medical examination by a registered medical professional is the way to go."



# Midwives question draft birthing policy

PRESS 6/12/94

HAMILTON — Pregnant women employing midwives could have their care taken over at the last minute by Waikato Hospital staff under a Health Waikato draft policy.

Midwives say the proposed hand-over policy gives hospital staff the right to "sack" a woman's chosen lead practitioner, whether GP or midwife, if they believe there is a risk or crisis that warrants it.

The woman and her practitioner will have to agree to this before being admitted to the hospital. Practitioners who withhold consent could have their hospital access agreements revoked.

Independent midwives, who have taken an increasing share of the birthing market over the last five years, believe the move is aimed at them — and will take away a woman's right to choose.

Health Waikato, however, said it was trying to develop a policy allowing for immediate action in emergencies.

"When a situation arises, we can't afford to stand around arguing when decisions have to be made quickly," the general manager for women and children's health, Bev Adlam, said.

The existing system for take-over action by hospital staff was difficult to enforce, and the aim was to develop a set of guidelines which would provide certainty.

Ms Adlam said the draft policy was no more than a discussion document.

She confirmed that the need had increased with the "increasing involvement of midwives" in maternity services.

Waikato co-ordinator Lynne McCroskery said the policy on mandatory hand-over would deny women the right to choose their practitioner, and it implied that midwives were professionally incapable of assessing risk or knowing when to call in the hospital team.

—NZPA

## GESTATIONAL DIABETES OR IMPARIED GLUCOSE TOLERANCE OF PREGNANCY

Extracts from comments on the position statement from NZSSD and ADP, November 1990.

The situation in New Zealand which favours a screening programme is the high prevalence of undiagnosed NIDDM and IGT, particularly in Pacific Islanders and the Maori. If this is to be the justification for screening here then the blood glucose level on the oral glucose challenge (OGC) which triggers a formal glucose tolerance test (GTT) should be set at a level which is going to detect undiagnosed NIDDM and IGT, but not initiate an unnecessarily large number of GTTs. Similarly, the GTT criteria for diagnosing gestational diabetes should not be so low that large numbers of women in the upper end of the normal range for glucose tolerance, whose pregnancies are not at any demonstrative risk, are subject to unnecessary intervention. The one hour blood glucose of 8.0 mmol/L on the 75g OGC, as proposed, probably gives an acceptable balance between sensitivity and specificity.[4] However, the criteria for the 75g GTT are not satisfactory. The proposed upper limit for the fasting level of 5.5 mmol/L would not over diagnose gestational diabetes, but the 1hr value of 9.5 mmol/L and the 2 hr value of 8.0 mmol/L would diagnose 8% and 12% respectively of normal European women in the 2nd and 3rd trimester as having this condition.[5] In the community at large (non-pregnant) the prevalence of undiagnosed NIDDM and IGT in the 40-44 yerar age group is 4% and 6% respectively in the Maori and Pacific Island communities, and 1 and 1.5% in European communities.[6] The prevalence rates are lower in younger age groups.

These data suggest that a substantial number of women with essentially normal glucose tolerance and low risk pregnancies are going to be diagnosed as having gestational diabetes and subjected to unjustified intervention at considerable cost. The effects of changing the 1 and 2 hr criteria are shown in the table.

| Blood Sugar (mmol/L) | 1 Hr | 2 Hr |
|---|---|---|
| 8.0 | - | 11.7 |
| 8.5 | - | 7.2 |
| 9.0 | - | 4.3 |
| 9.5 | 8.1 | 2.5 |
| 10.0 | 5.4 | - |
| 10.5 | 3.6 | - |
| 11.0 | 2.3 | - |

References available on request:


Tim Cundy, Auckland Hospital
Alistair Roberts, National Women's Hospital
Peter Dunn, Waikato Hospital

MINISTRY OF HEALTH
MANATU HAUORA

To Medical Practitioners and Midwives

## GLUCOSE *POWDER* IN GLUCOSE TOLERANCE/CHALLENGE TESTING

**You are recommended to review any patient that has been tested for diabetes over the last two years, where the result was based solely on a two-hour sample in an oral glucose tolerance test, using glucose *powder* measured *volumetrically*.**

Background

Because there may be a wide variation in density between different batches of glucose powders and several diagnostic laboratories have used volumetric measurement of the powder, there is a risk that too little or too much glucose has been used for the tests. This of course also applies where medical practitioners and midwives have measured glucose volumetrically and given it to their patients.

Douglas Nutrition, which distributes one brand of food grade glucose polymer powder, has already written about this problem to some laboratories. The Ministry of Health considers that the warning is relevant to all brands of glucose powders.

If users of Douglas Energy Plus have calibrated their own volumetric measures, there is a possibility that the actual dose weight could be between 70% - 140% of what was expected. If a cup provided by Douglas Nutrition has been used the dose range could be between 90% - 128% of the expected quantity. The figures are based on powders with densities ranging from 0.31 g/ml to 0.44 g/ml, which have been sold to laboratories.

The Ministry became aware of this problem as a result of an investigation into the withdrawal from laboratories of Douglas Energy Plus, batch number 94077, which had a density over 0.50 g/ml, which is the upper limit of the company's specification for the glucose powder.

Douglas Energy Plus contains 94 percent w/w glucose, according to Douglas Nutrition.

As there is limited information available on the density of other glucose products marketed as dietary supplements but used by diagnostic laboratories, the Ministry of Health recommends that all glucose powders should be weighed when used for diagnostic purposes.

Clinical effects

The New Zealand Society for the Study of Diabetes (NZSSD) has been consulted and its main concern is that: 1. Borderline forms of diabetes may have gone undetected if the patient has received the low density batches; 2. A small number of patients may have been over diagnosed.

G R Boyd
Manager
Therapeutics Section

Wellington 12 October 1994



# Tougher penalties for doctors in bill

## Medical Council powers 'inadequate'

The Press, 25/9/94

Wellington reporter

Doctors face tougher disciplinary procedures and regular tests of their competency under a revamp of the Medical Practitioners' Bill, introduced to Parliament last night.

Moving the first reading, the Minister of Health, Jenny Shipley, said disciplinary procedures imposed by the Medical Council were inadequate. Consumers did not have enough say in the process, and complaints took too long to be resolved.

The council itself had long campaigned for tougher disciplinary rules, but these had had to wait until companion complaint procedures under the Health and Disability Commissioner Act were passed. Drafting instructions for the bill were first issued in 1990, under the former Labour Government.

In future, doctors would have to pass annual competency tests to keep a certificate to practise. "One of the weaknesses of the existing act is that there is no check on the ongoing competence of a doctor," she said.

"The bill provides that the council may impose conditions on the certificate or decline to issue an annual practising certificate if it believes the practitioner has failed to maintain a reasonable standard of professional competence. This will provide a valuable check on doctors."

To ensure registered doctors were competent to practise, the council would be able to set or recognise recertification programmes. Doctors who wished to practise independently would have to be vocationally registered.

"Doctors who hold general registration will be entitled to practise any branch of medicine, but only while subject to the general oversight of a person who holds vocational registration in that branch of medicine."

At present disciplinary procedures were controlled by the council and the medical practitioners' disciplinary committee. Under the bill, responsibility for investigating complaints would be given to the health and disability commissioner or a complaints assessment committee.

Complaints would be heard in front of a new body, the medical practitioners' disciplinary tribunal. This would comprise five members, three of whom — including the chairman — would be doctors. Mrs Shipley said she was aware that consumer groups thought the chairman should not be a doctor.

