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

Sian BURGESS
17 Malvern Rd
Mt Albert
AUCKLAND 1003

****
* POSTAGE PAID *
* Christchurch NZ *
* Permit No. 2843 *
****

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

NATIONAL NEWSLETTER

September/October 1994

Goodbye to Steph Breen

Risk, Risk Assessment and Risk Labels

Physical Examination of the Full Term Baby

Interchangeable Multi-Source Medicines

NEW ZEALAND COLLEGE OF MIDWIVES (INC)
National Committee

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

BOARD OF MANAGEMENT

National Co-ordinator	*Karen Guilliland*	Phone 03-377-2732
906-908 Colombo Street	Christchurch 8000	Fax 03-377-2732
President	*Sally Pairman*	Phone 03-467-5046
90 Cannington Road	Maori Hill Dunedin	
Treasurer	*Linda Collier*	Phone 03-384-2288
48 Augusta Street	Christchurch 8008	
Newsletter Editor	*Julie Richards*	Phone 03-377-2481
81 Caledonian Road	Christchurch 8002	
Secretary	*Judy Henderson*	Phone 03-377-2732
906-908 Colombo Street	Christchurch 8000	

Northland
JANE FOX
RD 1 Okaihau
Bay of Plenty

Auckland
SANDY McAULEY
P O Box 24-403
Royal Oak Auckland

Wanganui/Taranaki
TRICIA THOMPSON
15 Stokes Street
New Plymouth

Maori Midwives Collective
TUI HAUPAPA
HOARANGI BIDDLE
RANGIMARIE HOHAIA
KATE SALMONS

Maternity Action Alliance
REA DAELLENBACH
8b McMillan Avenue
Christchurch

Waikato/BOP
VIOLET STOCK
c/- Tauranga Maternity
Annex Tauranga

LYN McCROSKERY
853 Te Pahu Road
RD 5 Hamilton

Canterbury/West Coast
JACQUI ANDERSON
P O Box 21-106
Christchurch

Wellington
BERYL DAVIES
P O Box 9600
Wellington

Parents Centres (NZ)
SHARRON COLE
12 Elmslie Place
Rotorua

Otago
ADRIENNE MULQUEEN
Harrington Pt Road
RD 2 Dunedin

Southland
JO MAWDSLEY
P O Box 31
Queenstown

Nelson
MARIANNE DUNCAN
15 Seaton Street
Nelson

Eastern/Central Districts
RUTH MARTIS
467 Church Street
Palmerston North

Home Birth Assoc
GLYNETTE GAINFORT
40a Paine Street
Tauranga

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	

REGIONAL 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	

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

NATIONAL TREASURERS / MEMBERSHIP PERSONS

SOUTHLAND
Marion Ferguson
56 Glenalmond Crescent
Invercargill

WELLINGTON
Lynley Davidson
25 Freeling Street
Island Bay

WANGANUI/TARANAKI
Sheryl Ross
Flat 1 Hawera Hospital
Hawera

WAIKATO/BAY OF PLENTY
Heather McFarlane
3 Frederick Drive
Hamilton

NELSON
Wendy Brookes
P O Box 672
Nelson

NORTHLAND
Betty Trenn
c/- Antenatal Clinic
Whangarei Hospital
Whangarei

OTAGO
Catherine Lynch
7 Morton Street
NEV Dunedin

AUCKLAND
The Treasurer
P O Box 24-403
Royal Oak Auckland

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

EASTERN / CENTRAL
Mary Mather
27 Shamrock Street
Palmerston North

LESBIANISM CAUSE STUDIED

By Michelle Nicolosi - Christchurch Press 6/9/94

Lesbianism in some women may be an inherited trait, not a lifestyle choice, according to a paper presented at the 76th annual Endocrine Society meeting in Anaheim, Los Angeles.

"We cannot assume that homosexuality is psychological," says Dr Robert Blizzard, who presented a review of studies and case histories on the subject. "At least in some instances I would say it is probable that it is an inborn trait."

Dr Blizzard, a retired University of Virginia professor, worked for 40 years with hundreds of patients with an adrenal-gland disorder that causes foetuses to produce too much male hormone called androgen.

He and other experts have observed that women born with the condition are more likely than most to be lesbians as adults.

Studies have shown that by injecting rodents with androgens, "you can take a chromosomally normal female and change sexual preference," says Dr Blizzard. He theorises that over-exposure to androgen in human foetuses has the same effect. The theory fits with recent studies on possible biological causes of homosexuality. ■

CONTENTS

MIDWIFERY STANDARDS REVIEW WORKSHOP

Regional Chairpersons

Friday 25th November 1994

10.00am - 6.00pm

Observers Welcome

NEXT NATIONAL COMMITTEE MEETING

Friday 25th November 6.00pm

Saturday 26th November 9.00am - 6.00pm

Midwifery Resource Centre Christchurch

OBSERVERS WELCOME

DEADLINE

for the next Newsletter is
1st December 1994
Posted
19th December 1994

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

PUBLISHING DETAILS

Editor - Julie Richards
Typesetting - Margaret Stacey
Printing & Collating by
MAS Business Services, Chch

Editorial

Hello, and welcome to the September/October newsletter.

This issue is filled with many pieces of vital information from small snippets to full length articles. We have received an influx of information on conferences for 1995 - so check these carefully.

You should have all received a copy of the latest Journal. Helen Manoharan, you've created another work of art.

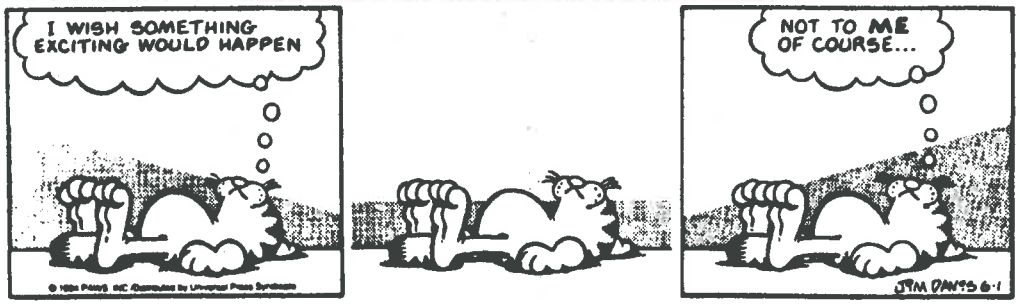
Many thanks to those of you who have sent me information. It ensures your newsletter has a local as well as national flavour and of course reassures me that you're reading it.

Look out for the Birth Registers and Birth Certificates - I can personally recommend them. Enjoy!

Julie Richards

NEWSLETTER DATES - 1994/95

Deadline	Posted
01 December	19 December
01 February	20 February
01 April	24 April
01 June	26 June
01 August	28 August



Book Review

From: Journal Human Lactation, Vol 10, No. 3 Sept 1994

Protecting, Promoting And Supporting Breastfeeding: The Handbook of the New Zealand College of Midwives

Dunedin: Right Words NZ Ltd, 1992 112 pages - illustrated - (NZ)$19.95 - softcover Orders: Midwifery Resource Centre, P O Box 21-106 Christchurch, New Zealand; Ph/Fax 03-377-2732

The New Zealand College of Midwives found that inconsistent advice was the main complaint women had about their breastfeeding experience. They decided that a review of current literature was needed and set about collecting, reviewing, and organizing data to produce this compact handbook. Although aimed at midwives, this handbook will benefit all those working within maternal and infant services dedaling with breastfeeding.

This handbook offers all basic breastfeeding information divided into eight sections. Each section is well referenced. The first section starts with an overview of the WHO code, followed by sections which include basic anatomy and physiology of the breast. Specific problems that relate to the baby such as jaundice, prematurity and rousing a sleepy baby are competently dealt with. Further sections deal with maternal problems including normal breast fullness versus engorgement, plugged ducts and thrush to mention a few.

A guide to taking breastfeeding history is given and consent forms are outlined for hospital use. These are designed to make sure women have all the basic facts about the negative effects of such practices as completmentary feeds and the use of nipple shields. This enables women to make informed choices.

The illustrations are helpful, appropriate, and clearly outlined; the photos are of realistic situations and add a feeling of naturalness. A subject index at the back of the book would have aided quick referencing of information. Also the list of resource groups would have been of greater value with accompanying addresses.

Overall this is a well planned and presented book, with up-to-date, thoroughly researched basic information to guide midwives and health professionals. The authors have met their goal of giving consistent, sound research based advice. This book was endorsed at the New Zealand College of Midwives Inc., Annual General Meeting, Dunedin, in August 1990.

Sharon Jones, RM, IBCLC
Auckland Aew Zealand

'Unnecessary' diabetes test concerns parent advocates

by Ashley Campbell

Parents' advocates have spoken out against what they see as an unnecessary trial of a diabetes screening test for pregnant women.

They claim pregnant women throughout the country are being asked to take the polycose test without being told it is voluntary, or that it is part of a national trial.

Sharron Cole, national president of the Parents Centre organisation, said she became aware a few months ago that many women attending her antenatal classes in Rotorua were asking about gestational diabetes (diabetes occurring during pregnancy).

Ms Cole said even women who had no risk factors suggesting they would develop diabetes were being asked to take the test.

"They are not being told it's a trial, and that it's a test that has a very high failure rate," she said.

The test is used to determine which women should have a glucose tolerance test, which determines whether they have diabetes or not. But Ms Cole said the polycose test had a high failure rate.

Gestational diabetes can cause several problems, the most common being very large babies, which can lead to problems during delivery.

Women who develop gestational diabetes, which usually disappears once the baby is born, are also more likely to develop diabetes later in life.

Ms Cole said she believed the polycose test was useful for women who had some risk of developing diabetes, but she questioned why so many women were being urged to take it.

And she claimed the test, which involves swallowing a large amount of sugar, could have unpleasant side-effects that women should be aware of.

As the woman's body tried to balance out its blood sugar, important trace minerals such as zinc and chromium were leached from her body, she said. Anecdotal evidence suggested it lowered the woman's immunity.

The Ministry of Health's chief medical adviser Colin Feek said a national research project to document the effects of gestational diabetes was taking place, and the polycose test was part of this. However, not every area in the country was involved, and Dr Feek did not believe Nelson was taking part.

But Dr Feek said the polycose test was an international standard for diabetes screening, and he was not aware of any side-effects.

Nelson-Marlborough chairwoman of the College of Midwives, Marianne Duncan, said at a clinical meeting involving GPs, midwives and obstetricians about three months ago, pathologist Charles Cameron asked for more women to be given the test.

"Medical practitioners and midwives were left with the impression that to ensure the figures were accurate, more women should be encouraged (to take the test)," Mrs Duncan said.

But she said independent midwives would never administer the test without gaining informed consent from the woman first.

And pathologist Stephen Clark, who attended the meeting in Nelson, said GPs and midwives were urged to offer the test simply because "it's another screening mechanism for diabetes".

"Nobody here feels very strongly about it," he said. "If mothers don't want to have it, they don't have it."

NELSON EVENING MAIL 21/8/94

Maternity Services Referral Criteria Update

The establishment of this criteria is a joint RHA project in consultation with national representatives of midwives, obstetricians, general practitioners, anaesthetists and paediatricians. The College is awaiting a further meeting following the second draft of this document.

The College has opposed the principle of labelling women using risk criteria. The College representatives are working to ensure the referral criteria do not become a risk list. The following is a letter recently sent to Gillian Bishop of the Central RHA regarding the referral criteria.

"Dear Gillian,
re : **Maternity Services Referral Criteria**

We understand the RHAs recently received a letter from the Royal New Zealand College of General Practitioners outlining their concerns about the Maternity Referral Criteria document.

The College of Midwives (Inc), as you know, endorses many of the comments outlined by the doctors. We agree with their view that the refrral lists are unlikely to be utilised as they impinge on women's right to self determination and choice and the health professionals clinical judgement based on individual assessment.

