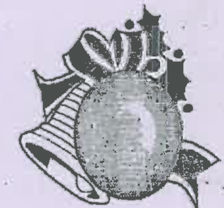
NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

December 1995



Midwives' Prescribing Rights

Medical Misadventure

New Zealand Breast-feeding Rates

AUCKLAND HOME BIRTH ASSOCIATION (INC)
P O BOX 7093
Wellesley Street
AUCKLAND

POSTAGE PAID
CHRISTCHURCH NZ
PERMIT NO. 2843

Sender : NEW ZE...
P O Bo...

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

National Office: P O Box 21-106, Edgeware, Christchurch 906-908 Colombo Street
Telephone (03) 3772-732 Fax (03) 365-2789

Board of Management

Karen Guilliland	**National Co-ordinator**	C/- National Office
Sally Pairman	**President**	90 Cannington Road, Dunedin - Phone 03-467-5046
Linda Collier	**National Treasurer**	C/- National Office
Julie Richards	**Newsletter Editor**	81 Caledonian Road, Christchurch - Phone 03-377-2481

National Office

Judy Henderson	**Secretary**	
Jackie Pearse	**Legal Advisor**	
Marita Perini	**Membership/Finance Clerk**	(Hours: 9.30am-3pm Monday-Friday)

Regional Chairpersons

Auckland
Sandy Grey
827 Te Atatu Road
Te Atatu Peninsul
AUCKLAND
Ph: 09-836-0822
8345704

Canterbury/W Coast
Jacqui Anderson
27 Charnwood Crescent
Harewood
CHRISTCHURCH 5
Ph/Fax: 03-359-7811

Central
Ruth Martis
467 Church Street
PALMERSTON NTH
Ph/Fax: 06-834-5704

Nelson
Kirsty Prichard
P O Box 307
MOTUEKA
Ph: 03-528-8669

Northland
Jane Fox
R D 1 Okaihau
BAY OF ISLANDS
Ph: 09-401-9015

Otago
Mary Gamble
3 Ings Avenue
St Clair DUNEDIN
Ph: 03-455-8643

Southland
Jenny Humphries
Mokoreta 2 RD
Wyndham SOUTHLAND
Ph: 03-2064-022

Waikato/Taranaki
Adele Buckton
Okete Road
R D 1 RAGLAN
Ph: 07-8258-942

BOP/Tairawhiti
Ann Hopkirk
15 Sumner Street
ROTORUA
Ph: 07-347-9917

Wellington
Sue Calvert
39 Kiriwai Road
Paremata
Ph: 04-233-1060

Nga Maia O Aotearoa Me Te Waipounamu
Ellen Tito 10 Birch Place East Tamaki AUCKLAND Ph: 09-276-0000
Harangi Biddle C/- Post Office Lake Rotoma ROTORUA Ph: 07-362-0061
Estelle Marment 34 Dowling Rd U Hutt WELLINGTON Ph: 04-5277-807
Ranui Parata 157 Mulford Street Concord DUNEDIN

Regional Sub-Committees

Gisborne	Napier Hastings	Taranaki	Wanganui
Sue Bowler	Fiona Pullar	Carolyn Crawford	Lenna Young
Greendale	5 Chamber Street	36c Beaumont Crescent	18 Totara Street
RD1 GISBORNE	HAVELOCK NORTH	NEW PLYMOUTH	WANGANUI
Ph: 06-867-5317	Ph: 06-877-4578	Ph: 06-753-9950	Ph: 06-344-4188

Consumer Representatives
Parents Centre Diane Matsas 39 Grange Street, Opawa, Christchurch - Ph: 03-337-1419
Maternity Action Alliance Rea Daellenbach 8b McMillan Avenue, Christchurch - Ph: 03-3325-739
Home Birth Association Glynette Gainfort c/- Tauranga HBA, Box 729, Tauranga - Ph: 07-5710-387

OPPORTUNITY

Delivery Suite Services
Clinical Midwife Advisor

As part of the implementation of the new Nursing Practice Structure the position of Clinical Nurse Advisor – Delivery Suite Services has become available.

This is an exciting era for health care in Hawke's Bay and we are looking for an enthusiastic, innovative and well qualified Midwife to assist in the development of Maternity Services as the Company moves towards one regional hospital.

The Clinical Midwife Advisor – Delivery Suite Services is one of three expert clinical practitioners together acting as a resource, leaders and educators in midwifery practice and quality maternity care.

There are approximately 2,000 births per annum. High risk deliveries are cared for at Hastings with primary and secondary specialist care currently available at Napier. This is an opportunity for the right person to have influence and input into the development of Delivery Suite Services under the regional model.

Applicants must be registered midwives, preferably with a post graduate qualification. Remuneration will be negotiated.

Applications close: 4.30pm, Friday 19 January 1996

FOR FURTHER INFORMATION

Contact: The Personnel Officer,
Health Care Hawke's Bay
Private Bag 6023, Napier.
Ph: (06) 835 9241 • Fax (06) 835 9290

HAWKES BAY

SITUATIONS VACANT

Tairawhiti Healthcare Limited

Midwives

We invite you to join us in Gisborne. The first city to see the Sun.

Registered Midwives are required for our Obstetric Unit to undertake full time rostered duties.

If you enjoy a family centered approach to care, have good interpersonal skills and an interest in Team Midwifery. We have what you are looking for!

For more information contact Sandi French or Jillian Mitchinson, phone 06 867 9099, ext 8019 or 8414.

Application Form and Position Profile available from:

Human Resource Dept
Tairawhiti Healthcare Ltd,
Private Bag 7001,
Gisborne

Closing Date: Open

EXPERIENCED SELF EMPLOYED MIDWIFE

required for large rural area:
Morrinsville
Te Aroha
(30 minutes from Hamilton)

Access to local CHE facilities
Supportive local team of five midwives

All enquiries to
Mary Ivory
829 Tauheri Road
Morrinsville
Phone (07) 887 6736
Fax (07) 887 6803

CONTENTS

National Committee Directory	fic
Editorial	2
Letter to the Editor	3
Midwife Profiles	4
Obituary	7
National CommitteeSummary	9
Events Calendar	14
Current Issues	17
Articles of Interest	40
Media Watch	50
Situations Vacant	56
Membership Application Form	centre

ADVERTISING

Advertising in the National Newsletter is FREE to affiliated non-profit making organisations with maternity related issues, i.e. NZCOMI Regions, Home Birth Association, etc. For advertising rates and more information, please contact:

Barbra Pullar
NZCOMI
P O Box 21-106 Christchurch
Phone/Fax (03) 377-2732

NATIONAL COMMITTEE MEETING CALENDAR 1996

February 1996
Wellington
Date to be Advised

Any contributions to the National Newsletter should be addressed to:
Barbra Pullar
P O Box 21-106
Christchurch

PUBLISHING DETAILS

Editor - Julie Richards
Typesetting - Marita Perini & Judy Henderson
Printing & Collating by Marau Enterprises, Chch
Folding - IHC Shirley Rd, Chch

DISCLAIMER

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

Wishing you and your family a Happy and Safe Festive Season

EDITORIAL

Seasons Greetings as Christmas and the New Year loom closer. Another "full on" year passes.

Our amazing President now has a new son!

Heartfelt Congratulations to Sally Pairman, Michael and Oscar on the birth of Felix.
Felix was born at home on the 9th November.

Midwives have been hitting the media in a very positive form over the last few months. I have been overwhelmed by large feature newspaper articles promoting midwives and continuity of care. This is a wonderful, positive shift in focus and congratulations to those of you who are making it happen. Unfortunately most of the articles are too long to print but they will be held in the archives.

There have been a few changes in the National Office in the last few months. Linda Collier has completed her contract as Assistant Co-ordinator and has returned to Self Employed practice. She continues as National Treasurer and can be contacted via the National Office.

The College warmly welcomes Jackie Pearse to the position of Legal Advisor. A profile of Jackie is included in the newsletter.