The Government had an open mind and would welcome submissions.

The tribunal would be able to impose much tougher penalties than the council. Maximum fines would go from $1000 to $10,000. Hearings — traditionally held in private — would be thrown open, subject to conditions.

# Islanders' abortions in isolation 'worrying'

The Press 5/11/94

by Sarona Iosefa

Health workers are increasingly concerned at the number of Pacific Island women having abortions in isolation because of shame, and fear of their families.

Health workers say they feel powerless to help Pacific Island women who so fear being discovered as having had a termination that some beg to be let out the back door when they see another Pacific Islander at the clinic.

The abortion rate among Pacific Islanders is about double that of pakeha and Maori women, yet health workers say they cannot address such statistics when Pacific Island culture is so averse to discussing sex openly.

An abortion clinic senior social worker, who did not wish to be named, said her clinic could not even place two Pacific Island women on the same day's theatre list because they got so upset if they saw each other.

"The thing that really scares and worries me is the isolation of these women.

"They are very stoic. They come in, get it done, and then leave without any further contact," she said.

She suspected that reported cases of new-born babies being abandoned in Auckland were the product of such fear and isolation.

High abortion statistics meant it was highly likely that Pacific Island women were not being informed about contraception. The majority indicated that the use of contraception was an outward sign of their having sex, which was unacceptable in their culture before marriage, she said.

### National problem

Assistant director of nursing at Manawatu Polytechnic Karl Pulotu-Endemann, a Samoan writing a paper on the issue for the first Pacific Rim Conference of the International Association of Adolescent Health in Auckland this weekend, said the problem was a national one needing to be addressed at community level.

He is convinced that existing abortion statistics are the tip of an iceberg because many Pacific Island women lie about ethnicity to remain anonymous.

Education needed to begin at community level among such groups, and particularly at primary school and early childhood level, he said.

"It involves a total deprogramming of colonial attitudes from Pacific Island culture so it will not happen overnight," he said.

"It is ridiculous that usually the only time a couple will be told about sex is in preparation for marriage.

"Unless Pacific Islanders can freely discuss sex, and preventative education, abortion statistics will continue to rise," Mr Pulotu-Endemann said.

Christchurch Family Planning Association medical director Sue Bagshaw said she was hopeful the Pacific Island plight would change as the young received health education at school.

Cervical screening had helped open sex education for many Pacific Island women, allowing health services to answer other concerns, but it was still a topic that could not be openly discussed in front of Pacific Island men, she said.



## NZCOMI NATIONAL DIRECTORY OF INDEPENDENT MIDWIVES

The National Office receives a number of calls from midwives seeking information regarding midwives in other areas of the country. This is often on behalf of a client who's moving town or going on holiday.

The College is considering formulating a National Directory of self employed midwives which could be available for sale to practitioners. It would not be sold for commercial gain, e.g. Insurance Companies.

If you do not wish to have your name included in this directory, or you would like further information added, please contact :

Judy Henderson, Secretary
NZ College of Midwives
P O Box 21-106 Christchurch

## Booklet - Alcohol and Pregnancy: A Manual for Health Professionals

This is a booklet designed specifically for health professionals. It includes the background to the discovery of Foetal Alcohol Syndrome and Foetal Alcohol Effects; details alcohol's effects on foetal development; lists criteria diagnosis of the conditions; and emphasises the importance of the health professional's role in prevention of alcohol-related birth defects.

Cost : $20 per copy

Please enclose fullscap/A4 stamped (80c) self-addressed envelope with order. Make cheque payable to **"Alcohol Healthwatch Trust"**

Please forward orders to: Alcohol Healthwatch
P O Box 99 407
Newmarket
AUCKLAND

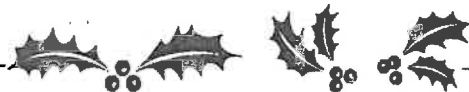
## DIRECTORY OF WOMEN'S ORGANISATIONS AND GROUPS IN NEW ZEALAND

## TE RĀRANGI INGOA O NGĀ RŌPU WĀHINE KEI AOTEAROA NEI

A completely revised and updated edition of this directory has been produced by the Ministry of Women's Affairs. Nearly 600 women's organisations and groups are included, along with government agencies, women's bookshops and women's studies courses. The Directory is available for $10 (payment with orders please) from:

Ministry of WOmen's Affairs
P O Box 10-049 Wellington

Ph (04) 473-4112 or Fax (04) 472-0961



## INTERNATIONAL LACTATION CONSULTANT ASSOCIATION

### SUMMARY OF THE HAZARDS OF INFANT FORMULA

**INFANT FORMULA IS ASSOCIATED WITH COGNITIVE (LEARNING) DEFICIENCIES IN PRE-SCHOOL AND SCHOOL-AGED CHILDREN**

*Formula-fed preterm infants had lower Bayley Mental Development scores at 18 months, even after adjusting for social and demographic influence.*
Morley R, Cole TJ, Powell R, et al. Mother's choice to provide breastmilk and developmental outcome. *Arch Dis Child* 63:1382-1385, 1988

*Scores on the Bayley Mental Development Index were lower in formula-fed children at 1-2 years of age. Scores were directly correlated with duration of breastfeeding.*
Morrow-Tlucak M, Haude RH, Emhart CB. Breastfeeding and cognitive development in the first two years of life. *Soc Sci Med* 26:635-639, 1988

*Scores on the McCarthy Scales of Children's Abilities were significantly lower at three years of age as the duration of breastfeeding decreased.*
Bauer G, Ewald LS, Hoffman J, et al. Breastfeeding and cognitive development of three-year-old children. *Psychological Reports* 68:1218. 1991

*Bottlefed children showed reduced performance on developmental tests at age five years.*
Taylor B, Wadsworth J. Breastfeeding and child development at five years. *Dev Med Child Neurol* 26:73-80, 1984

*Formula-fed preterm infants had lower IQ scores at age 7-8 years than breastfed preemies, even after adjustment for mother's education and social class.*
Lucas A, Morley R, Cole TJ, et al. Breastmilk and subsequent intelligence quotient in children born preterm. *Lancet* 339:261-264, 1992.



# Media Watch

Chch Press Sept. 5 1994

## Avoid the blame game by taking responsibility

**INTIMACY**

by Neil Rosenthal

What or who are you most fond of blaming? Whatever your favourite blame may be, fault-finding and finger-pointing is a way of protecting yourself. It is a coping mechanism that is designed to take the responsibility off you.

Blame is used to turn attention away. It is backward-looking, not forward-looking. It asks or demands that others change; not you. People who blame tend not to take responsibility for causing or contributing to a problem, or for solving it.

The flip side of blame ("you are responsible for creating the problem") is guilt ("I'm responsible for the problem"). People may blame their spouse for things that are not right in their life: "If only you would work less and pay more attention to me, I'd feel loved and cared about."

A third party may also be blamed: "I hate your boss for making you work so much so that you have less energy for me." Finally, people blame themselves: "I'm not lovable enough for you. That's why you don't want to spend more time with me."

Blame is often based on reality. Our partner really may have done something to hurt us, whether it was intentional or not. But blamers see only the other person as the culprit, and they hold other people responsible for their feelings, behaviours, or moods. They spend large amounts of time trying to change other people, who may or may not want to be changed.

There are, make no mistake, rapes, accidents, and genuine injustices where we really are victimised by someone else's thoughtless, hurtful, or insensitive behaviour. But most of the time, and especially in our intimate relationships, we are not victims.