We agree also that the referral list approach is:

- Unscientific
- Unnecessarily beaurecratic
- Costly (because of unnecessary referrals to secondary care)
- Inappropriately applied across practitioners where there are variations in experience and skills
- Inequitable for rural women and decreases (even obliterates) choice of practitioners and place of birth. Centralisation also provides major problems for rural practitioners. Isolation also means rural communities will have difficulty attracting practitioners.

The College does not however agree with the doctors concerns on the safety of midwifery practice. There are numerous studies which support independent midwifery and we have included some for your interest. It should also be pointed out that none of the studies quoted by NZGPA identified the extent of the midwife or GP involvement and the effect of this involvement on outcomes. In many of their cases reviewed the midwife may have been the only person present during labour and birth. It has been common practice in the past for the GP to take a minimal role in the birth process. This is not to denigrate or ignore the place of the GP in primary maternity care history, but rather to acknowledge the often ignored role of the midwife.

Yours sincerely,
Karen Guilliland, National Co-ordinator"

SAMPLES OF

THE SCIENTIFIC SUPPORT FOR MIDWIFERY

Montgomery TA *Case for nurse-midwives. Am J Obstet Gynecol,* 1969;105:3. Data showing superiority of certified nurse-midwives in hospital setting as measured by lower mortalities and rates of prematurity compared to doctors in same hospital setting with same population demographies.

Levy B, et al. *Reducing neonatal mortality rates with nurse-midwives.* **Am J Obstet Gynecol,** 1971;109:50-59. Data showing superiority of certified nurse-midwives compared to doctors in same hospital setting.

Mehl L, et al. *Outcomes of elective home births.* **J Reprod Med,** 1977;19:281-290. Gives data showing safety of home births attended by Direct-Entry ("Lay" midwives.

Mehl L. *Scientific research on childbirth alternatives and what it tells us about hospital practice.* **In: 21st Century Obstetrics. NAPSAC International Public,** 1978;1:171-207. Only matched population study ever done on the relative safety of home vs hospital. 2092 matched pairs. Shows home birth safer than hospital when assisted by midwife or family physician.

Burnett C, et al. *Home delivery and neonatal mortality in North Caroline.* **J Am Med Assoc,** 1980;244:2741-2745. Excellent study showing safety of planned, attended home births with direct entry (lay) midwives or family physicians.

Taffel S. *Midwive and out-of-hospital deliveries in the US.* **US Center for Health Statistics, 1984. (Series 21, No 40).** Gives data showing that, in hospital and at home, midwives get better outcomes as measured by lower rates of prematurity and low-birth-weight babies.

Tew M. *Safety in intranatal care: the statistics.* **In: Survey of British Births.** OUP, 1985. 80% of women could more safety give birth at home with midwife or general practitioner than by the usual practices of obstetric specialists in hospitals.

Hinds M, et al. *Neonatal outcome of planned versus unplanned out-of-hospital births in Kentucky.* **J Am Med Assoc,** 1985;253:1578-1582. Safety of home birth attended by direct entry midwives. Corroborates Reference 8.

Kloosterman GJ. *Why midwifery?* **Practicing Midwife,** 1985;2:5-10. Midwifery outcomes from 16th century to present show consistently better results than doctors. Dutch data for 1982 (when Holland had 40% home births) shows significantly better outcomes for home over hospital with care of direct entry midwives.

WHO. *Appropriate technology for birth.* **Lancet,** 1985;ii:436-437. Recommends training and use of direct entry midwives as best way to help improve pregnancy outcome worldwide, including developed countries.

Tew M. *The practices of birth attendants and the safety of birth.* **Midwifery,** 1985;1:1-8. Overuse of hospital for birth increases overall death rates. Natural approach of midwifery results in better outcomes for women and babies.

Louden I. *Obstetric care, social class and maternal mortality.* **Br Med J,**

which still claim a benefit from fluoridation, or find no association with hip fractures or bone cancer. These less comprehensive studies, according to the Public Health Commission's new report, make the balance of evidence such that fluoridation should continue. However, in spite of that and other instances of obvious bias, the new report, unlike earlier ones, does list most of the evidence for and against fluoridation - and so has had to admit that there is some evidence of harm resulting from the procedure. Thus the earlier claims - of "absolutely no evidence of harm", or that fluoridation is "perfectly safe" - have had to be abandoned. The report also admits that more research is needed into the safety of fluoridation because present evidence is "inconclusive". Many citizens will not appreciate being compelled to receive an uncontrolled dose of a controversial chemical, while the conservative orthodox medical profession makes up its mind.

John Colquhoun BDS PhD
Honorary Research Fellow, University of Auckland

Funding arrangement paves way for maternity services

CH CH Press 2/9/94

A new funding arrangement between Healthlink South and the Southern Regional Health Authority has helped secure maternity services at Lincoln and Rangiora hospitals.

The chief executive of Healthlink South, Paul Wylie, said that under the new arrangement the Crown health enterprise would be funded on a per-patient basis. Traditionally, maternity services had been bulk-funded.

The CHE was pleased it could continue to offer maternity services at three locations, but the decision on whether those services were retained lay with the community, Mr Wylie said.

"We're happy to let the mothers make the decisions. If people choose to come to us we'll get the funding, and if they don't we will have to act accordingly."

Under bulk-funding the level of funding struck each year was based on demand for the service during the previous financial year.

Mr Wylie said that system was inflexible and unsatisfactory. The new funding system addressed that problem. It meant the CHE was paid for the work it did.

Mr Wylie said the CHE and the health authority had been negotiating the new deal for many months.

The result was a "sensible approach" to funding that allowed the CHE to offer a service that looked after itself and eliminated the need to redirect funding from other services.

"The beauty of it is if we fill the beds we get the money," he said.

"The downside is that if people choose to go elsewhere we don't get the money."

- Christchurch Press 24/8/94

Female civil servants paid less than males

CH CH Press 24/8/94.

WELLINGTON — Sixty per cent of female public servants earn less than $30,000 a year, but only 24 per cent of their male colleagues are in the same salary group.

Salary statistics from 37 government departments to June this year show that most public servants — 90 per cent — earn less than $50,000 gross a year.

More men than women are in the higher salary brackets, with 2.1 per cent of men earning $80,000 or more, compared with 0.3 per cent of women.

The figures cover 20,436 women and 16,421 men and are calculated as full-time equivalents. For example, a person earning $41,000 and working half-time would be recorded as 0.5 in the $40,000-$44,999 category.

The survey, by the State Services Commission, does not include staff in State owned enterprises, schools, or Crown health enterprises.

The largest group of women, 29 per cent, are in the $25,000 to $29,000 bracket, while 40 per cent of men earn between $30,000 and $40,000.

General wage statistics put average weekly earnings for males at $680.31 ($35,376 a year) and for females $497.80 ($25,885).

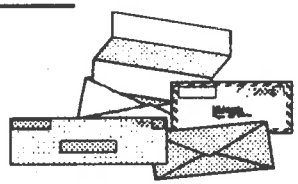
SSC human resources spokeswoman Julie Craig said its latest data suggested that more women were starting to move into management positions in the State sector but that had yet to impact on the salary statistics.

The scope for salary movement for women had been limited because the public sector had not been recruiting much in recent years.

Public Service Association general secretary David Thorp said his organisation believed that the gap in salary levels was widening because equal employment opportunity programmes were not being implemented. —NZPA

LETTER TO THE EDITOR

Star Midweek, Dunedin
August 1994



On reading the Public Health Commission's latest report supporting fluoridation, I was reminded of a recent article in the English medical journal The Lancet entitled "Is the study worth doing?" The article stressed the elementary statistical fact that the degree of uncertainty increases with decreasing size of the sample of subjects studied, and stated "studies that are too small may fail to detect medically important effects or produce estimates too imprecise to be useful." The latest pro-fluoride report defies such common-sense advise. It criticises the recent large-scale comprehensive studies which report little or no benefit from water fluoridation, or a significant association between fluoridation and the increase in hip fractures in the elderly and bone cancer in young men, claiming such studies are "unsubstantiated". On the other hand the report overlooks obvious defects of the more numerous small-sample studies which still claim a benefit from fluoridation, or find no association with hip fractures or bone cancer.

1986;293:606-608. Published data since 1785 shows that improvements in pregnancy outcome since 1900 cannot be due to increased obstetric intervention, nor hospitals, that these technologies are more closely correlated with bad outcomes than good.

"The quality of CNM care is equivalent to physicians care within their area of competence, according to a 1986 study by the Office of Technology Assessment. Further, they are better than physicians at providing services which depend on communication with patients and preventive action". (Source: Department of Health and Human Services, Office of Inspector General, "A Survey of Certified Nurse-Midwives", March 1992, p. F-2).

The Medical University of South Carolina Twin Clinic study demonstrated a lower rate of very early preterm births, very low birthweight infants, neonatal intensive care admissions, and perinatal mortality in a CNM directed clinic where CNM care is given when compared to a MD directed team where MD care is given. This demonstrated that the contribution of CNMs to high-risk prenatal care can be considerable. (Source: "Certified Nurse-Midwife Directed Twin Clinic Reduces Very Low Birthweight Delivery and Perinatal Mortality". Ellings, Janna M., et al. Accepted for publication in Journal of Obstetrics and Gynecology in 1993).

BIRTH CERTIFICATES

Midwives : something extra special for your clients. These beautiful certificates are A5 size and available in green, purple, buff, lilac.

ONLY $10 for 25 Certificates

Please send money with your order to:
Dunedin Home Birth Association, c/- 17 King George Street, Broad Bay, Dunedin

Upcoming Events

Domiciliary Midwives Workshop

11th, 12th, & 13th November 1994 Capital House, Wellington

A forum for midwives who attend women planning to birth at home, to discuss any aspects of their practice.

You are required to be a member of the Domiciliary Midwives Society but may join at the time.

The workshop will run from 5pm 11th November to 2pm 13th November.
All enquiries to: Jenny Johnson, PDC Waiomu Thames Ph: (07) 868-2116

NZCOMI Eastern & Central Districts Regional Midwives Workshop

12th - 13th November 1995 COST : $20-45.00
Manawatu Polytechnic, Grey Street Campus, Palmerston North

Contact: Nicky Budding, 7 McDonald Place, Palmerston North Ph: (06) 354-5936

Hurry registration closes 30th October!

International Year of the Family Conference

1st-3rd December 1994 Auckland
Contact: Moira Ransom, IYF Committee, Private Bag 21, Wellington
Ph: (04) 473-5872 Fax: (04) 474-3426

BIRTH ISSUES - 1st Annual Conference

Choices - Decision Making and Control

University of Melbourne - Melbourne - 18-20 November 1994

COST : A$295.00

Pre Conference Workshops 17 & 18 November 1994 COST A$110-195.00

A one day Conference will be held in Brisbane **Wednesday 16 November 1994**

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

EVENING POST 29/9/94

All GPs put on pregnancy alert

By JAMES HOLLINGS
Health reporter

GPs have been warned to be alert for the possibility of pregnancy in female patients of child-bearing age.

The extraordinary warning comes from the Auckland Divisional Disciplinary Committee of the Medical Council after a GP failed to observe that a woman was five months pregnant.

The fit 34-year-old woman saw her GP two months after stopping the pill, with no period, breast tenderness and abdominal swelling. A provisional diagnosis of post-pill amenorrhea (no period) was made. Three months later she went back to the GP with weight gain, mood swings and stress incontinence. The GP's diagnosis was unchanged.

A month later she asked to see a specialist who found she was six months pregnant. Her GP had not performed a pregnancy test or physical examination at any stage.

The committee said the case "emphasises the need for all GPs to be constantly alert to the possibility of pregnancy in female patients of child-bearing age."

GPs should exclude the possibility of pregnancy by conducting tests before alerting the patient to other possible causes.