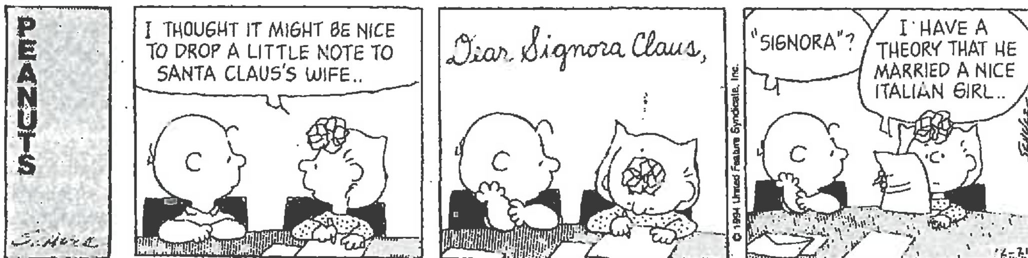
This is my last issue as Editor of the Newsletter. It has been an interesting role, especially having access to so much information about current issues. Barbra Pullar, yet another enthusiastic midwife in Christchurch, keenly offered to take on the position. Welcome Barb, I'm sure you'll enjoy it. Barb has also included a profile on herself.

The Conference clothing is now available and will be dispatched to you on receipt of your order form and cheque. They look fantastic and make great Christmas presents.

Wishing you a peaceful Christmas and relaxing Summer.

Take care,

Julie Richards



SELFISH

But Mid Canterbury General Practitioners Association spokesperson Dr Peter Sparks said those who chose homebirth without general practitioner care had a selfish attitude where the baby took second place. He said advocates should visit early cemeteries and see the graves of young women who had died while giving birth.

"There are whole sections of young women who died in child birth. Does anybody want to return to those standards?"

"Let's maintain the standards we have built up over this century. I would not want to see them abandoned." - *Ashburton Guardian - Saturday November 4, 1995*

Ashburton Hospital maternity centre midwife Edith Smith weighs new family addition Tennyso Horsburgh on a post-natal visit to his home. Mum Viv Horsburgh looks on with Kinnear Horsburgl 3, and Chantelle O'Brien, 13.

Photo Monique Foi

Women's choice mark of modern maternity care

By Bill Robson

WOMEN are becoming the "meat in the sandwich" as doctors and midwives battle for a share of the new-look maternity market, a consumer representative on the College of Midwives said yesterday.

Tauranga mother Glynette Gainfort said it was up to New Zealand women to ensure the Government's new maternity services policies worked to their benefit — but they would need to receive solid information from someone other than vested interests.

Ms Gainfort is a member of the Tauranga Home Birth Association and the college, but said she was speaking as someone who had "consumed" the service several times" and was concerned that GPs and midwives were "fighting over our bodies". Only women could ensure success of the new maternity services package, but a concerted education programme was needed to ensure they were aware of their choices.

Many women still went to the family GP when they became pregnant — and many GPs were still holding back information on the availability of midwives or, in at least one case, claiming that home births were illegal.

Despite publicity surrounding the new policies, many women were still not aware they would have the right to choose a lead carer — a GP, a midwife, or a specialist — and that only the chosen lead carer would be paid. "Women are being led down the garden path. When we talk to them, they're surprised at the choices they have," Ms Gainfort said.

Education was the only answer and she said it was time the Government considered introducing pregnancy care options in secondary school living skills programmes. As well, she saw value in advertising campaigns, particularly on television, advising pregnant women to seek out all available information.

Meanwhile, she said the Home Birth Association had applied for a budget-holding contract with Midland Health, which would give the association the right to purchase all pre-natal, childbirth and post-natal services required by women — including the hiring of GPs or midwives according to the woman's choice.

BOP TIMES 22.6.95

MIDWIFE SERVICES THREATENED BY POSSIBLE FUNDING CHANGES

- Nelson Evening Mail 11/11/95

Proposed changes to Regional Health Authority funding of rural services could be the death knell for some independent midwifery services in country areas, according to a regional spokeswoman.

The Nelson-Marlborough chairwoman of the New Zealand College of Midwives, Kirsty Prichard said during the past five years independent midwives had travelled to rural areas to give women antenatal care and postnatal support at home.

She said proposed funding changes failed to make adequate allowance for vehicle running costs to allow a continuation of these services in rural areas and rural women, already disadvantaged, would be the losers.

"At the suggested funding levels rural midwives will be unable to provide a service."

Ms Prichard said RHAs professed to support a choice of maternity caregiver, continuity of care and home-based care, but they had not made adequate allowance for services to be delivered in rural areas.

She said the proposed rates came after about two years of negotiations with the joint RHA Maternity Project Team.

A project spokeswoman said midwives were paid $1 per kilometre travelled, the same as is paid to general practitioners. It included an allowance for travelling time. Under the proposed system a flat rate would be paid per client.

Ms Prichard said the changes would affect five independent midwives in the Nelson region.

"I have had calls from some of them who have done their figures and they doubt they will be able to carry on."

Tapawera midwife Jill Bonny said she was concerned at the impact this would have on already isolated rural women.

"Some of these women are unable to travel to town and they will just miss out. From what I can see the proposed rates will mean I have to severely curtail my practice."

She said a large part of her time was spent travelling to clients living in an area from Nelson Lakes and Murchison to Dovedale.

The flat rates would not allow for the travel time involved nor would midwives be able to put money away for vehicle replacement.

"And without a vehicle you can't be a practising midwife."

Motueka midwife Maggie Matthews said she had worked out the rates she would receive for three existing clients living 64km, 130km and 210km away from Motueka.

The lowest mileage rate calculated was 8 cents per kilometre, the highest was 17 cents.

"It is obvious from these calculations that it is uneconomical for midwives to service rural women."

She said the further a woman lived from the town the less likely she was to get care.

Joint RHA maternity project spokeswoman Sam Denny, of Auckland, said yesterday the project team was still in discussion with the midwives and wanted to ensure a continuation of service to rural women.

But more money was currently being spent on midwives' travel than for services they provided to women. A balance needed to be reached.

"We also need to ensure we are not paying for one provider to travel great distances when there is another provider close by who can provide the same service."

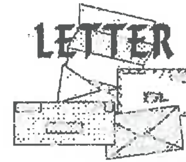
Spending through the Maternity Benefit Schedule had increased from $35 million in 1988 to $86 million in the current year.

Homebirth Debate Alive in Mid Canterbury

The Ashburton Guardian recently featured a full page article exploring the home birth debate. The article goes on to promote all of the midwife care options available in Mid Canterbury including the CHE's continuity of care scheme.

It is an extremely informative and positive article and particularly offers support to families considering homebirth in a town where the medical profession are openly hostile about homebirth.

The hostility is obvious in the following statement from the article.



LETTER TO THE EDITOR

November 1995

To the Editor

In reply to Mrs P Anstice's letter (Sept/Oct Issue) in which she refers to her discomfort with God being referred to as a "she". In this she states that "if midwives are to have credibility with our medical colleagues, and the public, such comments are unnecessary and counter-productive". My reply to Mrs Anstice is two-fold.

Firstly, it has been well documented throughout world history that prior to "God" a number of Gods were worshipped, most of which were infact female. Some feminists would argue that it is the worshipping of a singular male God that supports our patriarchal system in its oppression of women. The burning of the witches is a classic historical example of this, where the Church and the State were directly responsible for the death of thousands of women healers, and midwives. Their wisdom and knowledge of women was seen as a political and religious threat.

Secondly, on the subject of credibility with "our medical colleagues", I am of the opinion that it is not the medical profession from which we should seek credibility. The midwifery model, which is clearly demonstrated in the NZ College of Midwives Handbook for Practice, clearly supports a partnership with women, not the medical profession. Therefore I strongly believe that midwifery credibility lies firmly in the hands of those we work with, women.

I fail to see how seeking credibility with the medical profession, especially the gender of God, has anything to do with empowering women to take back ownership of their own birth experience.