Both people choose to enter and stay in a relationship, and either is free to leave if they see fit. If you do not leave, you are an equal participant, even if you are only a passive participant, and you are not, therefore, a victim.

Personal growth and happiness happens when you let go of feeling like a victim and take back your power. You take back your power when you take responsibility for the outcome of a situation. You can do this by knowing what your needs are, and by holding yourself and other people "able" and accountable for behaviour.

Learning to express what you need or want is healthy, and gets you out of the blame-game cycle. Part of not being a victim is to realise that nobody is doing it to you. Usually, you are responsible — or partly responsible — for the position you are in, by not having taken a stance, made your wishes known, or by being too patient or tolerant.

**Be willing to become more of an expert on yourself, and less of an expert on other people.**

We are responsible for our own behaviour (or our lack of behaviour). We are not responsible for other people's reactions, just as they are not responsible for ours. Be willing to become more of an expert on yourself, and less of an expert on other people. This is about taking responsibility and owning up to your part. The position you are in is usually because of your decisions, not because of what "he" or "she" has done to you.

If you wish to be happy, you will have to give up finger-pointing and fault-finding. Ask yourself the question: "Do I want to be right, or do I want to be happy?" "Righteous" people are seldom happy people.

Neil Rosenthal is a licensed family therapist. Readers can write to him c/o Intimacy column, PO Box 1005, Christchurch. He is unable to reply to individual letters.

a constant standard of practice, irrespective of external issues. In the particular context, this nurse did not use skills that may reasonably be expected of a registered nurse. Instead the patient was subjected to physical abuse.

Regardless of the behaviour a nurse faces, the council concluded there can be no justification for aggression on the part of the nurse and violence cannot be condoned in any way.

● An enrolled nurse in financial straits took advantage of a position of trust. An elderly, dependent woman with progressive memory loss was taken to the bank. On four occasions large sums of money were withdrawn from the patient's bank account for the nurse's own use. The woman's family became suspicisous when the woman could not recollect withdrawing the cash on the days she visited the day centre where the enrolled nurse worked.

Dependency through impaired health can put a person in a precarious position. In this situation the nurse had an easy opportunity for deliberate and repeated theft. The financial risk is compounded as a nurse who is in debt may not be able to repay it, even if there is an intention to do so.

Taking patients' money for personal use is grossly unethical. The nurse was removed from the roll and the council expressed "extreme concern" that a nurse should betray trust in such a way.

● Abuse of trust and deliberate actions to secure financial gain occurred in another context. Over several months a nurse/midwife in independent practice fraudulently claimed maternity benefits from the Department of Health. Routine audit procedures showed an abnormally high claiming rate. Subsequent investigations revealed excessive claims made by overstating mileage and hours with clients, false dates and claims for visits which did not occur.

Accepting an excessive workload and adverse family events may have influenced this practitioner's dishonest acts.

The enquiry led to a court conviction where the midwife pleaded guilty to 40 charges of fraud under section 229A of the Crimes Act 1961 and was sentenced to seven months' periodic detention.

The crime for which the midwife was convicted carried a potential for seven years' imprisonment.

At its hearing the council concluded that the profession and the public had a right to expect that a registered nurse/midwife would act with integrity. Removal of the practitioner's name from both parts of the register (nurse and midwife) resulted.

● A psychiatric nurse was ordered to practise only under specified conditions for 12 months after being found guilty of professional misconduct on the grounds of malpractice and negligence.

The charges involved an unprofessional relationship with a patient, including alcohol consumption, and failure to report an incident concerning the client.

Whenever a nurse abuses a privileged position or oversteps the boundaries of professional relationships, no matter what the motivation, the situation is a serious one. Failure in a duty of care is equally serious.

The council set conditions requiring a contract with a mentor and subsequent reports show this has had a positive and sustained impact on the nurse's practice.

### Council censure

A censure is the most serious penalty the council can impose without interfering with the right of a nurse to practise. A written statement expressing the council's displeasure is delivered to the nurse.

## SAFE PRACTICE

**THE RECENT cases reported in the accompanying article show the variety of issues which can come before the Nursing Council.**

**These cases are only a small proportion of the complaints which would be received by the council, NZNO's legal adviser Laura Cronin said.**

**"It is important that nurses who believe they may be the subject of a complaint to the council to contact their NZNO organiser as soon as possible. Any nurse who appears before the council, or its preliminary proceedings committee, is entitled to representation. NZNO will provide this represen-tation to all its members," Cronin said.**

**The disciplinary powers of the council are intended to address serious professional or practice problems to protect the public and the standards of the profession.**

**"It is extremely important that all nurses practise ethically, safely and within the law," Cronin said.**

● After conviction under sections 9(1) and 9(3) of the Misuse of Drugs Act 1975 for growing prohibited plants, a comprehensive nurse received this censure.

*"The Nursing Council views with extreme concern where a nurse is involved in the misuse of drugs and is even more concerned where there has been deliberate and calculated breaking of the law such as in the cultivation of cannabis plants. Such conduct by a registered nurse brings the profession into disrepute and erodes public confidence in the profession. It is incompatible with standards of conduct expected of a registered nurse and the council will not tolerate conduct of the type which lead to this court conviction."*

There appeared to be no mitigating circumstances surrounding the conviction. However, the nurse indicated remorse and had re-evaluated her lifestyle after the conviction. The council was told of her shame and embarrassment from publicity, having a criminal record, being fined and having resigned.

A registered nurse/midwife practising as an independent midwife was also censured. Negligence in failing to keep records of meetings with a pregnant woman, to write a plan of care for her labour or to inform another midwife taking over responsibility were the elements of professional misconduct.

In making its judgement the council noted that comprehensive record keeping is integral to nursing and midwifery in order to provide optimal and safe care. Failure to keep records and to write a care plan compromised the client's expressed expectations of care and contributed to unacceptable and unprofessional standards.

On the transfer of clients from one practitioner to another, the council considered the provision of clear, specific information about the intended plan of care and details of the client's obstetric history essential to sound midwifery practice.

### Punitive element

The primary purposes of the council's disciplinary powers are to protect the public and the reputation and integrity of the nursing and midwifery professions. Punishment of the nurse or midwife is not an express purpose, yet any penalty imposed has an unavoidable punitive element.

**● The processes of the Nursing Council were outlined in "Discipline and disability," (*New Zealand Nursing Journal*, February 1993) and NZNO's role in representing nurses before the council in "A nurse's guide to the Nursing Council," (*New Zealand Nursing Journal*, March 1993).**



❖ SIDS Talk ❖

Issue 6 November 1994

# "Your involvement brings us closer to solutions"

This was the theme of the Third SIDS International Conference held in August this year in Stavanger, Norway. There were 400 participants from 34 countries and a total of 249 papers or posters presented. Five of the eight New Zealanders who attended presented papers at the conference.

### *Sleep position*

A feature of the conference was the widespread acceptance of the strength of sleeping on the tummy as a risk for SIDS. On a world scale, the huge impact of sleep position advice on reducing deaths from SIDS was celebrated as a major paediatric break through.

It was a conference of celebration for all the children around the world who have survived SIDS because they slept on their back or side as a baby.

### *Co-sleeping*

Co-sleeping was the issue that took centre stage at the conference. Abstracts from two presenters at a symposium on the pro's and con's of co-sleeping, Dr James McKenna, an anthropologist from the USA, and Dr Ed Mitchell, epidemiologist from NZ, are included on page four. Riripeti Haretuku, also from NZ, shared the Maori perspective on sharing beds with babies and stimulated discussions of cultural issues.