Committee chairman Dr Stuart Brown said today the doctor was "very very contrite" about the case. But he refused to name the doctor, saying it could make identification of the patient easier.

He said the doctor was neither old nor incompetent, but had simply got an idea in his head that the woman could not have been pregnant because she had recently been on the pill.

"The problem is that it's very common for women to have no periods for some time after a long time on the pill. That's why he got sucked in. He should have been more alert, but it's understandable. I would be very suprised if this guy ever does it again." The woman now had a healthy baby, he said.

FOOTROT FLATS by Murray Ball

Benefits of feeding breastmilk pushed

by Kathryn McNeil

CH CH PRESS 23/8/94

A Christchurch dietitian is promoting exclusive breast-feeding as a means to improve infant health and nutrition.

Gendy Brown said her enthusiasm for breast-feeding came from working in Oman, where an international campaign called the baby-friendly hospital initiative is proving successful in reducing infant mortality and improving nutrition.

In 1981 the World Health Assembly adopted an international code of marketing for breast-milk substitutes. New Zealand was one of 118 countries to adopt the code, but successive governments had been slow to put the articles of the code into legislation, she said.

The initiative was launched by the World Health Organisation and Unicef in 1991, with the aim of promoting breast-feeding worldwide.

New Zealand was yet to take up the initiative, and developing countries were leading the way, Mrs Brown said.

In Oman all infant formula, bottles, and teats were removed from baby-friendly hospitals, and were only available on prescription.

Women there were not given the option of using baby formula, and Mrs Brown said the assumption in New Zealand should be that mothers would breast-feed as a matter of course.

Research indicated that the longer babies were exclusively breast-fed, the healthier they were. They developed fewer allergies, had a lower incidence of cot death, had healthier immune systems, and improved cognitive development, she said.

As a signatory to the code, New Zealand had an obligation by ensuring hospitals and health workers participated in the campaign.

Mrs Brown expressed concern that New Zealand Government funding for the campaign had not yet been secured.

The issue became political when one considered that New Zealand was a leading manufacturer of milk products.

All children would benefit from a return to traditional feeding techniques. A growing number of New Zealand dietitians were concerned at low breast-feeding rates, Mrs Brown said.

The initiative urges mothers to breast-feed exclusively for the first four to six months, unless medically indicated.

FREE CHILDBIRTH EDUCATION URGED cont'd

"Most people are motivated to be good parents, but many don't have access to the information that allows that to happen."

The role of childbirth educators was more important now than ever. "We are fulfilling the role of the extended family, providing new parents with information and support." "Nobody here feels very strongly about it," he said. "If mothers don't want to have it, they don't have it." ●

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 and Karen Guilliland

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]

One Day Workshop with Chloe Fisher

22nd March 1995
Christchurch Medical School
Call for papers - please submit by 30th November 1994

Further Enquiries: Heather Jackson
38 Seaview Terrace
Mt Albert, Auckland

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 : £180 for waged
£ 90 for students/unwaged

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

Breastfeeding - Refresh, Renew, Revitalize

Melbourne : 1st and 2nd April 1995
Brisbane : 20th and 21st May 1995

PLUS

Breastfeeding Update & IBLCE Exam Preparation Seminar

Brisbane 22nd May 1995

Seminars conducted by : Mary Lantry, Angela Smith and Ruth Worgan

Cost : $175 if paid before 15th March 1995 or 1st May 1995.

Contact : CAPERS
P O Box 567
Nundah
Queensland 4012
Phone 02 266 9573 Fax 07 260 5009

give birth alone at home or have babies they do not want. The personal and social costs of this don't bear thinking about.

North Health, the northern regional health authority which funds A-plus, is increasingly fixated on the concept of "eligible" residents. It doesn't want to pay for people whom central government hasn't given it any funding for.

North Health wants people to prove their "eligibility" before they get services; hence it plans a massive data base of "good" citizens, so it can make the "bad" ones pay.

But this approach destroys the purpose of our public health system, which is to protect the health of the population and provide universal access. I'm waiting for health professional groups to protest that these new policies violate their professional ethics.

And National Women's is only the start of the rot. Soon other hospitals, including emergency and accident services, will follow suit.

Would any decent New Zealander want parents to remove their premature baby from the neo-natal intensive care unit because they can't pay? Or see a woman, whatever her citizenship status, labour agonisingly on because she can't afford a caesarean?

Of course this is what happens in America. The charity hospitals collect rubbish sacks full of identification braclets from people who can't pay and who have been thrown out by paying hospitals.

In New Zealand we used to do better. Used to, being the operative word. We are now in the midst of the brave new world of health "reforms".

The message is: If you're about to have a baby, take your passport and your chequebook along with the nappies. Then everything will be A-plus.

FREE CHILDBIRTH EDUCATION URGED

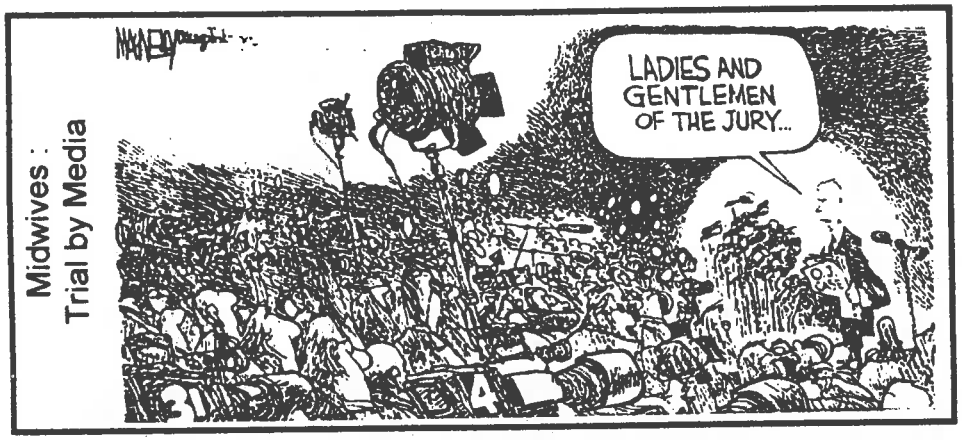
By Kathryn McNeil, Christchurch Press 12/9/94

Childbirth education should be freely available to all new parents as part of the maternity benefit, says the national co-ordinator of Childbirth Education New Zealand, Wendy Maw. A lack of parenting skills has been widely blamed for the violent deaths of five children in the past month. Mrs Maw said it was estimated only 53 per cent of New Zealand women expecting their first baby received recognised parenting education.

The maternity benefit, paid by the Government to doctors and midwives, covered ante-natal care and delivery but not ante-natal education. The benefits of childbirth education to the family and the community were long-term and far-reaching, and should be available to all new parents, Mrs Maw said. Funding ante-natal classes as part of the maternity package would put a fence at the top of the cliff, reducing the incidence of social agencies having to pick up the pieces, she said.

It was generally accepted that many parents were ill-prepared for the task of bringing up children, said Mrs Maw. People needed to acknowledge society had changed, and many new parents lacked good role models and had no extended family to offer support. The Year of the Family was a chance for childbirth education to begin to become a cultural norm. cont'd on page 42

Media Watch



Hospitals check passports before pulses

- Sunday Times, 7/8/94. Report by Sandra Coney

Welcome to the new era of chequebook-driven public hospital services. The Auckland central crown health enterprise has recently issued instructions to staff on how to extract money from non-New Zealand residents who want to enter National Women's Hospital.

Auckland Central CHE calls itself A-plus. Like Good Health Wanganui, it seems to think that a positive corporate image will convince us of excellence.

The memo from A-plus sets out fees for non-residents and the conditions under which they will get treatment. The first antenatal visit costs a massive $200, normal labour costs $50 per hour (better keep it short), a premature labour, $900 all up. A caesarean costs $3,000, a delivery per vagina $500.

Gynaecological services are similarly itemised. One visit to the colposcopy clinic costs $300, a cone biopsy $560 and if you have the misfortune to have cancer, the first clinic visit costs $250 - and that's only the beginning. Theatre costs $588 for the first one-quarter hour, a day in Ward 5 $600. Lab tests, scans and x-rays are extra.

Prospective patients will have to pay a "booking fee" before their admission of $300-$400. For "elective admissions", National Women's Hospital has the "right to refuse treatment where a booking fee has not been paid".

It's not clear what "elective" means. The delivery of a baby? An abortion? Treatment for cancer, perhaps? Non-payment of the booking fee will "alert management to potential credit control problems" and allow a "pro-active approach to recovery of debt".

The new regime is imaginatively justified as "improving communication with patients". The end result is a "paying patient, resulting in increased revenue". Anyone not born in New Zealand is advised "to bring their passport on their first visit for verification of citizen status".

In Auckland, the greatest number of non-residents will be Pacific Islands people, many of whom are on low incomes and unable to pay. Refugees would be in the same boat. Caught between the devil and the deep blue sea, they may simply delay needed treatments, miss antenatal care,

Teaching Skills Courses
for Childbirth Educators and Other Health Professionals

Brisbane	5th - 8th December 1994
Townsville	25th - 28th February 1995
Adelaide	6th - 9th May 1995
Sydney	2rd - 6th June 1995

Workshops conducted by Ronnie Pratt

Cost : A$350.00 if paid 21 days prior to starting date

Enquiries : CAPERS
P O Box 567 Nundah, Queensland 4012
Phone 07 266 9573 Fax 07 260 5009

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*

More information to follow

Current Issues

NOTICE : Midwives Attending Home Births

An increasing number of midwives are extending their practice to attend women who want to birth at home. This is great as it increases women's birthing choices.

As a result of the constant challenge home birth has been under for many years the New Zealand Home Birth Association developed a perinatal data base to collect the essential information from women birthing at home to establish its safety. As the only National Perinatal Database this information has been invaluable during the changes to the Nurses Amendment Act onwards.

Therefore it is extremely important that if you attend a home birth that a statistic form is filled out for each women, even if you only attend one or two women a year.

The statistics form is enclosed, please use it to photocopy others. It costs $3 per form to be entered and processed which is to be sent with the form. At the completion of each year you will receive your personal collated statistics plus a copy of the national collated statistics - it's extremely good value.

Please post your completed forms to:

Auckland Home Birth Association
PO Box 7093, Wellesley Street, AUCKLAND

NZCOMI BIRTH REGISTERS

A 30-page book that enables midwives to keep comprehensive records of client details, using the Midwifery Standards Review format.

Benefits:
- meets legal requirement for each midwife to keeping a register of birth
- no duplication of information for annual Midwifery Standards Review
- easy collation of stats for local and national submissions

COST - $18.00 each

Please send money with order to:

Violet Stock
NZCOMI Waikato/Bay of Plenty
P O Box 88
TAURANGA

NZCOMI CONFERENCE, Te Papi-o-uru Marae, Rotorua August 1994

Opening Address - Karen Guilliland (Nat. Co-ordinator), Sally Pairman (President), Lianne Dalziel (Labour MP)., Caroline Flint (Keynote Speaker) and Joan Donley (Matriarch, Mentor, Midwife)

During the Powhiri at Te Papai-o-uru Marae

Abortion Despite Birth Control

- Federation of Women's Health Councils Newsletter Jul/Aug 1994

More than half of the women surveyed when seeking abortion at the Epsom Day abortion clinic were practicing birth control when they became pregnant. The study, which was carried out over a 2-month period by medical school researchers involved 256 women. 61% were using some form of contraceptive method in the month they conceived. However, many were not using the contraception correctly which increased their chances of getting pregnant.

Almost half of the 42% of women using the pill did not take it everyday, and more than a quarter suffered diahorrea or vomiting in the month they conceived. About a fifth had taken antibiotics also reducing the effectiveness of the pill. About half of the 48% who opted for condoms did not use them in every instance.

The results also showed that many women who cannot afford to have a baby cannot pay for contraception. 21% of those in the survey said cost was a significant barrier. The study included women who had stopped using contraceptives as well as those who could not afford to start.