P London

ULTRASOUND SCANS DURING PREGNANCY

Pamphlets Now Available

The Women's Health Action Trust have recently produced a balanced, well written pamphlet on ultrasound scanning in pregnancy.

Issues included in the pamphlet are:

- *What is Ultrasound*
- *What is Ultrasound used for*
- *Benefits of Ultrasound*
- *Concerns about Ultrasound including Ethics*
- *Women's Reaction to Ultrasound*

Current references are used.

Congratulations to the Women's Health Action Trust for producing a clear easily read pamphlet that will greatly assist women in deciding about Ultrasound in pregnancy.

Pamphlet cost 80 cents each

Available from: Julie Best
Women's Health Information Service
PO Box 9947
Newmarket
AUCKLAND
Phone: (09) 520 5295
Fax: (09) 520 4152

Oral Contraceptives and Blood Clots Fact Sheet on this also available from Women's Health Information Service.

PROFILES

Jackie Pearse - Legal Advisor, NZ College of Midwives

Jackie was recently employed by the NZCOM to manage the College's increasing amount of legal work.

Jackie has the mix of qualifications the College has been looking for as she is both a midwife and a lawyer.

Jackie is married to Lemuel whom she met in Hawkes Bay at the time of taking up her first nursing position. Lemuel is Ngati Kahungunu and they have two children Phillippa and Ben and a grandson Temuera. The family moved to Dunedin from the North Island for Lemuel and Jackie to study and have now moved to Christchurch.

Jackie's professional career continued in Hawkes Bay following registration as an RGON in Southland in 1979. She has worked in a variety of areas ranging from ICU to Practice Nursing and assisted in the establishment of the Hastings Family Planning Clinic.

In 1982 Jackie was employed in the Turangi Maternity Hospital as a Staff nurse but realised she was actually working illegally as a midwife. Jackie stated this was the first time she became fully aware of what it meant to be legally accountable for her professional actions.

In 1984 she went to Wellington and completed her midwifery education with ADN. She added her own personal experience by giving birth to her son 3 days before state finals.

From there Jackie worked as a midwife in Turangi, and also helped establish a district nursing service, and then later as a midwife at Elderslea Hospital in Upper Hutt.

NZ midwifery 'world leader'

OTAGO DAILY TIMES 1/9/95

By Lee Harris

English midwifery professor Prof Lesley Page believes New Zealand and the United Kingdom are world leaders in midwifery with much to offer each other.

The visitor to Dunedin has a joint appointment as professor of midwifery practice at Queen Charlotte Hospital and Thames Valley University in London and also practises at Queen Charlotte and Hammersmith Hospitals.

Prof Page was brought to New Zealand as a visiting scholar by the Otago Polytechnic School of Midwifery.

She gave a public lecture at Dunedin Hospital.

About two years ago Prof Page initiated the One To One Midwifery Practice Project to enable midwives to follow one woman all the way through her pregnancy, childbirth and post-natal care.

In 80% of all births, a midwife could provide complete care, Prof Page said.

While British women could choose to have medically led births, with the assistance of a doctor, most chose midwives to help them.

However, the system had become fragmented, with no one person responsible for the care of pregnant women.

Women preferred midwives because of the supportive relationship they were able to form. The midwife was trained to meet women's individual needs and help women take control of their pregnancy and birth.

Prof Page's project had involved about 800 women a year and was being rigorously evaluated.

Early indications of cost showed that having a midwife follow a women right through her pregnancy did not cost any more and could even cost less than the current service involving many different health practitioners.

One of the problems with the service in both Britain and New Zealand was the duplication of care and waste of time.

Prof Page's intent with the project was to ensure that midwives were available when needed, to reduce duplication of services, the number of tests, admissions and the length of stay in hospitals.

Many tests, such as urine samples, were repeated because a pregnant woman visited so many different practitioners and each one wanted to reassure themselves that the pregnancy was going smoothly.

Some tests had been introduced without proper evaluation of their effectiveness.

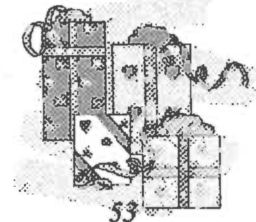
Research had shown for instance that routine electronic foetal monitoring to listen to a baby's heart during labour increased the likelihood that a woman might have to have a Caesarean or other operation.

Changes were taking place throughout England, Scotland and Wales with a renewed emphasis on the continuity of midwifery care.

Prof Page was taking note of the consumer involvement in the New Zealand College of Midwives development of standards and ethics and review procedures.

While there was consumer involvement with the British College of Midwives, it was more informal than the New Zealand practice of using affiliated consumer groups.

New Zealand College of Midwives president Sally Pairman said Prof Page's research would be very useful in New Zealand, where the Joint Maternity Health Project had been launched by regional health authorities without any real data.



"BY THE TIME people hear about me they've already booked in somewhere else. A lot of them don't realise their choices, and that they can go to a low tech unit. Clients who can't communicate are automatically sent to the high tech unit because of communication barriers. That's something I'm trying to work at.

"Deaf people are isolated. People don't bother to take the time and just fob them onto somebody else. They pass through the system. It must be very frightening and isolating for them."

Gaye can relate to these difficulties through the personal experiences of her mother and some of her cousins, who have had "frightening" birth experiences because of their disability.

"They had horrific experiences 20 years ago and are still dealing with them today. It's really unnecessary. Even things like waiting for your antenatal appointment are difficult. You sit there and people come past and their mouths are opening and shutting, but you don't know what anybody is saying."

"If only somebody would just come up to you and tap you on the shoulder rather than leaving you to wonder if you are going to miss out on the appointment because you don't hear the midwife or nurse call your name."

Midwifery was not Gaye's first choice of career. Her original interest was psychiatric nursing, but she found during her training that her greatest strength lay in obstetrics. After graduation she worked in medical and surgical areas. However, midwifery and child health seemed to "keep coming back" to her, so she applied for midwifery and was accepted.

The change to a "quieter and less chaotic" area of nursing has been a welcome one, she says. An aspect she particularly appreciates is the personal contact she has with her clients.

"You build up a partnership with the women, and get to know each other. A lot of them are really curious about working with a midwife who's deaf. I'm relaxed and open about it, and they're great."

Gaye has no immediate plans for working as an independent midwife. At present she is enjoying working as part of a team of experienced midwives, especially at this early stage of her career. One hope for the future is to move into the area of education; she is currently involved in public education with the Deaf Association, and last year won a Deaf Achievers' Scholarship.

According to Birthing Unit Practice Manager Chris Hendry, one of Gaye's strongest contributions to the unit has been her ability to highlight the needs of clients with hearing or other disabilities that other staff would not have thought of.

An unusual example is the fact that hearing-impaired women often prefer to be in a single room with their babies. Staff had automatically assumed that a shared room would be suitable because they would not be disturbed by the noise made by other babies.

However, as Gaye pointed out, the level of noise in a shared room creates vibrations which may set off the baby alarms hearing-impaired women.

Chris Hendry says that Gaye has proved to be a highly valued member of the Birthing Unit team who more than meets the expectation that she will achieve the same high professional standard as the other midwives.

Two Canterbury people received awards from the Governor General, Dame Catherine Tizard, in Christchurch this week for their work for Save the Children Fund. Pictured with Dame Catherine are Angela Kearney, who received the gallantry award, and John Withington, who received the long service award. Ch Ch Star 22/7/95

After moving to Dunedin in 1988 Jackie began tutoring at Otago Polytechnic in the Midwifery and Nursing Programmes.

Jackie commenced law 4 years ago and has completed an Honours Degree this year. Her impetus to study law was related to advocacy, in a wider context than midwifery.