### *Smoking*

Smoking is internationally acknowledged as a major SIDS risk. Reducing maternal smoking levels was put up as the next international challenge for SIDS prevention.

SIDS International is a network of 24 nations working for the global advancement of public understanding, parent support, medical research and prevention in the area of SIDS.

## Global Strategies

The Second SIDS Global Strategy meeting followed the Norway conference. Four New Zealanders participated. The Global Strategy Task Force is an independent group of SIDS researchers, clinicians and educationalists working to combine their efforts on an international level to enhance SIDS research and education. There are working groups in Pathology, Epidemiology, Physiology and Education and Training.

### *Definition of SIDS*

Re-defining SIDS has been a "hot" issue with pathologists for some time. After many discussions, meetings and presentations the original 1969 Seattle definition was endorsed. It defines Sudden Infant Death Syndrome as:

***" The sudden death of an infant or young child which is unexpected by history and in which a thorough post-mortem examination fails to demonstrate an adequate cause of death."***

## New National SIDS Contract

A new national SIDS prevention contract has been signed between the Public Health Commission and Family Education Servces of Christchurch. The contract is worth $148 500 over 3 years and will provide advisory, information and training services to health and education workers involved in SIDS.

A major part of the contract for the first year is to develop a training programme. A major emphasis in this training will be on protecting babies from tobacco smoke. Trial workshops will be held later in 1995 and then 10 per year in the next two years to introduce health workers to the programme. Ideas and suggestions are sought from health workers and educators at this the planning stages of the programme.

### *Thank you SIDS Canterbury*

The new contract is an opportunity to develop further, and for the whole country, work started in Canterbury with the former Canterbury Cot Death Society (now SIDS Canterbury Inc). Funding support from this group and the Canterbury community has led to the development of initiatives such as "SIDS Talk", "ACT NOW" - a smoke free child project, and "KIDS AGAINST SIDS" - a project to involve teenagers in SIDS prevention.

### *Thank you CDA*

Funding and advisory support for the production of SIDS information leaflets and other work, has also been appreciated in the past from the Cot Death Association of New Zealand.

**Stephanie Cowan**
**Family Education Services**

*Contact your local College of Midwives Chairperson for more details or write to Stephanie Cowan at 117 Clyde Road, Christchurch 4, Phone 03-351-6528*

# Research Focus - Co-sleeping and SIDS

Abstracts from the Third SIDS International Conference, August 1994, Stavanger, Norway

## SIDS epidemiology, evolution and infant-parent co-sleeping: can they be reconciled?

J McKenna, Pomona College, USA

The diverse social and physical environmental factors that characterise and differentiate forms of infant-parent co-sleeping, both within and between populations, must be recognised if scientifically valid conclusions about the potential benefits or risks of co-sleeping are ever to be drawn. SIDS epidemiological studies should begin with a conceptualization of the appropriateness of infant parent co-sleeping, as well as an appreciation of the complex cultural factors that must be reflected in the wording of questions and the types of questions asked if the data are to be useful and/or interpreted correctly. We note parallels in the difficulties faced by epidemiologists and laboratory workers in searching for SIDS co-factors. For example, psychobiological and evolutionary studies suggest unequivocally that co-sleeping should be inherently beneficial to human infants, and, as hypothesized elsewhere, possibly protective against some types of SIDS. However the types of beds used, the cleanliness and characteristics of bedding materials, room and bed temperature, quality of air, and the number and status of co-sleepers (their size, weight, mental state and sensitivity to safety issues) are all factors that can affect these potential benefits, making sweeping generalisations about co-sleeping benefits difficult. One way to reconcile the apparent conflicts between advocates of co-sleeping and those who warn against co-sleeping is to appreciate that co-sleeping is not a unitary behaviour, it takes diverse forms, is underreported, and means different things to different people. *Under most circumstances*, increasing rather than decreasing, contact and proximity between informed, loving, caregivers and their infants has the best chance of promoting the wellbeing of both.

## Co-sleeping increases the risk of SIDS

E Mitchell, University of Auckland, NZ

Definitions of co-sleeping vary considerably and include sharing the same bed, sleeping in close proximity and infants sleeping in the arms of an awake parent. The behaviour of concern is both infant and parent sleeping in the same bed.

Eight case-control studies have shown an increased risk of SIDS when an infant sleeps in the same bed as the parent. The New Zealand Cot Death Study (NZCDS) found that 24% of SIDS cases died in bed with another person compared with only 10.5% of infants co-sleeping in the control group (odds ratio=2.7; 95% confidence interval 2.0-3.6; adjusted OR=2.0).

In some communities (eg, Hong Kong, Bangladeshi infants in Wales) co-sleeping is common and SIDS deaths are rare, which appears to conflict with case-control studies.

Further analysis of the NZCDS found that bed sharing was a very strong risk factor for SIDS where the mother smoked (adj OR=3.9), but only slightly increased where the mother was a non-smoker (adj OR=1.7). Furthermore the risk increased with duration of bedsharing. For infants sharing a bed for more than five hours the adjusted relative risk was 5.7 for infants of mothers who smoked and 2.5 for infants of mother who were non-smokers. These new findings explain the data from countries with high prevalence of co-sleeping and low SIDS rates, as in these communities, maternal smoking is uncommon.

New data from the NZCDS was presented at the conference which shows infants sleeping in the same room as the parent are at *lower* risk of SIDS.

### Commentary

There seemed to be no disagreement amongst those present at the Norway symposium, that maternal smoking is likely to be one of those circumstances that *decrease* the benefits of parent-infant closeness during sleep. Regarding the message to non-smoking women about bed sharing with babies, it was my understanding that the feeling of the meeting was summarised by Dr Peter Fleming from Bristol, UK, when he said that we are in no position to advise non-smoking women *either for or against* bed sharing, in our current state of knowledge and as it relates to SIDS. This is consistent with the PHC Board's policy on bed sharing. More research is needed to clarify the issues.

Stephanie Cowan

The purpose of "SIDS Talk" is to stimulate talk about SIDS prevention amongst health and education workers - to share ideas and information. It began as a SIDS Canterbury publication with a readership of mainly Canterbury health workers. It is now a Family Education Services publication and this is the first national issue. Please help to distribute it to interested colleagues - thank you.

### *Thank you*

We are most grateful to Peter Heron, Shane Colman and Thomas Allely for contributing articles, and to all of you for your efforts to reduce SIDS.

Family Education Services, 117 Clyde Rd, Christchurch 4.
Tel: (03) 351 6775 Fax: (03) 351 6528





# PROTECTING THE PUBLIC

The Nursing Council, which has been appointed for the next three years, is from left: Charmaine Hamilton, Jacqueline Gunn, Bridget Parle, Christine Smith, Wayne McLean, Elaine Papps (chairperson), Michael MacPherson, (deputy chairperson), Gillian Grew, Karen Palmer, Lyndsay Rendall, Frances Russell and Isabelle Sherrard.

By Allison Chapell

*The Nursing Council's role is to protect the public and the reputation of the nursing and midwifery professions. What happens to nurses whose actions may jeopardise that protection or reputation?*

ANYONE CAN complain to the Nursing Council about the conduct of a nurse or midwife.

The Nurses Act 1977 requires that the complaints be in writing addressed to the registrar. All such complaints are referred to the preliminary proceedings committee of three council members two of whom must be nurses or nurse/midwives. Only council members can serve on this committee.

When the committee decides that the council should inquire into a complaint, it formulates one or more particular charges of professional misconduct against a nurse or midwife. Each charge specifies the date, location, a named patient where appropriate, and the particulars of the alleged behaviour in a certain situation.