It is hoped that the research will help provoke an increased awareness of the need for more education about contraception use as well as a push for free contraception. Cost barriers are among issues addressed in a Ministry of Health paper on unwanted pregnancies. The document is being considered by Associate Health Minister, Katherine O'Regan who is expected to make recommendations on the matter in June.

Steve Chadwick (Conference Host), Sally Pairman (President) and Angela Kearney (Guest Speaker) during the first day of the Conference

World Health Organisation Statement

ROUTINE ULTRASOUND SCANNING DURING PREGNANCY

- Mark S Tsechkovski
Director, Disease Prevention & Quality of Care (WHO)

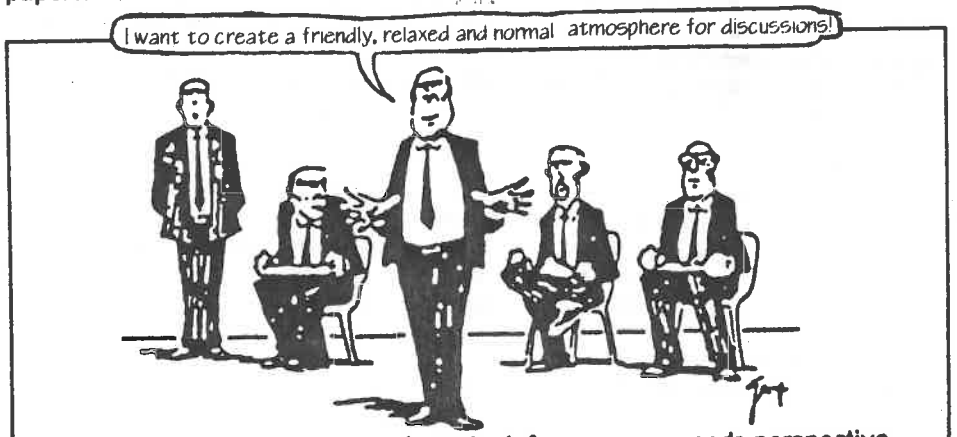
We should like to call your attention to two extremely important scientific papers published this fall. Both papers report on large randomized controlled trials which, as you know, is by far the most valid of all scientific methods.

The American paper has been carefully evaluated by the National Institutes of Health in Washington DC and there can be no question of the results. This paper shows that there is no benefit from routine ultrasound scanning of all pregnant women and the authors recommend that there be no further routine scanning.

The second paper reveals the possibility of serious risks associated with routine scanning. As you will see, the experimental group with intensive scanning had over one-third more cases of intrauterine growth retardation. Clearly, more research needs to be done to determine whether or not such a serious risk exists, but the authors of this paper recommend that for the present time there be no more routine scanning.

It is fair to say that at the moment the best research shows no benefit from routine ultrasound scanning and the real possibility of a serious risk. Added to this are questions of costs. We have data from Member States showing that they spend more money on ultrasound scanning during pregnancy than on all other health services for pregnancy combined.

For all of these reasons, we urge you to reconsider all present policy with regard to routine ultrasound scanning during pregnancy, based on these important scientific papers.



How consultation can sometimes look from a consumer's perspective

"KEEPSAKE" VIDEOS MAY BE MISUSE:FDA

- American College of Nurse Midwives, Sept/Oct 1994., Vol 25 No 5

The Food & Drug Administration (FDA) has announced it is aware of several U.S. enterprises that are "commercializing ultrasonic imaging of fetuses by making 'keepsake' videos", causing concern about "the misuse of diagnostic ultrasound equipment."

Ultrasound fetal scanning is considered safe for most usage, the FDA said in a recent announcement, but "ultrasound energy delivered to the fetus cannot be regarded as innocuous... exposing the fetus to ultrasound with no anticipation of medical benefits is not justified. Thus, we believe these prenatal entertainment videos should not be performed."

For more information on the FDA action against non-medical uses of ultrasound equipment, write or call: Promotion and Advertising Policy Staff, Office of Compliance, Centre for Devices and Radiological Health, FDA, 2098 Gaither Road, Rockville, MD 20850. Phone (301) 594-4639; Fax (301) 594-4609.

CONTINUITY OF MIDWIFERY CARE UPDATE

-Exerts from National Women's Hospital Update
May 1994

Continuity of Midwifery Care
Judging from the feedback received from women choosing care through the scheme, the scheme it is highly successful in meeting the requirements of women to have continuity. To have access to one caregiver is appreciated and enhances the experience of childbirth for the women.

Of women booked, 65% received continuity of care from their primary midwife throughout antenatal, delivery, and post natal care. A six month review of the scheme indicates that fine tuning only is required. A proposal is nearing completion which seeks funding from North Health to extend this service for women at low risk of having complications.

Direct Care
This is a pilot scheme to provide continuity of midwifery care for women with potential for complications or high risk. The objectives of the scheme include to:
- increase continuity of care for women with high risk factors
- increase job satisfaction for the Maternal Foetal Medicine team midwifery staff
- act as a base to build a larger direct care scheme

Community Clinics
A working party is developing an action plan for implementing the establishment of three locations for the provision of maternity clinic services and a home base for continuity of midwifery care teams. One location is the previous St Helen's Hospital.

Editors note: *Although we would commend this move, isn't this revising the centralisation that management has been soooo insistent on? The next good move would be to open birthing units on these sites - what about a unit at the old St Helens?!*

Preterm IUGR babies likely to stay small

New Zealand Doctor Practice Newsletter 18 / 8 / 94
By Charles Essex

Children who have suffered intrauterine growth retardation (IUGR) tend to remain small especially if they were also born prematurely.

Although IUGR babies have some catch up growth in the first six to 12 months of life, as a group their mean weights and heights over that period are about one standard deviation lower than full term babies of normal birth weight, according to Dr. Paul Hoffman, paediatric endocrinology fellow at the Starship Hospital, Auckland.

He told paediatricians at the Starship that there is much mythology and misunderstanding about IUGR.

"We have all been taught that there are differences between symmetrical IUGR, where thee length and weight are proportional, and asymmetrical IUGR, where they are not," he said. "They are in fact parts of the continuum of IUGR." Many professionals and parents have long held the belief that bigger babies are healthier than smaller babies, and that smaller babies need extra feeding to catch up.

However the evidence suggests that feeding excess calories to these infants does not make them catch up, according to Dr. Hoffman.

Some intrauterine effect associated with IUGR has constrained subsequent postnatal growth.

Premature IUGR infants do not grow as well as premature infants whose weights are appropriate for their gestational age. On standard growth charts, IUGR infants appear to be failing to thrive, even when plotted at their corrected age.

The catch up growth of preterm IUGR infants tend to be less than that of the term IUGR babies.

"Failure to show catch up growth in the first six months of life is a good predictor that they will not catch up, and will remain smaller and thinner than their peers."

These infants do not realise their genetic growth potential. IUGR, particularly in premature infants, is also associated with an increased incidence of specific learning disabilities and attention deficit disorder.

The affect of IUGR can remain into adolescence. Further research need to be done to see if being smaller into adulthood has adverse health consequences, said Dr. Hoffman.

Dr. Charles Essex is a community paediatrician in Auckland. Thank to Dr. Hoffman for assistance with this article.

NZ Doctor 15/9/94

Seventh pregnancy more likely to be defective

Women who have had six or more children are at increased risk of giving birth to a child with Down syndrome, according to Israeli research.

These women are at least 15 per cent more likely to have a child with the genetic abnormality - and if the women are over 40, their risk is even higher, according to a team of doctors at Shaare Zedek Medical Center.

The Israeli researchers recommended that based on their findings, all pregnant women who have had several children should be tested for the disorder, irrespective of their age.

Their recommendation follows examination of all 37,110 birth records at Shaare Zedek between 1981 and 1989. Of these births, 54 of the infants were diagnosed with Down syndrome.

The researchers analysed the births according to their mothers' ages and the number of previous children they had in their families.

The incidence of Down syndrome births among women who had six or more children was significantly higher in each age group of mothers, compared to women who had fewer children.

For women aged 40 to 44, the chance of having a child with Down syndrome reached 29 per 10,000 in women who had six or more previous births.

"This is the first time that a risk factor related to parity has emerged from genetic and obstetric research," said Dr. Michael Schimmel, who headed the research team.

Professor Arthur Eidelman, head of the department of neonatology at Shaare Zedek, said "the take home message is that we have to start treating each woman as an individual, not as part of a theoretical population.

"We now have the techniques for prenatal testing to find every woman's actual risk of having an offspring with a chromosomal defect."

TASKFORCE FOR BREASTFEEDING

- Little Treasures, Aug/Sept 1994

A plan to implement the global WHO/UNICEF Baby Friendly Hospital initiative for New Zealand is being prepared by three women who have been appointed as the New Zealand Breastfeeding Initiative Taskforce.

Marcia Annandale (Christchurch), Tui Bevan (Dunedin) and Harangi Biddle (Opotiki) are working towards making recommendations to introduce the initiative in all areas of the health care system to enable women to successfully breastfeed their babies.

"While most women in New Zealand begin breastfeeding, many wean their babies in the first few months," says Marcia. "This has particular significance in the light of findings from the New Zealand Cot Death Study which identified breastfeeding as a factor to reduce the risk of cot death (SIDS). "When a mother is unable to breastfeed successfully, the baby and mother may miss out on the life-long health benefits that breastfeeding confers."

A recognition of breastfeeding in 1994 as the International Year of the Family emphasises the ability of the family to meet its needs with respect to nurturing, values and culture as breastfeeding benefits all society.

The taskforce was convened, under the auspices of the New Zealand Committee for UNICEF, following a national workshop hosted by the Ministry of Health.

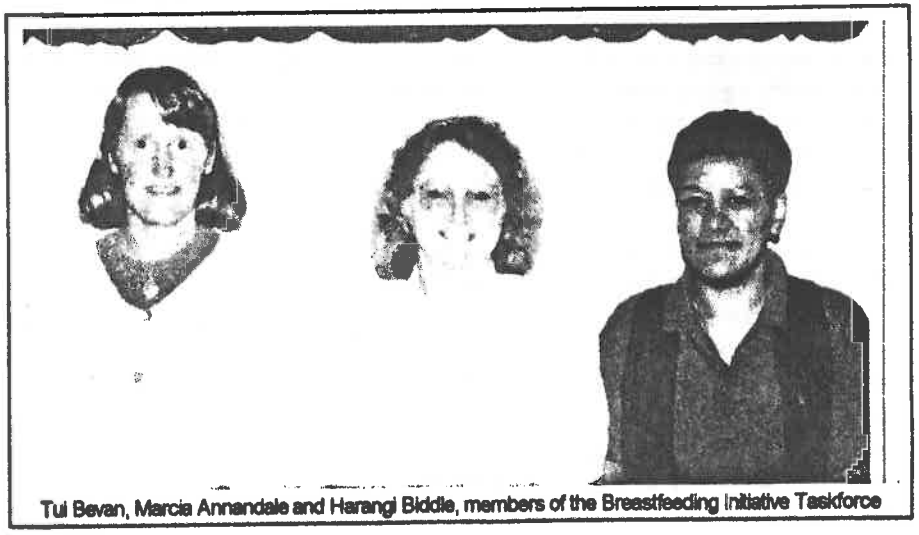
The Baby Friendly Hospital Initiative sets a standard of excellence in breastfeeding policies and practices and a number of countries have adopted policies for implementation.

In Sweden, 20 of its 66 maternity facilities are baby-friendly, in Korea DPR 6, Japan, Switzerland and the Czech Republic each have 2 and Hungary and Denmark each have one.