Jackie has been working in part time law positions while completing her study. She had anticipated working for the College once she had gained further experience but as the need for a Legal Advisor was immediate she applied for the position. Jackie states ***"I feel that Midwives are extremely vulnerable at the moment as they adjust to the demands of professionalism and try to maintain their practice and philosophy in the face of continual political manoeuvring. I welcome the chance to serve the profession by being part of the safety net during this transition."***

Jackie has been extremely busy since commencing work 4 weeks ago. She is concerned about the increasing number of complaints to be investigated and believes there are 3 main areas of concern:

- Midwives have been legally "innocent" of their rights and responsibility. As a result they are not good at protecting themselves and still believe the best of everyone.
- Women are not standing by the choices that they make and when there is an unexpected outcome, they blame their midwife.
- Midwives are not clear and accurate in their documentation and unfortunately this is what they are judged on if a case goes to hearing. If you are checking a FHR - note it.

Jackie is planning to commence education sessions next year in the Regions. She is available Monday to Friday through the National Office and is happy to discuss concerns that you may have.

ABOVE ALL REMEMBER
If you suspect that an incident may give rise to a complaint, your indemnity insurance requires you contact the College immediately

A Postnatal Drip is a person who asks you when you are due, two weeks after the baby is born.

INCOMING NEWSLETTER EDITOR

BARBRA PULLAR

I undertook my Midwifery training in the last hospital based programme at Christchurch Women's Hospital in 1979.

Until the birth of our first daughter, Jessica, I worked in the Labour Ward there and returned four years later after Emily, our second daughter was born. I also worked with a group of midwives providing antenatal and postnatal care in the community but thankfully it was not long until I could provide continuity of care when the Nurses Amendment Act was passed.

Since then I have been working in a practice which now comprises of six midwives providing full midwifery care.

Over the years I have been involved in College matters, sometimes at committee level and latterly as joint Convenor of our local Midwifery Standards Review Committee.

I am very much looking forward (although with some trepidition!) to becoming editor, learning new skills and being more "up with the play" in regard to new developments.

I hope my enthusiasm will make up for shortcomings as I take up my new role.

Regards, *Barbra Pullar*

Deafness no bar to midwife

Healthwise, Sept/Oct 1995

When you meet Burwood Hospital midwife Gaye Blondell, you find yourself talking to a bright, friendly and dedicated young woman who is enthusiastic about the promising career opening in front of her.

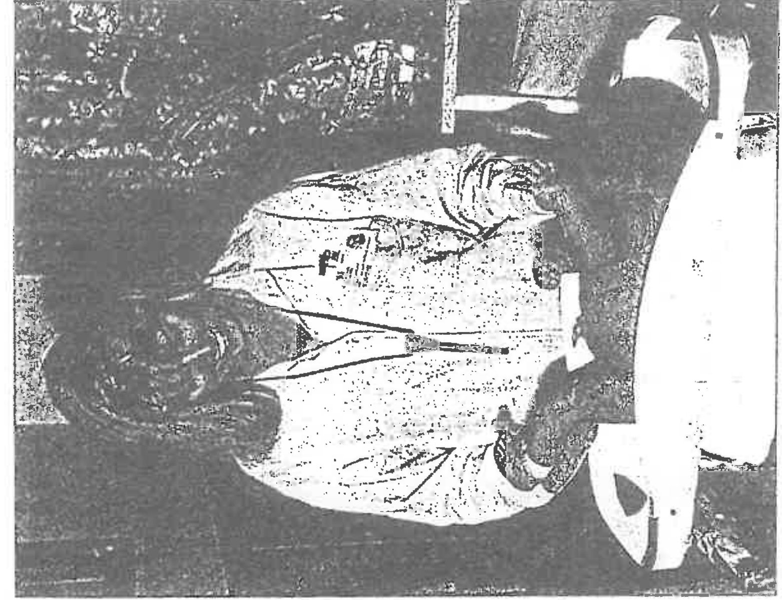
It's not until she asks you to look directly at her while you speak to her that you realise she's deaf.

A graduate of 1993, Gaye is in her second year of midwifery and has worked with three hearing-impaired clients so far. she is keen for the word to get out among the 500 profoundly deaf people in Christchurch, and also among general practitioners and other health care professionals, that a midwife who can use sign language and communicate with deaf clients is now available.

Since making contact with the deaf association in Christchurch, more people have been contacting her by her fax at home, she says.

Gaye was born in Southland to a profoundly deaf mother and a hearing father. She has a profoundly deaf brother and two hearing sisters. Eighteen members of her wider family are deaf to some extent.

Although her hearing was normal when she was born, she started to lose capacity at the age of 12, because of a genetic disorder.



Deaf midwife Gaye blondell . . . succeeding in "a normal job and a normal life."

Gaye is able to hear monitors, blood pressure and babies' heart beats, and can just hear enough to talk on the telephone. Her home phone has an amplifier, as do the phones in the birthing unit at Burwood.

Like the rest of the unit staff she has a pager which prints out messages. This helps her to piece together the context of the conversation when she rings her caller back.

When she is required at night, she is woken at home by a siren and a flashing light linked to her telephone.

Gaye currently has about 10 percent speech discrimination. She can hear certain speech sounds but doesn't pick up enough to make sense of them or to put sentences together. The effect is like listening to a different language, she says.

A hearing aid provides some assistance, supplemented by lip reading, generally regarded by hearing-impaired people as "60 percent guesswork."

Gaye is grateful to her parents for sending her to normal schools and encouraging her to "get out there in the normal world and succeed in a normal job and a normal life."

Although she has deaf friends and attends the Deaf Club when she has time, she doesn't generally mix in deaf circles, and appears very much at home in the hearing world.

However, she says she feels "stuck between both worlds.

"I can understand hearing culture and I can understand deaf culture, but I'm not really in either one."

Gaye works with hearing clients as well as hearing-impaired women. When dealing with hearing clients, she informs them at them at the outset about her disability, and has experienced no problems, even when helping women in labour.

With deaf clients she mostly communicates with the sign language, which she has been learning for about a year. "Sometimes I have to finger spell because I don't know the sign, but I know enough signs to hold a basic conversation."

Despite being deaf herself, the process can sometimes be hard work, she admits.

Gaye is concerned by the fact that deaf women are routinely sent to high tech birthing units, even though their hearing impairment does not necessarily mean their birth experience will be difficult.

MEDIA WATCH

Maori home birth group grows

BAY NEWS, WEDNESDAY, AUGUST 30, 1995

THE process of birth from a Maori woman's perspective plays a key role in the running of Te Ahuru Mowai (The Sheltered Haven), a Maori home-birthing group.

The voluntary organisation was established two years ago, under the guidance of the Tauranga Home-birth Association. However, according to committee members Teressa Ngawaka, Mere Hapimarika and Tania Rangi, it is only in the last two months that Te Ahuru Mowai has grown big enough to offer a full range of services to the public.

"The group has not always been at the strong stage it is now. We are an incorporated society, run under the Maori kaupapa and funded through Midland Health by the Government. We now feel that we have a strong range of services and support to offer, which is why we are now going public." Mrs Ngawaka said.

The committee say Te Ahuru Mowai was set up to fill a void in the health system and to offer birthing practices from a Maori woman's perspective. However, all say there is no radical or racial about the group.

"We are an independent Maori group working for Maori, but this is not because we want to take a stand and say 'we demand our own rights'. It is only because some Maori feel shy or uncomfortable when attending a European clinic or doctor."

Mrs Ngawaka said the aim of the group is to bring Maori women back to the natural process of birthing, to put them in touch with midwives and to offer support.

"We try to guide a woman through her pregnancy, teaching her, for example, good kai to eat for both her and baby. We also offer homoeopathic and aromatherapy to help during the pregnancy. Our attitude is holistic — to service the spiritual, emotional, physical and family side of the woman."

Services offered by Te Ahuru Mowai include a pelvic rocking stool, transportable birthing pool, library, support contacts, and a two-week nappy service. All of the services are free and can also be used by mothers who choose a hospital birth.

Mrs Ngawaka said a key to the success of the group is its support and referral service.

"We are not midwives but we are a group that can give help, support and encouragement and put people in contact with the right people."