During the 1993-1994 year, the council heard such charges laid against four nurses and one nurse/midwife. One other nurse and a nurse/midwife appeared before the council as a consequence of court convictions. Disciplinary orders were made in each case. One has lodged an appeal with the High Court.

Similar to previous years, the nurses whose conduct was the subject of council hearings in 1993/1994 represented different categories of registration and enrolment, worked in different practice settings and came from urban and rural New Zealand. The women and men, aged from 26 to 55, were all experienced in their fields.

Marriage breakdown, financial difficulties and family stress were personal factors submitted as relevant in some cases. Other than the two matters referred to council after court convictions, five hearings were as a result of an inquiry by the preliminary proceedings committee following complaints received from one consumer and four employers.

## Disciplinary powers

The council exercised its disciplinary powers against six registered and one enrolled nurse. Penalties imposed included removal of names from the register or roll in three cases, supervised practice for a psychiatric nurse and one comprehensive nurse who also received a censure as did another comprehensive nurse and another registered as a general and obstetric nurse and midwife.

Those whose names were removed from the register or roll had to return all badges and certificates issued by the council. Publication of names and decisions and award of costs were ordered in each case.

Assault, theft, fraud, unprofessional relationship/failure to report, cannabis cultivation and deficient documentation/handover summarise the conduct which led to disciplinary action in six cases.

- A forceful punch in the face used against a patient meant deregistration for a psychopaedic nurse.

Any patient in a vulnerable state requires

Allison Chappell, RGON, RM, Diploma of Nursing (SANS), BA (Nursing), Diploma of Health Administration, is projects co-ordinator for the the Nursing Council and former council chairperson (May 1987-October 1990).

multiple problem behaviour as a teenager. In contrast, over a fifth of the children whose families were members of the most disadvantaged 5% of the sample developed multiple problem behaviours as teenagers. These results imply the presence of a very strong gradient of risk across the social spectrum suggesting that the nature of childhood and childhood family circumstances acts as a strong determination of vulnerabilities to teenager multiple problem behaviours.

Detailed examination of the outcomes of children reared in seriously disadvantaged home environments suggested that by the age of 15 years, 87% of these children had developed at least one behavioural or mental health problem and that only 13% were problem free teenagers. In contrast, of the children reared in the most advantaged 50% of the sample, 80% were problem free teenagers.

The results of this study do not show overwhelmingly strong relationships between parental behaviours such as criminality, substance abuse and mental health problems and risks of multiple problem behaviours in adolescence. Given this evidence it seems reasonable to conclude that, whilst genetic factors may play some role in predisposing young people to multiple problem behaviours, the effects of a disadvantaged, disorganised and dysfunctional childhood probably make a far greater contribution to the development of such behaviours.

There is widespread concern in many Western societies to devise methods, structures and mechanisms to address what is seen as a rising wave of antisocial behaviour, lawlessness and drug abuse in adolscent and young adult populations.

However, on reviewing the childhood of the group of multiple problem children examined in this research it becomes apparent that while external controls may inhibit or reduce the expression of antisocial behaviours (and this may be debated, see for example Currie & Wilson 1991) these controls are unlikely to address the root causes of antisocial behaviour and disturbances.

In general, the findings of this study tend to support the conclusion that, if solutions to the problems of increasing antisocial behaviours among young people exist, these solutions are likely to lie with macrosociological changes and processes of social reconstruction which attempt to minimise the number of seriously disadvantaged, dysfunction and disorganised families within the community.

**Table 2 Rates (%) of disadvantageous family background features, antenatal practices and perinatal outcomes amongst multiple problem and other teenagers**

| Measures | Multiple Problem Teenagers | Other | Odds |
|---|---|---|---|
| *Antenatal Practices and Perinatal Outcome* | | | |
| Pregnancy unplanned | 66.7 | 36.7 | 3.5 |
| Birth ex-nuptial | 55.6 | 14.3 | 7.5 |
| Mother did not attend antenatal classes | 77.8 | 60.2 | 2.3 |
| Mother failed to seek antenatal care before the fifth month of pregnancy | 22.2 | 4.2 | 6.5 |
| Mother smoked during pregnancy | 55.6 | 32.2 | 2.6 |
| Child required intensive care at birth | 33.3 | 16.2 | 2.6 |
| Child was not breastfed | 55.6 | 28.3 | 3.2 |



## Century Child Restraint Extension Strap Recall

- Consumer Affairs, Nov 1994 No. 1

Foldaway Industries has announced a recall of a faulty batch of child restraint extension straps. The straps are used in some cars to tether the child restraint to distant seat anchorage points. The faulty batch carries the marking "No:957" on a white tag attached to the extension strap. If you have one of these straps you should phone Foldaway Industries on free-phone 0508-222-437 for a free replacement. Straps carrying other batch numbers are safe to use.

## Women campaign for safe motherhood

Safe Motherhood - Issue 15, October 1994

For every woman who dies from the complications of pregnancy and childbirth in a developed country, there are 99 maternal deaths in the developing world. Yet in the last century maternal mortality was as high in Europe as it is in parts of Africa today.

What caused the change in Europe? Earlier this century, "women's organizations and medical professionals decided to take an active role in challenging fatalistic concepts and sought ways to reduce maternal deaths," according to a new WHO Document.

The activities of these organizations in Europe at the turn of the century are "no different from the activities needed and being undertaken in developing countries today," the document says.

The document, *Women's groups, NGOs and safe motherhood**, describes what women's groups and other nongovernmental organizations are doing to prevent and reduce maternal mortality and morbidity in countries throughout the world.

The efforts described include information, media campaigns, community education, health services, local and national events, meetings and workshops, and lobbying for better laws and policies. A range of issues is addressed – such as pregnancy and childbirth, unwanted pregnancy, abortion, adolescent sexuality and pregnancy, quality of care, counselling, reproductive tract infections, women's rights, and HIV/AIDS.

The intention of the document is to share experiences with people who are looking for ideas and examples that they can follow or adapt to their own situation. ■

# FEDERATION OF WOMEN'S HEALTH COUNCILS AND NATIONAL WOMEN'S HEALTH CONFERENCE

29-30 October 1994

Some of the resolutions from the Conference:

**Health Commissioner to Oversee Ethical Issues**
Women strongly recommend that all health and disability ethical review committees be placed under the umbrella of the Office of the Health Commissioner. As the Commissioner will be dealing with ther rights of health and disability consumers it is essential that ethical matters also come under her jurisdiction at the earliest possible opportunity.

**Putting Women's Health Back on the Agenda**
We demand that the Minister of Health designates women's health as a priority area within the health system and instructs Regional Health Authorities accordingly.

This will involve:

- the reinstatement of a women's health section and a women's health manager appointed at a senior level within the Ministry of Health;
- a specific women's health focus as a priority area within the Public Health Commission;
- a senior manager responsible for the development of women's health within all Regional health Authorities;
- a comprehensive national women's health policy, developed through extensive consultation with women's advocacy groups;
- meaningful consultation with women's health organisations in establishing priorities for women's health;
- adequate funding for community-based women's health organisations.

**Hui on Maori Women's Health**
There is strong support for the call by Maori women for government organisations to set up and resource a national hui to focus on and explore health and well-being for Maori women.

**Pacific Islands Advisors**
The Minister of Health is urged to provide directives to the Ministry of Health, the Public Health Commission and the Regional Health Authorities to urgently employ Pacific Island advisors.