Taskforce members collectively have the skills and attributes to plan New Zealand's implementation of the initiative:

Marcia Annandale (Chch) is a La Leche League leader since nursing her four children and is a qualified International Board Certified Lactation Consultant. She has been a member of the New Zealand College of Midwives National Committee and is a tutor in antenatal classes and co-founder of the New Zealand Lactation Consultants Association.

cont'd on page 14



Tui Bevan, Marcia Annandale and Harangi Biddle, members of the Breastfeeding Initiative Taskforce

Tui Bevan (Dunedin) is an independent Lactation Consultant offering specialist breastfeeding counselling, education, information and resources. She is a La Leche League leader and breastfed her three children. As a WHO Code advocate she monitors and reports contraventions of the Code in New Zealand.

Harangi Biddle (Opotiki) is a registered general and obstetric nurse and registered midwife and recognised by Tipu Ora of Rotorua/Arawa as Whangai U, a Maori Lactation Consultant. She is employed by the Whakatohea Maori Trustboard as a practice nurse, midwife and Whangai U, providing health promotion and education on successful breastfeeding from a Maori perspective. ❑

Breastfeeding and the World Health Organisation (WHO) Code

- ICEA New Zealand Newsletter, August 1994

After signing the international code on WHO and UNICEF initiatives to promote breastfeeding, and after setting up a taskforce to encourage breastfeeding in New Zealand hospitals, the Government has announced that the Ministry of Health will not provide ongoing funds and that the taskforce must find its own funding.

The WHO-UNICEF Innocenti Declaration on infant feeding points out that it is a Government's responsibility to support the goal of exclusive breastfeeding of babies in the first four to six months. So far 19 industrialised nations have set up national authorities to supervise their programmes. Most Governments have begun baby-friendly hospital campaigns, selecting influential hospitals to pioneer the scheme. The New Zealand Government is abdicating its responsibilities in this respect, despite the fact that promoting breastfeeding has been identified as a health priority by the Public Health Commission, and despite the fact that New Zealand rates of breastfeeding are declining. It seems that the Government has passed the buck to the Regional Health Authorities; but the RHAs regard the CHEs as their main focus - and breastfeeding as a community activity.

Tui Bevin, a Dunedin lactation consultant and member of the New Zealand taskforce, reports that they are now having to apply for funds from charities and various organisations.

What can you do? If you feel concerned that the Government is opting out of its responsibilities in this respect, please write your concerns directly to Health Minister Jenny Shipley - and send a copy to your local MP. Tui Bevin would be pleased to answer any queries on this issue and provide information. Her address is 128 Signal Hill Road, Dunedin.

- GP Weekly - 20/7/94

Giving birth affects cancer risk

BOSTON: Doctors trying to pin down the link between pregnancy and breast cancer have concluded that giving birth to at least one child provides long-term protection but only after temporarily raising the risk for up to 15 years.

The findings, published in the *New England Journal of Medicine*, explained why childless women 'have a lower risk of breast cancer ... during the childbearing years or before the age of 35 or 40,' said the group of Swedish researchers led by Dr Mats Lambe of the University Hospital in Uppsala.

It also explained why that trend reversed after the childbearing years end.

The Lambe team said it appeared the elevated levels of oestrogen during pregnancy may do more than enhance the growth of breast cells. They may also encourage the growth of cancerous cells lurking in the breast.

But if no cancer cells are present, pregnancy apparently protects against future breast cancer because it causes immature cells, which might otherwise turn cancerous, into mature healthy cells.

The conclusions come from data collected by the Swedish Cancer Registry and the country's national Fertility Registry. Each of 12,666 women with breast cancer born between 1925 and 1960 were compared with 62,121 women with the same age profile to see how childbirth influenced the numbers.

The Lambe team also found the women facing the highest risk of breast cancer after giving birth tended to be women who were older when they had their first child.

'The increased risk immediately after delivery is most pronounced in women who were 30 years old or older at the time of their first delivery,' they said.

Among women who were 35 years old when they had their first baby, for example, the risk of developing a breast tumour at age 40 was 26 percent higher than it was among women who had never been pregnant.

'Women who had two pregnancies had a less-striking increase in risk,' the researchers said.

For women who had given birth to more than one child, the cancer risk was lower than it was for women who had had only one child, except for women who were 35 or older.

Patient Outcomes for Certified Nurse-Midwives

- Brown, SA, Grimes DE

A meta analysis of process of care, clinical outcomes and cost effectiveness of Nurses in Primary Care roles: Nurse Practitioners and Certified Nurse Midwives. 1992. Washington DC. American Nurses Association

(CNMs) and nurse practitioners (NPs) are equivalent to or better than those for physicians, according to the report of a recent meta-analysis conducted for the American Nurses' Association by researchers at the University of Texas in Houston. The analysis included more than 38 studies of NPs and 15 studies of CNMs, using physician care as the standard for comparison. The studies did not control for patient risk. The following findings were reported for CNMs:

- CNMs had lower rates of analgesia and anaesthesia, electronic fetal monitoring, episiotomies, forceps deliveries, amniotomies, intravenous fluid administration, induction of labour, and Caesarean sections.
- Infant clinical outcomes in terms of fetal distress, 1-minute Apgar scores, and low birthweight, and neonatal mortality rates were equivalent.
- Infants had higher 5-minute Apgar scores.
- Mothers had more spontaneous vaginal deliveries.
- 58% of the mothers breastfed versus 24% of physician patients.
- 6.5% of the infants were low birthweight versus 7.4% for physician patients.
- Rates of prematurity were 4.5% for CNM mothers versus 10% for physician mothers.
- Length of hospital stays for CNM mothers was 2.1 days versus 2.9 days for physician mothers.
- CNM mothers had more prenatal and postpartum visits.

Based on the results, the researchers made the recommendation to "Encourage the continued and expanded use of NPs and CNMs as providers of primary care services to a wide variety of patient populations."

Do Cabbage Leaves Prevent Breast Engorgement? A Randomized, Controlled Study

V Cheryl Nikodem (Cur) RMRN, Donna Danziger, RMRN, Nicky Gebka, RMRN, A Metin Gulmezoglu, MD, and G Justus Hofmeyr, MROCG

ABSTRACT: *A randomized, controlled trial was conducted to evaluate the effect of cabbage leaves on mothers' perceptions of breast engorgement and the influence of this treatment on breastfeeding practices. The subjects, 120 breastfeeding women 72 hours postpartum, were randomly allocated to an experimental group who received application of cabbage leaves to their breasts, or to a control group who received routine care. The experimental group tended to report less breast engorgement, but this trend was not statistically significant. At six weeks, women who received the cabbage leaf application were more likely to be breastfeeding exclusively, 76 and 58 percent (35/46 vs 29/50; P=0.09), and their mean duration of exclusive breastfeeding was longer (36 vs 30 days; P= 0.04). The greater breastfeeding success in the experimental group may have been due to some beneficial effect of cabbage leaf application, or may have been secondary to reassurance and improved confidence and self-esteem in these mothers. (BIRTH 20:2, June 1993)*

Rural groups struggle to maintain services

- NZ Doctor, 13 October 1994

KAWAKAWA

North Health is working with GPs and other interested parties on a needs assessment for specialist services in Northland.

Kawakawa Hospital recently lost its caesarean services which means that women who need a caesarean section will have to travel by air or road ambulance from Kawakawa to base hospital in Whangarei.

North Health manager for special projects, Colin Tukuitonga, said around 500 deliveries are carried out in Kawakawa each year and about 100 of these require intervention.

"I would imagine for a woman in labour being in the back of an ambulance for an hour, even an air ambulance, is not exactly a pleasant experience.."

Dr Tukuitonga said he has appointed a project manager to work with locals to work out what level of services is needed.

FIELDING

Protecting the future of the Fielding Maternity Home is a priority for the Fielding community, according to local Community Health Group chairperson Barbara Robson.

Mrs Robson said the local CHE has made no commitment to keeping the unit open and the community is awaiting the results of the latest contracting round with Central RHA.

People are wary about a community trust taking over the facility if the CHE pulls out, she said.

"We could end up holding the baby; getting funding for a year and that's it."

Another issue being tackled by the RHA-funded group is immunisation.

Mrs Robson said the group has just completed a submission expressing the community's concern about the reporting of adverse reactions to vaccines. They believe doctors tend to be overly sceptical when an adverse reaction is notified.

Quote from the National President, National Council of Women, South Africa to NZNCW about their fight to increase the status of women.

"Our attitudes to other women must be positive, helpful, co-operative and accepting. The mistakes and faults of men are frequently tolerated and unquestioned, but the slightest deviation of women is roundly condemned. We need support and encouragement from our peers to achieve greater heights happily. Life must be enjoyable not an endless grind to battle."

She could be talking about the behaviour of some midwives/nurses towards each other in New Zealand. We should be ashamed!

GP Weekly 20/7/94

Poor maternity practise may jeopardise payment

By Vicky Tyler

There is speculation the planned new maternity system will withhold payments to midwives and GPs who fail to refer at-risk cases to specialists.

The Royal College of Obstetricians and Gynaecologists and the College of Midwives both suspect that is a possibility, even though regional health authorities are denying it.

The College of Obstetricians and Gynaecologists is in favour of payments being refused for primary care providers who do not follow referral guidelines because that would help guarantee patients' safety.

'If everyone agrees that a woman with pre-eclampsia needs specialist care, and if a midwife or a GP does not refer for specialist care, then that midwife or GP should not be able to claim any money for that care. Now, there is no reason why the State should pay someone to practice bad medicine,' says chairman Dr Tony Baird.

Linking payment to quality of care is something Dr Baird believes could be on the cards. He points out that maternity benefits have doubled since midwives were granted independence – and it is seen as a budget that is ripe for pruning.

'The whole point of the health reform, the point of the RHAs, is to cut costs. I've got very cynical over the years having seen so many changes. They're all dressed up as all sorts of exciting possibilities, challenges and choice, but they're really about keeping costs down and paying off our overseas debt.'

It is thought the whole exercise of drawing up referral guidelines should not be necessary.

'If the training of midwives and GPs is done properly, that training includes recognition of abnormalities. One of the problems is that a small number of midwives particularly, and also some GPs, seem to have very limited knowledge. Also, some of the midwives tend to flout the law,' claims Dr Baird.

'The Nurses Amendment Act was clearly about normal pregnancies and yet you have midwives saying that they can look after, on their own, women who have had caesarean sections previously, women whose babies pass meconium, and women who bleed,' he claims.

The key issue is defining normality, something Dr Baird believes should not have to be spelt out, but at the same time 'clearly has to be because some women are suffering'.

Under the new system, women will be able to go to a specialist but there has been no agreement yet on whether a specialist can become the 'lead professional'.

He agrees that midwives and doctors need to work together but objects to the suggestion that specialists are the only ones who need to change.

'I think that it's unrealistic to expect specialists to sit down with midwives while this public abuse is going on.'

Regional health authorities deny that payments for GPs and midwives will be linked to the guidelines for referral.

'The majority of criteria are, in fact, a 'must consult' rather than a 'must transfer'. Because they're a 'must consult', then the discretion as to whether or not a transfer is then required is a matter of discussion between the specialist, the woman and primary practitioner.

'In other words, it will vary around the woman's particular needs and circumstances,' explains North Health maternity services manager Sam Denny.

However, the RHAs would be concerned if a GP or midwife regularly worked outside the guidelines and may look at taking action.

What form any action could take has not been worked through yet.

Meanwhile, Dr Baird has criticised the Nursing Council's disciplinary procedures.

If midwives are able to act alone, then they must take responsibility for their actions and cannot hide behind the doctors, he says.

On the other hand, Dr Baird has praised the medical disciplinary system.

'They are very good hearings. Obviously the outcome isn't always good for doctors, but nor should it be.'

The New Zealand College of Midwives has written to the Nursing Council pointing out that its lack of openness about its disciplinary process compromises the midwifery profession and asked it to address that urgently.

The Nursing Council itself would like to change its disciplinary procedures to make them more open to public scrutiny, but says its hands are tied because of the out of date Nurses Act.