Te Ahuru Mowai are planning to run ante-natal courses next year, along with a childbirth educators' seminar. They are currently putting together a "preparation for birth" workshop which will include health professional's and personal accounts of both hospital and home births. The group is also planning to take part in the Te Puna Health Hui being run by the Maori Women's Welfare League next month. Another aim of the group is to take on a qualified midwife, as Mrs Ngawaka is considering completing a three-year Waikato University midwifery course. The course begins in 1997.

Te Ahuru Mowai can be contacted through Te Puna Hauora at Tauranga Hospital.

COMMITTEE members of Te Ahuru Mowai (The Sheltered Haven) from left Teressa Ngawaka, Mere Hapimarika and Tania Rangi.

C5503-28

OBITUARY

✝ Christine Smith ✝

Christine Catherine Smith, the Senior Nurse and Midwife for Healthcare Otago's South Otago health service and a member of the Nursing council of New Zealand, died in Dunedin last week after a long battle with breast cancer.

Christine (43) was born in Dunedin, the only child of Irene and Ron Smith. Her early years were spent in the Catlins and then the family returned to Dunedin when Christine started school. She attended St Peter Chanel in Green Island and then St Dominics. During these years Christine studied piano and speech therapy and developed a lifelong love for music.

Christine's father died when Christine was 10 years old and her mother supported the family through her work as a district nurse. Nursing was an early aim of Christine's and from the age of 14 she would spend school holidays working as a nurse aide at the Eventide home in Company Bay.

Upon leaving school, Christine undertook her general and obstetric nurse training at Masterton hospital.She returned to Dunedin to work in Dunedin hospital as a staff nurse before travelling first to Australia and then to England by way of Japan and the Trans Siberian railway. Christine lived in London for 4 years working as aRegistered Nurse for a variety of agencies and then completing her midwifery training through South London and St Georges Hospitals in 1977. On her return to New Zealand in 1979 Christine completed her Plunket nurse training in Wellington and then moved to Invercargill to work as a Plunket nurse. A year later Christine took up a position as public health nurse and plunket nurse in the Maniototo, a position she held until 1984, taking a year out to complete the Advanced Diploma of Nursing in Wellington. Christine's time in the Maniototo was very special to her and she was a much loved and respected member of the community. She was always ready with a listening ear and practical advice and she took a real interest in the children, women and young families she worked with.

Christine retained her interest in public health and maternal and child health nursing when she began teaching in these areas at the Nursing and Midwifery department at Otago Polytechnic. Christine was a dedicated teacher and she had wonderful organisational skills which she exhibited in her role as course supervisor for year three of the nursing programme and for midwifery.

In 1990 Christine took up a position as the Senior Nurse and Midwife of South Otago for Healthcare Otago. Here she again demonstrated her strong commitment to both nursing and midwifery through her clear leadership and active support for staff in the areas of ongoing education and the development of innovative health services which could survive the health reforms. Christine was a midwife representative on the NZQA panel for the approval and accreditation of the Bachelor of Midwifery degree at Otago

Polytechnic and she then continued as the NZQA monitor for the midwifery degree until monitoring was handed back to the department in 1995. Her support and guidance over this time had a significant impact on the development and success of the midwifery degree programme at Otago.

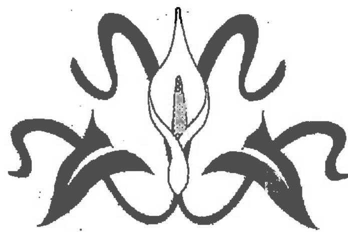
Christine's dedication and service to nursing and midwifery were recognised in 1993 by her appointment to the Nursing Council of New Zealand by the Minister of Health and she continued to make a major contribution as a Council member and member of the Preliminary Proceedings Committee until she resigned in 1995 due to her ill health.

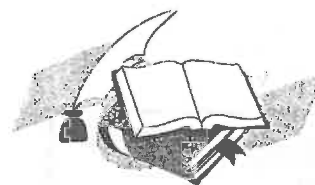
Nursing and Midwifery were very important parts of Christine's life. She was actively involved as a member of both the New Zealand Nurses Organisation and the New Zealand College of Midwives and had almost completed her Bachelors Degree in Nursing through extramural study at Deakin University in Australia. Christine strove always to support nurses and midwives in their practice and to ensure that their essential role in the health system was maintained.

Christine had many friends and always ensured that she kept in close contact with them. She had a genuine interest in people and was able to draw together a widely diverse group of people and leave behind her strengthened ties and new friendships. Christine will be remembered for her dignity and presence and for her sense of humour and great love for others. Throughout her long and courageous battle with breast cancer Christine maintained her optimism and good nature and held strongly to her faith. Christine's death is a huge loss, not only to those of us who loved her, but also to the wider nursing and midwifery communities where Christine would have continued to make a major contribution. Christine is survived by her much loved mother Rene and our thoughts are with her at this sad time.

Sally Pairman for Otago Polytechnic Nursing and Midwifery Dept.

October 1995





BOOKS AVAILABLE FROM NZCOM (P O BOX 21106, CHRISTCHURCH)

1. **PROTECTING, PROMOTING and SUPPORTING BREASTFEEDING** the Handbook of the New Zealand College of Midwives
   Cost: $19.95 + 80c Postage = $20.75

2. New Zealand College of Midwives **MIDWIVES HANDBOOK FOR PRACTICE**
   Cost: $5 + 80c postage = $5.80

3. **THE MIDWIFERY PARTNERSHIP** A model for Practice by Karen Guilliland & Sally Pairman
   Cost: $15 + 80c postage = $15.80

4. **PRESCRIPTION PADS** (please make cheques out to NZCOM, Canterbury/West Coast Region)
   Cost: $5 + 80c postage = $5.80

5. **JOURNALS** (a supply of most back issues)
   Cost: $5 + 80c postage = $5.80

6. ***Also:*** **PINARDS** (please make cheque out to Midwifery Resource Centre)
   Cost: $25 + $2.50 postage = $27.50

ORDER FORM:

NAME: ....

ADDRESS: ....
....Town/City: ....

PLEASE SEND ME: ....
....
....

Cheque/s encl: $............................ A receipt will be enclosed with your purchase/s

Newer OCs have good benefit-risk ratios

NZ Dr 24/11/95

Professor John Guillebaud provides reassurance that third-generation OCs still have an important role to play, following warning letters sent to British doctors regarding their safety.

The Committee on Safety of Medicines sent the letters prior to publication of three epidemiological trials suggesting an increased risk of venous thrombosis. All three studies gave similar congruent results.

However, these studies also "confirm the amazing safety of all modern formulations of the combined pill" in terms of venous thrombosis. Products containing desogestrel and gestodene are thought to increase risk of idiopathic venous thromboembolism from 5 in 100,000 for non-users to 30 cases per 100,000. This is double the rate associated with second-generation OCs containing levonorgestrel and norethisterone. But the rate of venous thromboembolism in pregnancy is 60 per 100,000.

Mortality from venous thromboembolism is low, around 1-2 per cent, making a death rate of 2-3 per million users which compares with all-cause mortality associated with pregnancy.

Furthermore, women need to be reminded of non-contraceptive benefits of OCs, including protection against ovarian and endometrial cancers, PID and various menstrual cycle disorders.

The author confirms contraindications to use of OCs containing desogestrel and gestodene; namely, body mass index >30, presence of varicose veins, immobility and a family history of DVT.

Dr Guillebaud advises the use of OCs containing levonorgestrel and norethisterone for women aged less than 30 years with no risk factors for vascular disease. Women over 30 years of age and without risk factors for arterial disease should be told of a possible slight increase in risk of venous thromboembolism (up by about 15/100,000) with newer agents. However, they should also be advised they may be less likely to suffer a heart attack or stroke (which are more life-threatening) than if they were on a levonorgestrel- or norethisterone-containing product.