# Articles of Interest

## Antenatal self care

- NZ Med Jnl, 28/7/93 pg 318-319

Over the last few years there has been a move towards increasing patients' involvement in their medical care. In the St Helens and National Womens Hospital antenatal clinic, women have been testing their urine for protein using dipsticks. They are taught at their first visit and then may ask for help at subsequent visits if they have difficulty.

We carried out a survey to assess the accuracy of dipstick testing during May 1993. One hundred antenatal patients on return visits were asked to dipstick their urine and record their result without assistance from the staff. The specimens were retested by a midwife with their knowledge and the results recorded separately. The two sets of results were then compared.

Fifty four results (54%) showed no difference between midwife and patient. Twenty four showed minor differences, for example between a trace of protein and negative. Nineteen results showed differences which would have significant implications for clinical management. In twelve instances there was no resemblance between the results. In seven instances the patient recorded a trace of protein and the midwife one + protein. Three patients stated that they did not know how to do the test and others were reluctant to test the urine for themselves and wanted the staff to interpret the results for them.

Antenatal urinalysis is important in the diagnosis of pre-eclampsia and is an aid to the diagnosis of asymptomatic renal disease and infection. One plus of protein measured on a dipstick is approximately equivalent to 0.3 g protein. Its significance needs to be determined by a 24 hour urine collection or a midstream urine sample depending on the clinical picture. False positives can arise from contamination from vaginal secretions and from certain drugs and antiseptics. In our survey only 54% of the results correlated with the midwives measurement which is cause for concern. Either better education for patients on how to perform this test is required or alternatively it should continue to be the responsibility of the clinic staff.

J Smalldridge
L Mc Cowan
N King
I Tolley
National Women's Hospital, Auckland.

## The Childhoods of Multiple Problem Adolescents: A 15-Year Longitudinal Study

David M Fergusson, L John Horwood and Michael Lynskey

*Summary of this article. Printed in Journal of Child Psychology & Psychiatry Vol 35, No 6 pp 1123-1140. 1994, Great Britain*

This paper examines the life history of a small group of adolescents (3%) who were identified during the course of a longitudinal study of a birth cohort of New Zealand children as displaying multiple problem behaviours at the age of 15 years. This group was characterised by conduct disorder, police contact, substance abuse behaviours, early onset sexual activity, suicidal ideation, mood disorders and lowered self esteem. Statistical biographies of this group of young people showed that many were the offspring of seriously disadvantaged, dysfunctional and disorganised home environments.

What, however, was of interest was the strength of this association and, particularly, the apparent effects of a generally advantaged home environment in protecting children from developing multiple problem behaviours. In particular, of the children whose family and childhood circumstances placed them in the most advantaged 50% of the cohort only one child (0.2%) was observed to develop

In order to finance the publications and to provide for an effective distribution, manufacturers who have an interest in the pregnancy and new mother market are asked to advertise and sample their products. All such advertising and promotion is carefully monitored by ***Bounty*** to ensure WHO, UNICEF and other requirements are strictly observed.

***Bounty Services*** would like to involve the services of Midwives, Practice Nurses and other Caregivers in the distribution of the Pregnancy Information Pack and the New Mother Pack. The benefits for Caregivers and hospitals could be in Bounty providing, for example, assistance with the purchase of specialised equipment, training courses, seminars or other mutually agreed resources. ***Bounty Services*** is committed to continual product improvement and encourages Caregivers to be involved with future editorial material and input with the ***Bounty*** products.

We look forward to your comments and feel confident you will find Bounty a valuable resource.

For more information and to obtain the Pregnancy Guide for your clients, please contact

*Anne Barnett (03-355-4983/025-3320393)*

*or*

*Helen O'Flynn (09-4436921 /025-764-174).*



**Restructuring of Primary Health Care**

There is a strong call from women for an immediate halt to any further implementation of the health restructuring programme and for the Government to urgently undertake meaningful consultation over the future of primary health care.

The Conference also recognised the urgent need for a critical reveiw of the health changes to ascertain the actual and likely social consequences and effects on public health of the present and any future changes.

**Medicalisation of Childbirth**

The Conference directs concerns to the Minister of Health about the increasing medicalisation of childbirth and the high incidence of operative births such as caesarean sections and forceps deliveries.

Rationale

With 24% operative births for 1993, the New Zealand childbirth statistics exposes us as well above the World Health Organisation recommended level for assisted operative deliveries.

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## *Private Lives?*

### AN INITIAL INVESTIGATION OF PRIVACY AND DISABILITY ISSUES

**QUESTION :** What is my legal position as a health practitioner regarding release of information about a patient? For example who can I release information to, what type of information, under what circumstances, with or without permission, in what form, written or verbal?

RESPONSE : A health practitioner should as a general rule maintain strict and absolute confidentiality except where it is necessary to use or disclosure the information for the purpose of dealing effectively with the current health care circumstances of the individual. In general, it would be wise for any other releases to occur on the basis of specific notice or informed consent.

As to federal health services and practitioners, the federal Privacy Act governs disclosures. Under the Information Privacy Principles disclosures are restricted to the following circumstances:

* where the individual is reasonably likely to be aware of the disclosures or has consented to the disclosure,

* where the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned of another person,

* where the disclosure is specifically authorised or required by law;

* where the disclosure is reasonably necessary for the enforcement of the criminal law or of a law imposing a pecuniary penalty.

As a general principle, any information released should be with the consent of the individual, limited to the minimum amount required for the purposes for which it is released and, if sufficient to meet the request, information should be provided in a de-identified form.

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## PICTORIAL MIDWIFERY

An Atlas of Midwifery for Pupil Midwives

BY

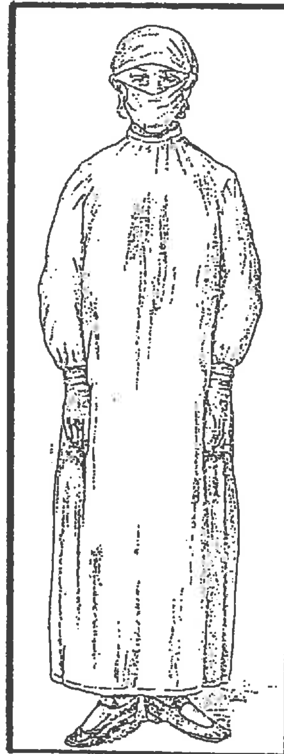
SIR COMYNS BERKELEY

MANAGEMENT OF SECOND STAGE

FIG. 112 - CORRECT DRESS FOR DELIVERING A PATIENT

A sterilized gown reaching down to the ankles. India rubber gloves into which the ends of the arms of the gown are tucked. A cap, or veil, to cover the head, and a mask to prevent droplet infection. India rubber boots, or linen boot-overalls, are used in hospitals.

The midwife, and also a doctor, should wear a mask and gloves when attending a patient in her confinement. Such articles form an efficient protection to the patient from the risk of infection, so far as the midwife and doctor are concerned. Moreover, the laity are now well aware that such articles should be used and, consequently, if they have not been used and infection occurs, there is a risk of legal proceedings. There have been several such of late years.



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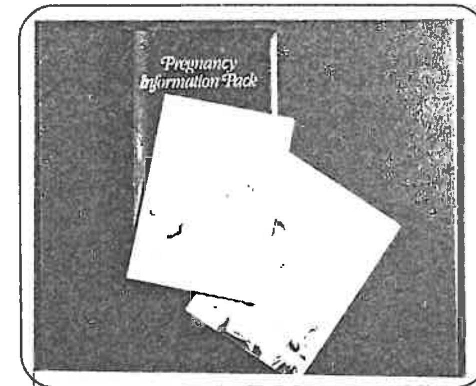
***Bounty Services Ltd*** will be introducing the ***Bounty*** concept to New Zealand as an extension of the highly professional and internationally recognised service already established in the UK, Europe, North America, Middle East and Australia.