'The Act states specifically that our hearings are not to be open to the public. 'Public' is open to interpretation, but our advice has been that public means even the complainant,' explains chairperson Elaine Papps.

The council has made submissions to Parliament about the need to change the Act.

National midwife coordinator Karen Guilliland believes the planned guidelines for referral could well limit women's choice of care.

'Women who've had a previous caesarean section who do want something different, who do want continuity of the midwife care, generally know all the information. It's their choice made in light of the information. It's a bit of a worry that those choices will be restricted. We still live in a country that actually believes that people should make decisions about their own health.'

She also believes the guidelines will place an unfair burden on specialists.

'The assumption by the RHAs that the specialist will always be right, I believe, is an unnecessarily harsh burden to place on a profession. It's not a criticism. It's basically an off loading of total responsibility onto the obstetrician which I don't believe is actually useful for either the obstetrician or the women,' says Ms Guilliland.

Furthermore, she doubts the guidelines will solve referral problems.

Since the guidelines are designed to guide practitioners, Ms Guilliland says it is unlikely they will be consulted by providers who do not believe they need to follow protocols.

HIV PREVENTION AND CARE - TEACHING MODULES FOR NURSES AND MIDWIVES

- The Newsletter of the World Health Organisation Global Programme on AIDS

No 2, 1994

Document WHO/ GPA/ CNP/ TMD/ 93.3

The global number of AIDS cases and deaths will grow rapidly in coming years as people already infected with HIV fall ill. Nurses in most countries are already caring for people with HIV/AIDS and their families, and contributing to efforts to prevent HIV transmission. They have a professional duty to keep up-to-date with advances in technical and scientific knowledge about HIV and HIV- related illness, and with the implications of these for clinical practice.

This new publication grew out of guidelines developed in 1988 by GPA and the International Council of Nurses and teaching modules produced by GPA and WHO's Regional Office for the Western Pacific on Basic nursing and midwifery education in the prevention and control of HIV infection.

In the light of feedback on these materials received from all over the world, GPA decided to adapt and update the modules to create a nursing education course on HIV-related illness based on current understanding of the pandemic. The course is divided into 11 modules, each of which builds on the previous one but can be presented separately in continuing education programmes. The modules cover epidemiology and transmission, HIV infection and HIV-related illness, prevention of transmission in health care settings, the psychosocial impact of infection on the individual and the community, counselling skills, patient education, nursing care of adults with HIV, nursing care of HIV-infected children, issues related to women and AIDS, terminal care, and education of traditional practitioners.

An important feature of the modules is the use of an interactive teaching approach, including visual aids, large and small group discussions, role play, fact finding, project work and case studies. This approach is considered crucial in addressing the sensitive issues raised by HIV/AIDS.

These documents are available from the GPA Document Centre, World Health Organization, 1211 Geneva 27, Switzerland. Individual copies will be supplied free. Supplies of multiple copies may incur a small charge.

Diet the key to limiting anaemia in pregnancy

- New Zealand Doctor, 4th August 1994

A British team examined iron absorption in 12 healthy pregnant women and found "that pregnancy stimulates absorption of iron and that in healthy women who eat an average diet this increase will balance the increased demands of pregnancy without the need for supplements".

Whether pregnant women require iron supplements is a contentious issue. A team from the Royal Victoria Infirmary performed serial iron absorption studies during and after pregnancy in 12 healthy women to determine whether increased iron absorption can cover the greater requirements.

Absorption increased dramatically during pregnancy. It rose from a mean of 7.2% of non-haem iron ingested at 12 weeks to 36% at 24 weeks and 66% at 36 weeks, falling back to 11% some weeks after delivery.

The mean Hb concentration fell about 10g/L between 12 and 24 weeks, stabilised and then returned to normal after delivery. One woman developed iron deficiency anaemia.

Normally, a foetus acquires 300mg of iron in each the second and third trimesters and the extra absorption should easily cover this need.

NZ Doctor 4/8/94

Environment plays big part in birth defects

Birth defects appear to run in families, with the environment playing a greater role than previously thought in the risk of having a baby with such defects, according to a Norwegian study of almost 375,000 women.

The study showed that women who moved to a new area after giving birth to a baby with a club foot, cleft palate or other defect were considerably less likely to have a second baby with the same defect than those who stayed in the same house - even if they did not change partners, reported researchers from the Medical Birth Registry of Norway in Bergen.

"Among the women who did not change partners, the reduction in risk associated with a change in municipality must have been purely an environmental effect," said study leader Rolv Terje Lie. Had genetic factors been the major cause of the defects, a change in residence should not have changed their risk as much as it did, he said.

Overall, the risk of having a second baby with the same birth defect as the first infant was more than doubled in women who lived in the same town during both pregnancies, compared with women who moved to another town after the first baby was born with a defect.

Regardless of where they lived, women whose first baby had a birth defect were nearly eight times more likely to have a second infant with the same defect, compared with women whose first baby had no defect, he reported in the *New England Journal of Medicine*.

"The traditional view has been that genetics play a major role in the risk of birth defects," said Dr Jose Cordero, a researcher at the Centers for Disease Control and Prevention in Atlanta. "But this study provides very strong evidence that there is a strong environmental component - a much greater role than genetics."

The problem now is determining what these environmental factors are - an issue now being studied at the CDC's birth defects branch.

MINISTRY OF HEALTH
MANATU HAUORA

Media Release

20 October 1994

INTERCHANGEABLE MULTI-SOURCE MEDICINES

Prescription costs for some patients should be reduced if doctors and pharmacists use new information sent to them by the Ministry of Health today.

Announcing the publication of a list of interchangeable medicines, Associate Minister of Health Maurice Williamson explained that patients had no need to pay the additional costs imposed by some multinational drug companies for their branded medicines when there was an approved generic copy available.

"For years the drug industry association has been promoting the idea that generic copies of their products are somehow unsafe and of poor quality.

Doctors in this country have continued to prescribe the brand-name medicines, even when less expensive alternatives become available," said Mr Williamson.

"This month every doctor and every pharmacy will receive a booklet containing the names of medicines which the Ministry of Health considers may be interchanged. This list was compiled following the consideration and comparison, by an expert committee, of the most frequently prescribed medicines and their generic alternatives."

"The result is a small booklet which I believe will prove to be a valuable tool for prescribers. It will be a useful guide when writing prescriptions and from now on, doctors will be able to give a general approval for pharmacists to dispense a substitute selected from the list."

The Ministry of Health will be publishing updates as patents on medicines run out and further approved generic copies regarded as interchangeable become available.

Available from: Margaret Ewen
Therapeutics Section
Ministry of Health
P O Box 5013 Wellington
Ph (04) 496-2107 Fx (04) 496-2340

Special Feature

Goodbye to Steph Breen

- Karen Guilliland

When the Nurses Organisation chose not to reappoint Steph to the Director's position, they lost, in my opinion, one of Nursing's strongest and most powerful leaders. I have known Steph Breen for over seventeen years.

I have worked with Steph in a variety of situations and consider her to be one of the most professionally competent and impressive nurses and midwives I have been privileged to work with.

My first contact with Steph was when I was a student midwife and she was a ward charge. Her leadership at Christchurch Women's was innovative and women centred. This at a time when medicalisation in childbirth ensured compliance and passivity in both staff and clients. Steph's ward was the first in Christchurch Women's to have documented care plans and primary caregivers. She was the first charge nurse in the Canterbury Area Health Board to introduce self medication. Her client advocacy was well known and respected. During the years I worked at Chriustchurch Women's, Steph was often the only senior staff member with the strength of conviction to support consumer demands for a more women centred service.

As a tutor years later, I found students always clamoured to work in Steph's ward. They valued the opportunities they were given to learn in a supportive but firm environment.

I have also known Steph as an employee. Back in 1987, Steph led the NZNU's split from NZNA setting up as a totally separate organisation. During the time I worked for the Nurses Union I observed (often with awe) Steph's capacity for work coupled with an ability to take "the team" along with her. Her total commitment to Union members never faltered. Her prinicples of social justice and equity run through everything she does. She demands high standards and commitment from those she works with but is a compassionate and fair employer. Her management skills are excellent and demonstrate her quick intelligence and quite remarkable memory.

I have also been Steph's "employer". The College of Midwives (inc) contracted Steph for her negotiation and legal skills to act as Co-advocate at the Maternity Benefit Tribunal. Her professionalism and understanding of the complex nature of the obstacles facing the midwifery profession were a major contributor to our success.

FETUS MAY FEEL PAIN

- GP Weekly, 20 July 1994

London: Unborn babies release stress hormones when doctors pierce their tissue for blood transfusions, suggesting that a semi-developed fetus may be able to feel pain, British researchers said recently.

The report in Lancet questioned the prevailing view that a fetus cannot experience pain until well into a pregnancy and suggested a baby's distress might be relieved if pain-killers are given before a transfusion.

The team from Queen Charlotte's and Chelsea Hospital in London measured stress hormone levels in babies between 20 and 34 weeks of gestation when doctors took blood samples from the umbilical cord and the fetal abdomen.

When the needle was inserted through the abdomen and left for 10 minutes or more, as in blood transfusion, the babies released stress hormones associated in children and adults with the sensation of pain. The longer the needle stayed in the abdomen, the greater concentration of hormones was produced.

When blood was taken from a site in the umbilical cord which is nerve-free, no such stress response was recorded.

'This data suggests that the fetus mounts a hormonal stress response to invasive procedures,' wrote Professor Nicholas Fisk. 'They raise the possibility that the human fetus feels pain in utero, and may benefit from anaesthesia and analgesia for invasive procedures.'

Anatomical studies suggest that unborn babies develop the systems necessary for pain perception from around six months into a pregnancy.

But Dr David Clark of McMaster University Medical Centre in Hamilton, Canada, urged caution over the findings, saying unconscious patients can show reflex reactions to painful stimuli without apparently feeling pain.

Gentle parting of the labia majora will reveal the labia minora, an intact hymen and sometimes a hymenal tag. Normally nothing needs to be done about this minor congenital variation.

Spine

The child should be suspended prone and the back inspected. In this position, the examiner can determine whether all neural arches are present. It also might reveal the tell-tale signs of a patch of hairiness over spina bifida occulta.

Dermal sinuses are very common in the sacral area and are usually of no significance. However, higher ones above S1/S2 more frequently communicate with the spinal cord and are a major risk for recurrent meningitis.

Arms and Legs

Limbs should be inspected for abnormalities, movement (to check that there are no contractures) and the correct number of digits. Polydactyly occurs in certain syndromes such as Laurence-Moon-Biedl syndrome.

The upper limbs should be examined, especially after an instrumental or difficult dystocia. Damage to the brachial plexus can result in Erb's palsy or Klumpke's paralysis, depending upon the nerve roots affected.

Hips

Much has been written about the importance of the examination of the hips. Missing a dislocated hip may condemn a child to many weeks in hospital on traction with closed reduction or, even more devastating, an open reduction, and the potential for a vascular necrosis of the femoral head. It is important, therefore, to develop a facility for this particular set of examinations. The two procedures mainly associated with hip examination are Ortolani's (Ortolani, 1937) and Barlow's (Barlow, 1962) manoeuvres.

Conclusion

Once the examination of the newborn infant has been completed, it is important to take a few minutes with the parents to reassure them that the examination has been normal and that they have a perfectly formed baby. If abnormalities have been unearthed, it is essential that this news, which will be devastating to the new parents, is imparted with sensitivity and feeling.

Steph's tenacity, industrial knowledge and skills are unique in nursing. Her networks amongst the health industry are wide-ranging and she commands respect amongst politicians and unionists. Her honest, open and practical style attracts loyalty and commitment.

> "Nice is nice but right is better and then it's not a matter of doing things right but doing the right things"

is typical of Steph's approach and one which many in the midwifery movement can relate to.