The author says he will be continuing to offer third-generation OCs to completely informed women with risk factors for arterial disease, and to others, when comparing their overall risks with those of alternative agents. Included must be minor annoyance side effects of other agents, like breakthrough bleeding, acne, headaches and weight gain, which are less problematic with desogestrel- and gestodene-containing compounds.

Guillebaud J. BMJ 311:1111-2, 28 Oct 1995

NATIONAL COMMITTEE SUMMARY

Notes of the NZCOM National Committee held on Saturday 18 November 1995 at National Office, 906-908 Colombo Street, Christchurch commencing at 9am.

Congratulations to Sally Pairman, Michael and Oscar on their new son and brother, Felix. Born at home surrounded by a loving family.

Healing energy and well wishes were sent to Irihapeti Ramsden currently in hospital.

Business Arising

Section 51
Concern and dissatisfaction throughout regions with the mileage rates proposed by RHAs. Rural midwives will not be able to sustain their midwifery service to rural areas.

Nelson/Marlborough have prepared a substantive submission which will be used as a base for further discussion with the RHAs. The principle of being paid for actual work or service provided will be vigorously pursued.

Major concerns also from many midwives in the Midland RHA Region. The MRHA appears to be either misinformed or deliberately undermining the College at some public meetings attended by midwives. The College will investigate these claims and raise the matter with Midland. It was noted that Midland had not raised any of their issues at Section 51 Meetings with the College. This apparent undermining strategy has a divide and rule flavour and members are urged to contact the College locally or nationally and check out the validity of claims or statements made.

The labour and birth price is capped at $350 and the postnatal module price is capped for the CHE at $180 was also cause for national concern. Concerns to be forwarded to CHE Women's Health Managers together with support for their initiatives to provide continuity of midwifery care. These schemes are threatened by the prices RHAs are currently offering CHEs. Further concerns voiced that women will be forced into secondary care services if primary budget inadequate. The current Australian-based DRGs (diagnostic related groupings) makes normal birth almost non-existent when forceps and ventouse can be classified as normal births. These types of payment mechanisms can influence and increase intervention rates.

The mandatory Referral Criteria also play a significant part in forcing primary or normal birth services into secondary care.

Referral Criteria
The medical profession NZMA/NZGPA/O&G College have not yet agreed to a meeting date with the College of Midwives to discuss the Referral Criteria. They are first trying to get agreement amongst themselves. NZMA report that Tony Baird, President of College of O&Gs has "done a turn around" and now does not support the National RHA Referral Criteria. The NZCOM had thought this had been agreed some months ago. The O&G College is sending mixed messages depending on which office bearer is consulted. The NZCOM had understood the drive for criteria had originated from obstetricians but several months ago at a meeting between Nursing and Medical Councils, RHAs and the Ministry of Health we had understood agreement had been reached in that all parties would meet and draft up a national document. Tony Baird now believes these criteria should be drafted locally by those concerned. This was received with some cynicism as local CHE-based criteria are what midwives have to cope with now and the majority are punitive for women and highly restrictive for midwifery practice. The Meeting agreed to support and urge for a national set of criteria guidelines. If the

medical profession will not progress with their agreement to national guidelines, the NZCOM is forced to pursue (with some changes) the current RHA guidelines as the most consensual and least prescriptive of the options available. Feedback from College members is urged.

The College has written to O&Gs requesting a Workshop between O&Gs and midwifery to address the issues including referral.

MPO

Midland Feasibility Study reported on by Michelle Fill, Project Leader. Final draft discussed.

North Health Feasibility Study finished and sent to North Health. Presently awaiting a response.

Southern Feasibility Study also in final draft.

Central's Application for Transitional Funding has been lodged and is awaiting a response.

The whole process has been very useful in scoping the extent and structure of contracting for midwifery as well as meeting and talking to hundreds of midwives throughout these regions. However, the general impression from those concerned and many individual midwives is that there is little will on the part of RHAs in recognising any collective midwifery structure either regionally or nationally. Many members commented on the differences in reception midwifery organisations have had in comparison to medicine. Medical IPOs have been encouraged and supported by millions of dollars and are increasingly becoming collective as it is realised how expensive it is for their members to have small contracting agencies if no administration funding goes with them.

So far the same recognition towards midwifery as a service has failed to materialise.

As a result of the MPOs networking discussion arose on the need to liaise and meet with Plunket as they are threatened by alternative contracting agencies which further fragment the maternity services. Some concerns raised that Plunket are getting into contracts for antenatal education when midwives report child health services are non existent in some places. Local regions will make contact with Plunket to discuss these issues. Support was voiced for the Plunket nurses who now "compete" with the GPs for the 8 well child visits. As these 8 visits mainly coincide with immunisation the Plunket nurses role is increasingly unrecognised and eroded.

Central's first MPO Steering Group Meeting will be on 25 November as they are anxious to get out to midwives. Waiting for a response from the Central RHA for funding could be some time away. The Steering Group consists of:

Jane Marshall	Midwife, Hastings (Chairperson)
Kirsty Prichard	Midwife, Motueka
Joy Christinson	Consumer, Palmerston North
Brenda Wraight	Consumer, Motueka
Lonna Young	Midwife, Wanganui
Christina Engel	Midwife, Wellington
Bev McIntosh	Midwife, Palmerston North
Sue Geard	Midwife, Palmerston North

Prescribing

A letter from Ministry of Health confirming the midwife's right to prescribe (and order laboratory tests) according to clinical judgement during pregnancy, birth and puerperium. This decision means CHE

NEW ZEALAND BREASTFEEDING RATES IN FIRST SIX MONTHS

NZMJ 8 September 1995

Essex C et al: Longitudinal cohort study on 3929 of 4286 infants born between 2 July 1990 and 30 June 1991. (E 2596, M 405, PI 194)

Exclusively Breastfeeding ...at birth	93.8%	n 3685
...at 6 weeks	69.4%	partial 79.5%
...at 3 months	47.6%	partial 71.3%
...at 6 months	2.5%	partial 56.0%

MAIN REASONS FOR STOPPING BREASTFEEDING (%)

	Overall	European	Pacific Island	Maori
Birth to 6 weeks	**n=589**	**n=363**	**n=25**	**n=53**
Perceived insufficient milk	29	28	20	36
Sore/cracked nipples	13	11	4	13
Unsettled baby	7	8	0	8
Going back to work/study	4	1	20	6
Inverted nipples	4	2	12	2
6 weeks to 3 months	**n=314**	**n=181**	**n=8**	**n=57**
Perceived insufficient milk	29	32	25	49
Sore/cracked nipples	4	2	13	4
Unsettled baby	8	12	0	7
Going back to work/study	7	7	38	5
Baby not gaining weight	8	10	13	4
3 months to 6 months	**n=591**	**n=414**	**n=31**	**n=54**
Perceived insufficient milk	33	26	29	39
Mother had enough	12	11	10	15
Going back to work/study	11	10	29	6
Concern about child's condition	5	4	0	7
Pregnant again	2	1	13	4

Suggested reasons for problems...

Early discharge from hospital, inability of postnatal staff to spend time with mothers due to work pressure, health professionals needing better training in management and problems of early breastfeeding.

Conclusion...

"Breast milk is the ideal sole food for infants for the first six months post partum, and from then on in combination with other foods until at least 12 months of age."

Needed...

Better training of health professionals and breastfeeding mothers; Employer support/facilities for breastfeeding mothers who are working or studying.

(Under ILO standards – to which New Zealand is a signatory – women are entitled to two half-hour breaks during each working day)

'Midwives News' Auckland, NZCOM, Nov 1995

UK GPs told to limit prescribing newer OCs

NZ Dr 24/11/95

The Committee on Safety of Medicines has advised doctors in the UK not to prescribe combined OCs containing desogestrel and gestodene routinely, after it examined data from three unpublished (two incomplete) trials.

The three studies were designed to determine whether the risk of vascular disease in women on newer OCs was any different from that of women on mainly levonorgestrel-containing OCs. Data to hand suggested an approximate doubling of the low risk of venous thromboembolism among users of newer agents.