***Bounty*** will be publishing two books, the **Pregnancy Guide** and the **Baby Care Guide**, in February 1995. These will be accompanied by three packs:- **Pregnancy Information Pack**, **Mother to be Pack** and **New Mother Pack** containing producers information and samples.

*Summary of recommendations re six week Check Diploma of Obstetrics. NWH 1993*

**SIX WEEK CHECK**

MOTHER-INFANT BOND

| MOTHER | BABY |
|---|---|
| **Functional Enquiry** | Review neonatal history |
| Coping / tiredness | Specific concerns |
| Feeding method | Sleeping / crying |
| Social supports | Feeding |
| Breasts | Development |
| Lochia | Physical examination |
| Perineum | (Record in Plunket Book) |
| Micturition | NB - hips, testes, femoral pulses, |
| Backache | heart sounds, skin, weight gain |
| Sexual activity | Immunisation |
| Mood | - Hep B |
| | - Hib / DPT |
| | - Set recall date for next immunisation |

**Examine**
Wt
BP
Breasts
Perineum
Pelvic examination (for specific identification)
Cervical smear due? - Recall
Edinburgh rating scale? PND
FBC / Fe study?

**Discuss**
Coping with motherhood
Contraception / sexual functioning
Cot death concerns
Labour debriefing / review obstetric history
Support breast-feeding

**Follow-up**
Next immunisation (also a mother check!)





## THE SIX WEEK CHECK

- The Completion of Midwifery Care

The six week post partum check of the woman and her baby has always been within the scope of practice of a midwife, yet most midwives are not providing this service.

Due to this fact and a strong lobby from some of the medical profession, the RHAs proposed that funding for maternity care should finish at two weeks after the birth rather than six weeks. This was announced at the recent Maternity Benefit Schedule negotiations and although strongly rejected by both the NZCOMI and NZMA, we are under real threat of having both our scope of practice reduced and the service we provide women and their babies.

**What can you do to prevent this happening?**

Offer the six week check for the woman and her baby, if you do not already do this. If you have the skills and expertise to provide the other aspects of care, you can also provide this service.

Attend a workshop if you need to update your skills. All chairpersons have been requested to organise a Six Week Check Workshop **early** in the new year.

**Misunderstandings about the 6-week check**

- Women must have a cervical smear.
  Assuming she is breast-feeding this is an inappropriate time for a woman to have a cervical smear as a lack of oestrogen at this time makes it difficult to obtain an adequate specimen. If a woman requires early follow up due to recent abnormal results she should see a specialist.

- A baby must have its first vaccination at the six week check.
  If parents wish their baby to commence the immunisation schedule at six weeks, the midwife has two options:
  - provide this vaccination; or
  - refer on to the GP for this service.

  The provision of immunisations is funded under a different schedule. Therefore if you have provided the six week check for a baby and do not give the vaccination, the parents can still obtain this service from their GP, free of charge.

- It is a good opportunity for the GP to recommence care for the family. But it is an even better time for the midwife to complete her care. Undoubtedly the benefits of continuity of care apply to this stage as they do to any other. With the knowledge obtained from the preceding care the midwife is the most appropriate practitioner to carry out this well woman and baby assessment.

The following correspondence is part of the organised lobby against midwives providing the six week check with the NZCOMI reply. The Medical Schools check list for obstetric diploma students outlines basic midwifery skills and further reinforces the role of the midwife in providing this service.

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THE UNIVERSITY OF AUCKLAND

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13 OCT 1994

7 October 1994

Dear Ms Denny

We are extremely concerned by the recent change in intent of the RHA to fund six week post-natal checks by Independent Midwives. This concern is for a small but very significant percentage of mothers or their babies for whom the six week check is a vital diagnostic opportunity that may have profound consequences if important conditions are missed. In addition to this, recent surveys in the medical literature have drawn attention to the high level of diverse morbidity experienced by women post-natally. For example, a survey of 11,701 women who delivered in a Birmingham hospital revealed that 47 per cent reported at least one of a list of 25 different symptoms, starting within three months of birth and lasting for at least six weeks[1]. We are concerned because midwives have not previously been trained and are not currently trained to perform this task that at times spans many medical specialties.

The six week check is one of the most challenging of all GP consultations. It has been said that for the midwife or the specialist obstetrician, maternity care progresses toward an ending, whereas for the family practitioner (and in particular the general practitioner obstetrician) it leads to a beginning. The six week check is the "initiation" of a new family member into a system of continuing primary health care provided by that family's chosen medical practitioner and his or her practice nurse. It is indeed the only opportunity offered by current funding arrangements for the GP and practice nurse team to offer a prolonged consultation at no cost to the patient. Within this consultation a number of important activities occur that require multifaceted medical skills. Briefly, they are:

1. A medical and psychosocial assessment of the mother.
2. A review of infant feeding and maternal bonding.
3. The medical examination and developmental assessment of the infant.
4. The instigation of immunisation programme and appropriate recall mechanisms.
5. A review of cervical screening and recall status.
6. The provision of family planning options.
7. A review of pregnancy, labour and delivery to enable "debriefing", if necessary, to occur.

Examples of important conditions that may be diagnosed in the mother include: post-natal depression, failure of maternal infant bonding, persisting perineal pain and associated sexual dysfunction and urinary incontinence. Examples of important conditions to be diagnosed in the infant include: feeding problems, failure to thrive, neurological or developmental disorders, congenital hip dysplasia, congenital heart disease, risk factors for cot death and a variety of skin conditions.





No other profession has the same depth of knowledge about normal childbirth. It is this knowledge which defines our profession just as medicine accountancy, law, physiotherapy etc has their specialty body of knowledge..

Midwifery draws from many disciplines but has a strong science-base with the added specialty dimension of psycho-social knowledge and skills which when combined make up the inherent nature of a midwife's skills. The tasks of resuscitation and other emergency measures, physical examination of women and newborn are expected competencies from any midwife wherever or whenever she is educated.

Examples of papers from current curricula are enclosed. These curricula are freely available from any midwifery school. Texts, assignments, references and workbooks are also available but are too extensive to include here.

Midwives who were trained in previous curricula reflected the knowledge and expectations of the day. It is not acceptable to say all these midwives are not competent in today's world. To do so is to deny individual experience, skills and ongoing education. It is no different to any other profession. Look back on the medical curriculum of twenty years ago and many of today's knowledge and skills are missing yet there is no organised campaign by midwives to deny these doctors the right to practice. Indeed midwives are involved in their re-education. Medicine must regain its perspective about midwives and midwifery and examine its motives behind this inability to accept colleagues expertise. Doctors in obstetrics rely on midwives to teach, guide and support them as do midwives rely on doctors - without this complementary system women, their babies and their families are denied a functioning and reliable maternity service.

Instead of working against each other both professions must find ways to heal this rift - all midwives are expecting is acceptance of the right to practice their profession in peace. It is disappointing that National Women's and the Auckland School of Medicine staff have not taken the opportunity to inform themselves about the education of midwives before slandering the profession in the manner chosen.

Yours sincerely

Karen Guilliland
**National Co-ordinator**

cc: Sam Denny
John Marwick, MOH
GP Association
RNZCOG
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Paediatric Society
Gillian Bishop

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The art and science of midwifery is well established and internationally recognised. The World Health Organisation definition adopted by the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians says, *"the midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the new born 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"*.