Steph believed in nurses, wherever they worked and whatever their rank. In the cynical world of health reforms and politics which are currently surrounding nursing, it takes a believer such as Steph to ensure nursing is fully recognised as an essential health service. Steph has played a major role in the professionalism and maintenance of nursing and nursing will be the poorer for her departure.

Midwifery also owes much to Steph. She has always been a strong supporter and is a founder member of the College. But she has been more than this. Steph's clarity of principle and personal integrity has ensured she has been a valuable resource for the College and its executive through its rapid development.

We will miss Steph's vital personality and business acuity but also her strength and power that few can match.

I will miss a mentor and friend. Perhaps when she gets tired of being a business woman and all that sunshine, sea, sand and wonderful Bali culture, we can entice her back to New Zealand to work for Midwifery.

Polycose Screening & Gestational Diabetes

Following is an excellent letter sent to Lakeland Health CHE on 13/9/94 by Sharron Cole, President, Parents Centre New Zealand.

Sharron asks questions which we would all be keen for an answer. I await the response to share with you.

"As a consumer organisation, Parents Centre has serious concerns about the introduction of routine polycose screening on pregnant women. We are aware that the rules pertaining to screening state that the disorder should be well defined, it should be serious and there must be an effective way of treating or preventing it which could not be achieved without screening.

We are also aware that there is a nationwide trial being conducted on the Oral Glucose Tolerance Test for diabetes in pregnancy and that there is a recommendation from ? that all pregnant women should have a 50g polycose screening load between 24 and 28 weeks.

Given that this is a "new" routine test and given that medicine and obstetrics claims to base its practice on scientifically valid research and method, I as a representative of consumer groups, would be reassurred if I could have answers (with appropriate references) to the following so that we can assist women to make an informed decision about whether or not to have the polycose test.

1. What is the agreed upon definition of gestational diabetes?
2. Is there an internationally agreed definition?
3. Before the introduction of routine polycose screening, what was the incidence of GD that went undetected?
4. Of those undetected, what was the perinatal outcome?
5. What is the incidence of macrosomic babies to non-diabetic women?
6. What are other tests that may accurately confirm the diagnosis of either GD or impaired glucose tolerance?
7. Of those women diagnosed as having GD, what is the percentage of these women who are then prescribed insulin?
8. What is the research that supports the assumption that the prescribing of insulin to those who fail the polycose and Glucose Tolerance Tests improves perinatal outcome?
9. What is the incidence of GD in the:- a) entire pregnant population? and b) the pregnant Polynesian population?

Less obvious, at times, is a cleft hard palate, cleft soft palate or absence of the soft palate. In the mouth, there may also be: Epstein's pearls, which are white raised lesions on the palate and gums; neonatal teeth which always become loose and should be removed; tongue ties, which generally needs no treatment; and ranuli, which are bluish mucus cysts, normally under the tongue.

It is also worth checking for facial palsy in children who have had instrumental delivery. Asymmetry of the naso-labial folds or of the mouth when the child cries are helpful signs.

Neck

The neck may give clues for Turner's syndrome where it is webbed, Klippel-Feil syndrome where it is very short, and trisomy 21 where there is a large fold of redundant skin at the back of the neck.

Chest and Heart

The air entry should be listened to on both sides of the chest, as a diaphragmatic hernia does not always present with early respiratory distress. While listening, the heart should be examined, listening for both first and second heart sounds. Significant changes occur in the cardiovascular system just after birth, with closure of the ductus venosus, the ductus arteriosus and foramen ovale.

Heart murmurs are sometimes noted shortly after birth. Many of these disappear but others, such as the murmur of a ventricular septal defect, may not be present at birth and will present in the first 2 months of life. While examining the heart, it is important to look at the child to make sure that there is no cyanosis and to examine the peripheral pulses. Femoral pulses are difficult to feel in coarctation of the aorta.

Abdomen

The abdomen should be gently but firmly palpated. A liver edge 2 cm below the costal margin is normal. It is also normally easy to palpate bimanually both kidneys. The spleen cannot normally be felt.

The umbilicus must be examined, partly for any infection, which is indicated by erythema around the umbilical stump, but also for the number of vessels. There are normally two arteries and one vein in the umbilical cord. Two vessels are associated with a non-specific increased incidence of congenital abnormalities.

Genitalia

Both testes should be descended well into the scrotum in a term pregnancy. Inguinal hernias (and hydrocoeles) are not uncommon. Transillumination of a testicular swelling should enable differentiation between an inguinal hernia and a hydrocoele. Abnormalities of the penis include hypospadias, where the urethral opening may be sited proximally on the ventral surface of the penis. This is often associated with a hooded prepuce.

There are considerable discussions at present between the midwifery/nursing fraternity and obstetricians. As an outside observer, I can see no reason why midwives should not take over the care of the normal, full-term infant, and I offer the following description of the minimum examination of the full-term baby that needs to be undertaken either by the paediatric medical staff or by midwives.

Before undertaking an examination, it is advisable to be fully cognisant of any problems that have occurred during the pregnancy and, moreover, in the obstetric history as a whole. Previous neonatal death may be significant and certain inherited diseases, e.g. congenital adrenal hyperplasia, have a 1:4 chance of affecting a subsequent offspring.

The examination of babies should involve a mixture of skill and serendipity. Observation of a sleeping infant is of value. Asleep, a normal baby will have flexed arms and legs; awake, the four limbs will move randomly. Twitching, with a high-pitched cry and an anxious look, could result from perinatal asphyxia. A severely asphyxiated infant may have fit or may, initially, lie motionless. Undressing infants, and testing the hips, are known to distress the infant; both of these should be delayed as far as possible.

Physical examination
The following plan is useful only in that it starts at one end of the body and finishes at the other, thereby reducing the chances of forgetting anything.

Head
The anterior and posterior fontanelles should be checked, noting also any overriding or indeed diastasis of the sutures. A third fontanelle between the anterior and posterior would alert the examiner to trisomy 21 (Down's syndrome). The ears are examined, not only for their position but also for the shape. Many syndromes are indicated by low set ears, i.e. ears set significantly beneath a line placed horizontally from the outer canthus of the eye. Accessory skin tags or accessory auricles are associated with an increased incidence of renal abnormalities.

Face
The eyes must be examined but beware of waking the child to do this. It may be sensible to do this last. Examine the slant of the eyes, epicanthic folds and then the iris, looking for abnormalities such as colobomas, and noting cataracts in the lens. Newborn babies do not open their eyes to order, but tipping a baby from the vertical to the horizontal frequently induces the eyes to open for a sufficient amount of time for examination. Make sure a nose is present and then look at the mouth.

Infants of alcoholic mothers may have a long philtrum, a thin upper lip and a so-called carp-shaped mouth. Check for cleft lips, which should have been obvious at birth.

10. What is the reliability and scientifc validity supporting routine polycose testing as an effective screening tool - i.e. what is its responsibility?
11. Similarly, what is the scientific validity of the GTT?
12. What is the incidence of glycosuria in the healthy, pregnant women?
13. What is the percentage of women who "fail" the polycose test and thus have to submit to the GTT, compared to the percentage of pregnant women who actually have blood sugar levels above those deemed normal for pregnancy?
14. What is the percentage of women who are shown by the GTT to have impaired glucose tolerance who actually develop GD?
15. What are the metabolic changes in the pregnant woman from the normal CHO metabolism?
16. What is the physiological response of the pregnant woman to a 50g load of polycose?
17. What is the role of the Glucose Tolerance Factor in the regulation of blood sugar and how is this affected/altered by the polycose loading?
18. Is there any evidence that the induced glycosuria has any harmful effects on the pregnant woman?
19. What is the role of stress in the increase of cortisol/glucose levels and what are the implications of increased stress levels for the woman who fails the polycose test?
20. What are the randomised controlled studies that support routine polycose testing as an effective screening tool?

It is the concern of Parents Centre that polycose testing is like many of the other tests and procedures that have been used in obstetrics on the basis of what is beneficial for some pregnant women, must be beneficial for all. However, later randomised studies have shown that many of these routine tests and procedures, far from being beneficial for all pregnant women, may actually be disadvantageous to many.

It therefore is unacceptable that yet another routine test is being introduced into pregnancy without scientfically valid backing - indeed, what has been done has shown that such screening is only "probably the best compromise". That is not good enough reason for routinely subjecting women to the physiological and psychological stress that accompanies polycose and glucose tolerance testing.

Given that support for routine polycose screening seems to be strong amongst certain care givers in Rotorua, I would like to be able to present consumers with the above ifnormation, on the basis of which they will be able to make informed decisions.

Sharron Cole
Consumer Representative"

Articles of Interest

RISK, RISK ASSESSMENT, AND RISK LABELS

- Journal of Nurse-Midwifery, Vol 39 No 2 - March/April 1994

Health promotion and disease prevention may be news as the nation plans a massive reform of its health care system, but nurse-midwives have long recognized these concepts as the basis of good health. For many of us, it is the focus on health and prevention that drew us to midwifery rather than to other more pathology-oriented disciplines. Even as we are necessarily drawn into dealing with the diagnosis and management of certain high-risk conditions, our focus rings loud and clear. Are these conditions preventable? If not, can we prevent adverse outcomes by early detection? If not, how can we best promote the health of mother, baby, and family within the context of their disease? In public health, these are the basics of prevention. Primary prevention of disease or outcome calls for altering susceptibility or reducing known factors; secondary prevention involves early detection and treatment; tertiary prevention is focused on the alleviation of disability and promotion of health within the disease state.

Much of primary care practice is aimed at primary and secondary prevention. To this end, clinicians have adopted an assortment of health risk assessment methods for the purposes of screening for disease, educating patients, or stimulating behaviour change. Risk factors are duly noted and summarized into an impression about a particular patient's potential for preterm birth, human immunodeficiency virus infection, or some other health problem. Once an individual is labelled "at risk", a series of interventions, from education to advice to diagnostic tests to assorted therapies, is set in motion in the hope of preventing or ameliorating the expected adverse outcome. In a risk-benefit equation, such assessment is presumed to be beneficial, in the best interests of the patient, and without ill effects.

There are several important things to note about the risk factors that comprise assessment tools. First, risk factors are statistically associated with adverse outcomes, but this does not necessarily mean they cause that outcome. In some cases, they are presumed to be causal; the role cigarette smoking plays in lung cancer is an example. Many risk factors, however, are not causal; they are surrogate markers for the real but as yet unidentified causes of disease . Lack of a high school education is often associated with higher risk. Does anyone believe that knowledge of algebra or English literature improves one's health? Clearly there are other causes of disease and the association of disease with poor education is because the true causes are also found more frequently among people who do not finish high school. Many established risk factors fall into this category.

However, concerns remain about the detection and diagnosis of congenitally dislocated hips (CDH) and ventricular septal defects. CDH may be difficult to uncover in the initial examination, especially as the infant's ligaments are relaxed at birth. The signs of ventricular septal defect are often not present at birth and may only become obvious in the first few days or even weeks of life.

In the new NHS, it could be argued that once the baby leaves the trust hospital its future health in the community is the responsibility of the health authority and thus any problems emanating from this change of trust activity will be laid on the doorstep of the health authority.

Midwifery care

The second challenge to examination procedure could emanate from the suggestion that midwives should take over the care of normal-term pregnancies and delivery. If a midwife is to act as an independent professional, taking full responsibility for the birth of normal, full-term infants, then it would seem a logical step for the same midwife to be responsible for the full examination of the infant. This would have the advantage of the infant being examined almost immediately after birth, therefore obviating the possibility of a delay in obtaining junior medical staff.

The midwives would have to accept that they would remain independent professionals and any misdiagnosis or missed abnormalities would be their personal responsibility. The paediatric medical team would no longer take responsibility for normal, full-term infants unless there was a specific referral to them.

The implication of this would be that all midwives attending deliveries would have to be fully trained in the examination of the normal and abnormal neonate. The variations of normality are considerable and it would not be cost-effective, nor would it be advantageous to the family, if there was an increase in unnecessary referrals back to the paediatric team because of midwife inexperience.