An association arising from an observational study does not prove cause and effect, since chance, confounding and bias may be influential. Significant associations were found in the studies but the lower limit of confidence intervals were close to unity, suggesting a weak link at best.

Adjustments were made for several possible confounding influences in two of the trials but in one residual confounding was possibly still present.

Bias is harder to determine but newer OCs might have been supplied to patients thought to be at higher cardiovascular risk because doctors consider newer OCs safer.

"The most disturbing issue, however, is the decision to base the warning solely on the likelihood of venous thrombosis". The newer progestogens were promoted on the platform of a reduced effect on lipid and carbohydrate metabolism compared with older agents. It was presumed they would be less likely to increase MI and stroke risk. Both are rare in young women but are at least 10-fold more likely to result in death than venous thrombosis.

And preliminary data suggested these newer OCs were protective against major cardiovascular events. However, it is now unlikely the incomplete studies will continue for long enough to determine this issue.

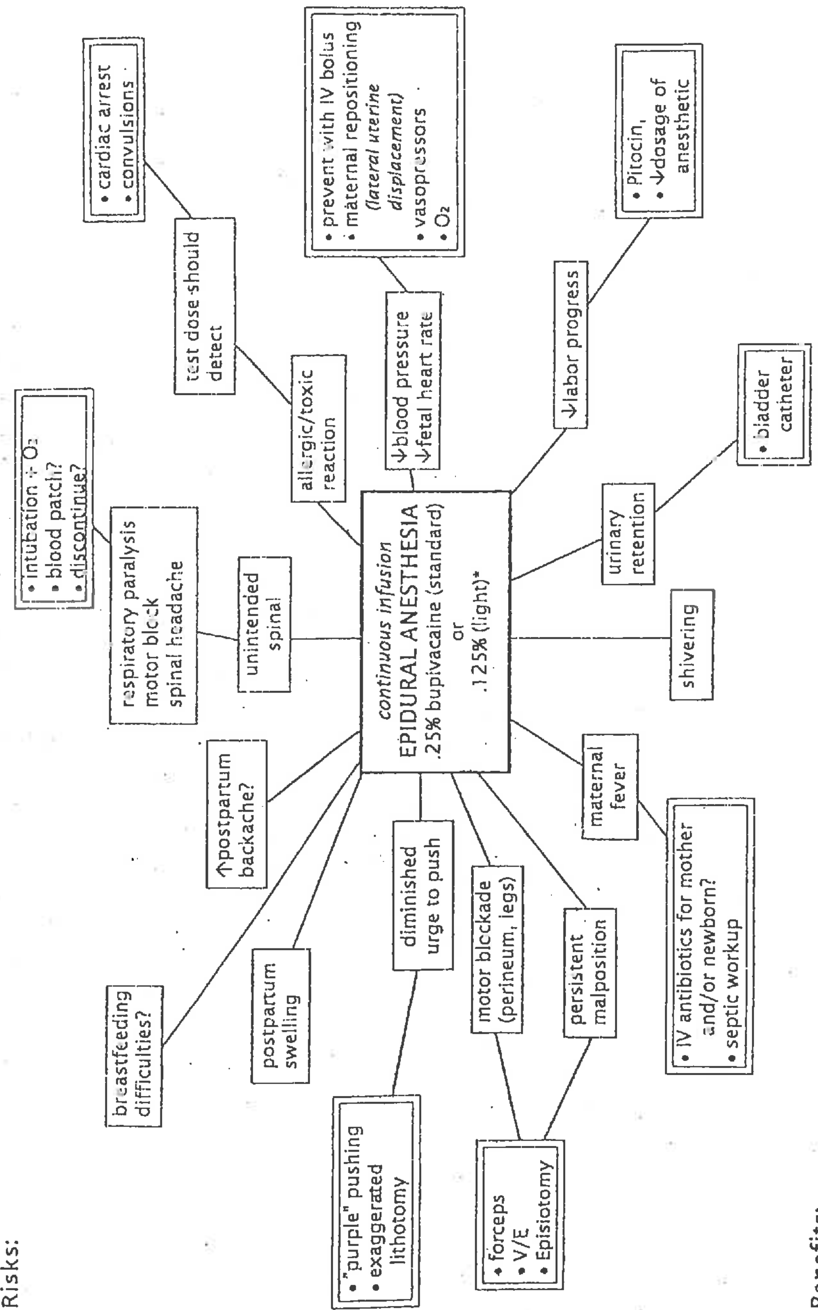
MacRae K, et al. BMJ 311:1112, 28 Oct 1995

Birth Babies and Bridges Conference Auckland Oct 1995

Epidural Anesthesia (Bupivacaine)--Risks & Benefits

by Penny Simkin, PT.

Risks:



Benefits:
- Excellent pain relief (80-85%)
- Rest for exhausted mother and possible improved labor progress (with or without Pitocin)
- Improved intervillous blood flow?

* Lower dose has same side effects, but reduced incidence

midwives need to take advantage of their right to autonomy as they needn't be affected by the payment schedule, as the CHEs are funded to provide the tests. Committee to urge hospital midwives to impress their autonomy on practice. Letter to go to Women's Health Managers. Whilst the ability to prescribe anything appropriate to the maternity experience is a statutory right not all prescriptions will be on the Pharmaceutical Schedule and therefore will not be subsidised/paid for. If it is not on the Schedule List this means a midwife may prescribe but she or her client will be required to pay for it. This is highly unsatisfactory and discriminates against midwife clients. The Ministry has requested HBL (pharmaceuticals) to review their Schedule. The College has requested the RHAs amend the situation urgently. Meanwhile a pharmacist cannot refuse to fill a midwife's script but can expect payment from the midwife if the prescription requested is not on the Schedule. NZCOM has written to the Pharmacy Guild.

NB: When writing prescriptions members are advised to use their NZCOM membership number rather than their practising certificate number.

Laboratory Tests

Terryll Muir, NZCOM Representative on SRHA Laboratory Tests & Diagnostics Advisory Committee attended the first meeting of the Committee on 19 October and her Report was discussed. Apparently the decisions made on this Committee will be considered by all RHAs, although Midland may be devising their own laboratory tests Schedule. Waikato/BOP to investigate and request representation if this is so.

The following list was negotiated by Terryll and feedback is requested from regions:

THE TESTS RECOMMENDED FOR MIDWIVES TO REFER ARE:

Test	Cost:
GT Polycose	$ 6.13
GTT Standard	19.61
Ferritin, Serum	6.92
Creatinine	3.52
Urate, Uric Acid	3.70
Serum Bilirubin	6.48
Liver Function Screen	21.79
Pregnancy Test (HCG)	14.65
Cytology of Cervical Smear	16.50
Chlamydia Antigen Test	19.08
Herpes Virus Antigen Test	19.08
Coagulation Screen	35.96
Blood Grouping - ABO	3.61
Blood Grouping - Rh	3.62
Blood Grouping - rhesus titre	16.35
Blood Grouping - rhesus phenotype	19.36
Skin/Wound/Pus Swab	13.97
Vaginal Swab	15.91
Cervical Swab	15.91
Eye Swab	13.97
Blood/Urine Culture	29.46
Sensitivities	17.85
<u>Group Tests</u>	
Complete Blood Count	11.80
First Antenatal Screen	38.80

Subsequent Antenatal Screen	15.78
Antenatal Antibodies	8.66
Neonatal Screen hb, pvc, blood film, (roombs, SBR, bloodgroup & Rh)	27 01

Terryll was unable to convince the mainly medical Committee to include iron studies, HIV or giardia. Cervical smear takers also not able to order swab. NZCOM to discuss with National Cervical Screening Programme.

Consensus Statements
Northland read their discussion paper urging support for rural midwives to use ventouse when no medical backup is available. The principle was supported by the majority. Northland to draft a statement for further circulation and discussion.

Consensus Statements on Breastfeeding, Cervical Screening, Diabetes in Pregnancy, Informed Consent, Management of 3rd Stage and VBAC were redrafted from submissions received and will be circulated for comment.