The midwives expertise then is on the normal aspects of pregnancy, childbirth and the newborn. It is this expertise which enables the midwife to assess, recognise and refer deviations from the norm. Medicines expertise is pathology with emphasis on diagnosis and treatment. There will be different levels of expertise however in both professions depending on an individuals experience.

Medicine therefore does not exist in isolation. It almost always relies on others bringing the problem to it! Without parents knowledge of their child as a normal functioning being, doctors would be without referral agents. Without the added (but different) knowledge and skill-base of Plunket nurses, Public Health nurses and GPs, specialists would be without a referral-base. Similarly without midwives, medical obstetrics would not only be without its referral-base but medical practitioners would be unable to practice obstetrics in its present form. Obstetrics, without exception has always relied on women and midwives working together in the normal birth process to recognise when the process has, or is likely to, deviate from normal and requiring medical input. Indeed some medical practitioners are unable to recognise normal, often medicalising what is essentially a deviation within normal limits. Midwives are the check and balance on that process as obstetricians are on the midwives diagnosis and observations. It must be a co-operative system to work. It relies on medicine trusting the professional right of midwives to exist and practice within standards set by their own profession. Internationally these standards are consistent and reliable. For as long as obstetrics has been a discipline it has in the main trusted midwives to call them in as necessary. Why is it that medicine is no longer apparently able to do that? The only change has been midwives statutory recognition lost in 1971 and regained in 1990. Consequently midwives now expect acknowledgment and respect for their professional judgment which has been previously taken for granted, often not even viewed as a skill at all, with midwifery care and assessments invisible until the medical 'expert' arrives.

Midwives today are taught from a comprehensive integrated curriculum specifically dedicated to childbirth from pre-conception to six weeks postpartum. Because their education focuses intensively on the "normal" progress of a woman and baby through pregnancy, birth and the postnatal period, as well as on the ability of midwives to make individual assessments enabling identification of each woman's individual range of "normal", their assessment skills are of a very high standard and incorporate evidence from all aspects of woman's life and environment.



Up until the present time midwives have not had the opportunity to acquire the full range of knowledge or skills necessary for a complete six week check. We are not aware of any sufficient component of their current training that would enable the six week check to be safe for mothers or infants with important but obscure diagnostic problems. We expect, therefore, that a considerable learning curve would have to occur at the expense of the current generation of New Zealand women and children.

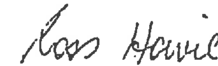
We would expect North Health to have given due regard to the safety implications of its innovative decision on this matter and suggest the following as minimum requirements in establishing such a position.

1. To have made available evidence of existing successful models for this change in family health care, with the emphasis upon proven safety.
2. To have consulted with a body of primary health care providers who have extensive experience and expertise in performing six week checks.
3. To have sought independent specialist advice concerning the specially relevant areas of diagnostic concern. This should include not only paediatricians and obstetricians, but also practice nurses, a psychiatrist, a paediatric orthopaedic surgeon, a paediatric infectious diseases specialist (re implications for New Zealand's immunisation programme), a paediatric cardiologist as well as Plunket and Family Planning advisers.
4. North Health should ensure that midwives who perform six week checks are prepared to inform women of the scope of their previous training and practice and the absence of any formal medical training.

In conclusion, we believe that in regard to this issue, by increasing options we have simply produced fragmentation and that continuity of care, in its wider context, has reverted to discontinuity of care. Most New Zealand women see the general practitioner of their choice for a six week check. They see value for themselves and their families in establishing a long-term and continuing relationship with a general practitioner and practice nurse team. We believe it remains one of the few aspects of our sorely strained health care system that people continue to value and respect. We do not believe that attempting to dismantle it serves the public health of New Zealand in any way.

Yours sincerely

William Ferguson
Clinical Teacher in General Practice
Kumeu Village Medical Centre
KUMEU



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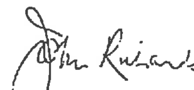

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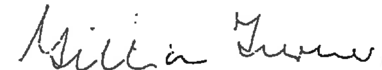

Gillian Turner
Postgraduate Professor and Head of Department
Department of Obstetrics and Gynaecology
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cc Gillian Bishop
Project Manager for Contracts
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Maternity Services Committee
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Mr C. Geddes
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# National Women's

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4 NOV 1994

28 October 1994

Sam Denny
Maternity Services Manager
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Dear Ms Denny

Re : Six Week Postnatal Checks by Independent Midwives

The paediatricians at National Women's Hospital are opposed to the intention of the RHA to fund six week postnatal checks by independent midwives.

We are concerned that midwives are not trained in the diagnosis of conditions in the infants such as congenital heart disease, congenital hip dysplasia, neurological and developmental disorders, feeding problems and failure to thrive. If the diagnosis of the important conditions is missed at an early stage when the signs may be subtle, long term consequences can be very serious for the child and their family. The independent midwives do not have this training in paediatric examination and differential diagnoses nor the ongoing care and treatment of the infant. This is a time that a course of immunisation should be discussed and commenced. The medical examination performed at 6 weeks is important for the future health of the baby and should be done by a medical practitioner who has both the appropriate training and ongoing care of the infant and family. Babies deserve the best quality of care possible.

Yours sincerely

Dr D B Knight
NEONATOLOGIST

Dr Tania Gunn
PAEDIATRICIAN

Dr Simon Rowley
PAEDIATRICIAN

Dr Peter Nobbs
PAEDIATRICIAN

Dr Guy Bloomfield
PAEDIATRICIAN

Dr Jane Harding
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The President Perinatal Society
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Mr C Geddes
North Health

# NEW ZEALAND COLLEGE OF MIDWIVES (INC)

15 November 1994

William Ferguson/Professor Gillian Turner/Jane Harding
School of Medicine
Department of Obstetrics & Gynecology
National Women's Hospital
Claude Road
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AUCKLAND

COPY

To: Teaching Staff School of Medicine

It was with amazement and increasing concern the College of Midwives read your letter to North Health regarding midwifery involvement in the six week postnatal check. Amazement that there is so little knowledge or understanding by educators of the medical workforce about the midwife's scope of practice or the education which governs that practice and concern at the prejudicial assumptions made by a university department staff which have little basis in fact.

Midwives have always been taught to perform the six week postnatal check on mothers and their babies. Independent midwives in New Zealand have been undertaking this examination on their own responsibility for the last four years. It is not a new service as implied by your letter.

The sheet enclosed from the Diploma of Obstetrics could have come from any midwifery curriculum in New Zealand, indeed many of those factors are basic competencies required in a general nursing programme. There is nothing exclusively medical about any of the topics identified. The difference in the midwifery curriculum is that the topic is much more extensively covered than in either medicine or nursing.

With the current move to continuity of care many midwives are very closely involved with their clients from early pregnancy to at least six week postnatally. They are able to develop close and trusting relationships through this very important time of transition for a woman and her family, and are often privy to information which is relevant to the health and well-being of the woman, her baby and the rest of the family. At the time of discharge the midwife refers the woman onto the health care provider of her choice, usually the GP and the Plunket nurse. Midwives strongly dispute that this leads to discontinuity of care. Returning to the GP for the six week examination is always an option offered to women by midwives, and one which some women choose. Some women opt to see the practice nurse for the six week immunisation as she will be the person most likely to continue with the follow-up vaccinations, indeed many midwives recommend this. When women do not have GPs (increasingly common), midwives will assist a woman to find a GP who best suits their needs.

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