These examinations would have to be absorbed into the present staffing allocation as most acute care hospitals have little or no money for staff increases and there would be immense resistance from paediatricians to funding this change by a reduction in junior medical staff.

It is assumed that if hospital midwives act as independent professionals, community midwives will similarly act as independent professionals. Thus, it could be argued that the detection of ventricular septal defect, a potentially fatal disease if missed, and CDH, a non-fatal disease but one with a high morbidity, would be the responsibility of community midwives would have to be fully trained in the examination of the newborn infant.

PHYSICAL EXAMINATION OF THE FULL-TERM BABY

- British Journal of Midwifery. 1994 Vol 2, No 5
An article by Stephen J Rose

The confirmation of pregnancy is, in the majority of cases, greeted with delight, happiness and anticipation. Over the ensuing months, this anticipation is not only directed towards the pending birth but also incorporates hopes and aspirations for the future. All of us anticipate that this conceptum will live out his or her biblical three score years and ten.

Notwithstanding this anticipation that all will be right, pregnancy is a time of anxiety which reaches its zenith at the time of birth and immediately afterwards. Thorough, compassionate examination of the full-term newborn infant is therefore of great importance (Grady, 1986).

This examination is not only part of preventive medicine (Hall et al, 1990), in that it attempts to discover adnormalities which may be corrected or at least contained, but also a time when both parents can be reassured that the embodiment of their immortality is entirely well and normal. It is therefore vital that examination of the newborn baby is undertaken in the presence of at least the mother, in a thorough and professional fashion, so that the parents can have confidence in the findings of the professional involved.

The newborn infant is given a quick 'once-over' either by the midwife or by an attending paediatrician, to check for major abnormalities before being handed to the parents. Traditionally, the infant is fully examined by a junior obstetric doctor within the first 24-28 hours, and another examination is performed on the day of discharge. This has usually occurred around days 4-5 for normal births and around 8-10 after caesarean section, but this traditional activity is now being challenged on two fronts.

Reduced financial support

The reduced financial support for acute hospital care has led to a reduction in obstetric beds in many places and, in order to maintain activity, or even increase activity, the period of admission for full-term pregnancies has been cut dramatically. A significant percentage of infants is now discharged within 24 hours and, as pressure mounts, there are suggestions that mother and newborn baby will be discharged from the labour ward perhaps 4-6 hours after birth. It would be patently absurd for a baby to have two examinations in this short period on the labour ward.

It is of vital importance that each newborn baby in hospital is examined fully by a member of the medical establishment, and the medical way forward has been to suggest that there should be only one examination of each infant, performed by paediatric senior house officers. This examination should take place as early as possible in the infant's life, so that the discharge of mother and baby is not held up for want of a paediatric examination.

Second, risk factors cannot always be eliminated in the hope of preventing adverse outcome. Some may be inherited, such as genetic susceptibility to sickle-cell disease. Many socio-demographic risk factors, such as age, race, and poverty, fall into this category. We may have the laudable goal of eliminating poverty and racism in society, but for the individual woman whose risk we are assessing, the end results are already part of her risk profile.

Finally, most risk factors, even if they are strongly associated with outcomes in population, do not predict adverse outcomes very well for individuals. Suppose for example that a certain fact in the health histories of pregnant women is associated with a fourfold increase in the development of gestational diabetes. This makes for an impressive risk factor, but it does not mean that all women with the risk factor will develop gestational diabetes. It may mean that, on average, 12 of 100 women with this factor and only three of 100 women without it will develop the condition: a fourfold increase. But most women, even if they have the risk factor, will never develop diabetes. The combination of poor specificity (a test with many false-positives) and the low prevalence of most adverse outcomes creates a low predictive value for positive test results (1). In other words, even the presence of many risk factors is no guarantee that a bad outcome will occur. The predictive value of preterm birth risk assessment tools, for example, is relatively low: only 10% to 25% of women designated as high risk go on to deliver preterm (2-5).

When risk factors (and their limitations) are incorporated into formal risk assessment screening and intervention programs, another problem emerges. Preventive health care strategies assume that, given certain risk factors or high risk scores, interventions are necessary to prevent adverse outcome. But because some risk assessment tools have low predictive ability, these interventions may be applied to many women who are not really at risk for the outcome (those with false-positive risk assessments). The result: Our advice and other interventions appear to work quite well in preventing adverse outcomes. The reason: Many of the women who were recipients of the interventions were never destined to have the outcome in the first place. In preterm birth prevention programs, the interventions seemed to work because most of the women labelled at risk delivered healthy babies at term. But if 75% to 90% of women were erroneously labelled as at risk for preterm delivery, the interventions may have had little or no role in preventing any adverse outcome. The appearance of benefit, however, reinforces the perceived value of risk screening and timely intervention, and makes it difficult to question whether assessment and intervention programs are beneficial or not.

Are there any risks associated with risk assessment? Risk assessment assigns risk labels, which result in interventions, which then produce more interventions. How many women labelled "at risk for prematurity" fell victim to such a cascade of intervention in preterm birth prevention programs?

There is ample evidence that those risk assessment strategies did not identify women destined for preterm birth with accuracy. Nonetheless, overassessed women were diagnosed, monitored, hospitalized, tocolyzed, given cerclages and/or weekly pelvic exams and advised any number of other interventions, all without any discernible effect on preventing preterm birth (6-9).

Unnecessary medical interventions are problematic enough, but there is more to consider. What happens psychologically or emotionally when women are labelled "at risk"? Do they perceive themselves as "problems waiting to happen"? What does this do to self-image? Are there adverse outcomes that could result from feelings of anxiety or helplessness? What happens when someone at risk for prematurity cannot follow advice to rest in bed and then delivers preterm? Does she blame herself for her premature baby (although it is possible that nothing we currently know could have prevented the outcome)? What if she follows all of the advice and still delivers a preterm infant? Even intervention strategies that might produce benefits in large populations may fail to prevent an adverse outcome in an individual woman. Will she feel she has "failed"? Some risk factors describe who the woman is; if she is poor or uneducated, will she feel inadequate? If she does not give up a preventable risk factor, like smoking, is she guilty? Clinicians would never deliberately pronounce such judgements, but is it possible to communicate them, however inadvertently? When risk screening assigns labels, or if interventions fail, do our patients judge themselves?

In public health policy there is an important consideration when determining whether to recommend a presumably beneficial screening and intervention program for the population at large: Are there health risks associated with the screening or intervention? The majority of people targeted are not at risk for the outcome one is trying to prevent. Thus, it is important to know that there is no threat to the health of a large number of "no-risk" individuals that could undercut the benefit of preventing a bad outcome in a small group of those at true risk. For example, before recommending routine alpha-fetoprotein testing for all pregnant women, advisory committees consider whether the benefits of detecting a few babies with neural tube defects could be offset by any possible increased pregnancy loss due to amniocentesis or false-positive diagnoses in women not at risk. Risk assessment as a routine screening and intervention program, although widespread in health care, is rarely considered in the same light. We assume its benefit, and only its benefit.

There are questions that should be asked, however, when initiating formal risk assessment programs. How accurate are the screening tools? What is the true value of the resulting interventions (not just the "apparent" value when applied to many not really at risk)? Are there any risks for those with "false-positive" risk profiles?

What about the additional diagnoses, tests, procedures, and other interventions that will automatically be set in motion once that label of risk is assigned? What if these are completely unnecessary? What if they create health risks of their own? What if the screening questions are perceived as an invasion of personal privacy or dignity? Are there psychological ill effects when labels are assigned? If these questions cannot be answered, then we must consider this. What are the ethics of assessing all women to identify hypothetical risk factors (that may not predict disease with accuracy) in order to prescribe interventions (which may be dubious value and possible harm) in the hopes of preventing an outcome (that will never happen to most of those subjected to this process)?

Both clinical practitioners and society in general view the benefits of prenatal and other health care as the result of prevention activities and early detection/treatment of disease. Risk assessment thus defines quality care; not to assess risk might certainly be considered negligent. But enthusiasm for risk assessment needs to be tempered with reality. For every mother and baby whose health is apparently assured by perinatal risk identification and intervention, there may be others who undergo unnecessary hospitalization, caesarean sections, false diagnoses of disease, unmeasured psychological impact, etc., that result from inaccurate screening. Despite good intentions, the truth is that we still do not know how to predict or prevent many adverse outcomes. Appreciating the limitations of risk assessment is not a licence for "laissez-faire" health care. However, as health professionals we need to understand the limitations and work toward minimizing their impact. Enthusiasm for prevention should not be allowed to create new risks of unnecessary intervention, unrealistic expectation, or undeserved blame.

Patricia Aikins Murphy, CNM, DrPh
Associate Editor

Section 51 Negotiations Between New Zealand College of Midwives NZ Medical Association & Regional Health Authorities

4 November 1994, Wellington

The meeting was to comment on the paper entitled "Maternity Services Joint RHA Maternity Strategy"

Following wide consultation with the College regions, the NZCOM negotiating team (Sally Pairman, Sian Burgess, Carey Virtue, Julie Richards and Karen Guilliland) presented the College's case.

Concerns included:

- the "invisibility" of the midwife
- the paper often assumed the lead professional to be a general practitioner
- the concept of lead professional could undermine co-operation and respect for individual practitioners. It could increase medicalisation and undervalue the woman's role in her own experience.
- nature of modular funding undermines continuity and encourages underservicing.
- administration costs shifted from RHA to midwife

The College and the NZMA were in agreement in their opposition to the Maternity Referral Criteria (both the process used to identify criteria and the actual criteria) and the Chapman Tripp Access agreement paper currently circulating via the CHE Women's Health Managers.

The RHA agreed to revisit the Maternity Referral Criteria process and the College will be able to comment further. The RHA's noted our concerns that midwifery research based opinion to be undervalued in the document.

It was agreed that the Chapman Tripp Access document is inappropriate and will not be the basis for CHE access for primary practitioners. The RHA's principles for Access will be used by NZCOM and NZMA when they draft up a base document together for perusal by the RHAs.

Other agreed principles:

- CHE consultant staff must accept a referral / transferral directly from a midwife or GP. It is not appropriate to require a midwife to consult via a general practitioner first.
- Epidurals are an anaesthetist's responsibility. A CHE cannot require midwives to produce substitute anaesthetist care other than the normal midwifery monitoring of woman and baby. Anaesthetist to accept referral from midwives and GPs.

- Lead professional cannot take responsibility for another practitioner's practice.
- A CHE, if contracted for normal birth under Section 51, must identify either an obstetrician or midwife (in some circumstances a GP) as the lead professional.
- It is not envisaged all CHEs will be funded under Section 51 in the near future but will continue to be bulk funded. Some may choose to continue to not provide normal birth services and RHAs will contract primary providers.
- In primary care the woman appoints the lead professional. This person will receive administration funds and is responsible for organising and administering payment for ongoing care. This person will be required to have significant clinical involvement in all modules.

Information Module : RHA will produce a generic leaflet on birth options. Providers will be expected to give this information but RHAs will also instigate other methods of distributing information.

Pregnancy Module :

- Antenatal education incorporated in module and lead professional will arrange with woman.
- ultrasound also within module's budget.
- consideration from RHA how miscarriage, termination, induction, ectopic are to fit into module.

Labour and Birth Module :

Induction : CHE cannot require midwife to remain with woman unnecessarily.
- Two birth attendants fees - one practitioner paid for labour and birth; one practitioner paid for birth.
- provision always for two practitioners at a birth.
- can have episodic consultations without losing care, e.g. forceps, epidural.
- Midwife can continue care up to Caesarean section if she and client wishes.

Postnatal Module :

RHA's proposal to finish maternity care at two weeks strongly apposed by both NZCOM and NZMA.

Proposed well child provider (apparently not always to be Plunket) will take over child care and mother will pay for further maternity needs.