Cultural Safety
Renewed commitment to improving our knowledge and understanding of this issue. Regions to hold workshops for members hopefully before the next National Committee Meeting. National Committee to have a day's co-facilitated Maori/Pakeha Workshop at end of February in conjunction with National Meeting and Midwifery Standards Review Committees Study Day. Venue to be in Wellington as facilitator is based there and the Marae there should be available.
Nga Maia O Aotearoa Me Te Waipounamu reported on Meeting at Nursing Council. Disappointing progress but NZCOM very keen to remain involved and to support Council towards excellent curriculum development. Nga Maia O Aotearoa Me Te Waipounamu to follow up with letter of support to Council.

Conference Report (Lincoln University - Canterbury 28-31 August)
Barbara Katz-Rothman (Sociologist), Professor Jill White and Jane Fisher (Psychologist) are the confirmed keynote speakers. Flier soon to be distributed to every College member asking for expression of interest.

Order forms for designer clothing distributed to regions. Samples available from each region.

Subscription Rates
Increased rates for next year have enabled NZCOM to employ an in-house Legal Advisor providing full legal services. Indemnity claims have increased for all professional groups and have become more complex. One complaint may need to be defended in three separate processes, eg, ACC, Preliminary Proceedings Committee, Nursing Council. This is a time consuming and expensive exercise. The legal activity generated means indemnity policy cover increases substantially and the College must have the mechanisms to afford these price increases. While there are many insurance brokers there are very few underwriters available to New Zealand who will cover professional indemnity insurance. Every claim made increases the likelihood of policy cover increase. NZCOM envisages an increase for next year. There is no way the College can continue to function on the current fees and the new fees only just cover our predicted costs, therefore reducing fees is not feasible. Chairpersons to make sure the membership understands the need for increased fees. National Office will include information re costs in next regional mailout.

there were significant differences between the behavioural assessments of babies whose mothers received pethidine and those whose mothers did not. These differences between the babies included cuddliness, consolability, self-quieting and hand to mouth activity.

Furthermore, recent research in Sweden has shown that pethidine given in the first stage of labour can interface with a baby's ability to "crawl" to the breast immediately after delivery (Widstrom).

Ragan (1994) found there was a significant association with the pethidine given closer to delivery and the likelihood of breastfeeding being successful—several women noticing the effect the drug had on the initiation of their relationship.

One study (C. M. Wilson *et al.* 1986) showed that the day after delivery, neonates of mothers given pethidine, had a higher percentage of lower neuro behavioural scores with respect to alertness, tone, moro reflex, rooting and sucking, and claimed that the neonate effects following maternal pethidine last two to three days.

Since the newborn infant is demethylating pethidine at a much lower rate than an adult, the clinical effects of a given dose, including a possible respiratory depression, should be mainly dependent upon the time of interuterine exposure to the drug. If the time is short, for example an hour or less, the total transfer to the foetus is comparatively low. After two hours it seems to have reached a maximum and thereafter the amounts in the foetus begins to fall. Data shows the neonatal urinary secretion of pethidine was highest when maternal medication was given two to three hours before delivery (Belsey *et al.* 1981). The study by Belsey on the "Influence of Maternal Pethidine on Neonatal Behaviour" carried out over the neonates' first six weeks, showed depressed attention and social responsiveness with few and less well-directed movements; were more likely to cry and less likely to quieten once aroused; noted as late as day 42 in infants whose drug exposure was high.

Righard (1990) study of 72 women showed that 40 (56 per cent) infants whose mothers had received pethidine during labour, the majority were sedated and did not suck after delivery. He concluded that contact between mother and infant should be uninterrupted during the first hour of birth, or until the first breast feed had been accomplished, and that the use of drugs such as pethidine should be restricted.

References

(1) Ragan, L., *Midwifery 10* (1994).
(2) Wilson, C. J., *Anaesthesia* (December 1986).
(3) Belfrage, P., *et al. Acta Obsete Gynae Scand* (1981).
(4) Belsey E. M., *et al. British Journal of Obs and Gynae* (1981).
(5) Lennart Righard, *Lancet* (1990).

Dawn Hunter
Lactation Co-ordinator
Women's Health Division

Magnesium sulphate for eclampsia

In developed countries eclampsia occurs in about 1 in 2000 deliveries and in the UK eclampsia is a factor in 10% of direct maternal deaths. There is controversy as to which anticonvulsant is best. Magnesium sulphate to control fits was introduced in 1906. More recently diazepam is another drug which finds favour as it is effective for other convulsions and lacks sedative effect. Controlled trials to assess the efficacy of these drugs are scarce.

In 1991 recruitment began to the multicentre randomised Collaborative Eclampsia Trial. Magnesium sulphate 4g iv followed byintramuscular dosage was to be used. Diazepam 10mg iv followed by further doses according to the level of consciouness was to be used. As phenytoin is to prevent fits, an initial dose of diazepam 10mg iv was to be followed by phenytoin 1g iv. Data was available from 1680 women. Magnesium sulphate was compared with diazepam, and magnesium sulphate with phenytoin.

Women allocated to magnesium sulphate had a 52% lower recurrent convulsion rate compared with 37% for diazepam. There were fewer nonsignificant deaths with magnesium sulphate. There were no other factors of outcome that were different between the two regimens. Women allocated to magnesium sulphate had a 67% lower risk of recurrent convulsions compared with 47% allocated to phenytoin. Maternal mortality was nonsignifcantly lower in magnesium sulphate group. Women allocated to magnesium sulphate were less likely to be ventilated, develop pneumonia and to need intensive care facilities compared with phenytoin. Babies of women allocated to magnesium sulphate were less likely to need intubation and admission to a special care nursery than with phenytoin.

Thus, all the evidence is heavily in favour of magnesium sulphate being used for eclampsia rather than diazepam and phytoin. Magnesium sulphate should be a gold standard for the treatment of eclampsia.

The Eclampsia Trial Collaborative Group. Which anticonvulsant for women with eclampsia? Evidence from the Collaborative Trial. Lancet 1995:345: 1455-63

The Effect of Pethidine Given in Labour on Breastfeeding

- Childbirth Communique, Healthlink South, October 1995

The effect on breastfeeding of drugs used as pain relief in labour and of obstetric procedures has been much researched in recent years. While the direct biochemical effects of the drugs used may be transient, there may be long-lasting indirect effects resulting from the mother's initial impression of her baby's behaviour and the methods she adopts to cope with them. The establishment of sucking and feeding is particularly vital in the early stages (L. Ragan 1994).

Richards and Bernal (1972) found that pethidine combined with a narcotic antagonist (pethilorfan), led to poor feeding behaviour for a minimum of 10 days after birth. Babies whose mothers had received 50–200 mg of pethilorfan fed for shorter periods of time, showed more interruptions during feeding, and required more stimulation from the mother to suck than those who were "non-premedicated".

A later American study (Kuhnert *et al.* 1984) found that even low doses of pethidine resulted in relatively high foetal levels of normeperidine, the active constituent of the drug; that the greater the drug-delivery interval, the higher these doses were; and that

Nursing Council Nominations

The following nominations for NZCOM Nursing Council Representative were forwarded to the Minister of Health:

Bronwen Pelvin — Jenny Johnson — Sue Bree

Grateful thanks were extended to the midwives who had their names put forward for selection. The standard of nominees was excellent. The Minister will appoint one midwife from these nominations.

Maternal Screening for HIV

Bay of Plenty to present a paper for discussion at next National Committee Meeting. Anyone interested in this increasingly contentious and complex issue asked to forward comment to your region's chairperson.

ICM

Delegates elected to ICM Congress and Business Meeting in Oslo are Karen Guilliland and Sally Pairman. Call for two observers to go also. No funds available so needs to be midwives already attending the ICM Conference the following week. Regional chairpersons to advise of interested midwives by 20 December.

ICM Regional Representation.

Agreed New Zealand would ask Australia and Japan to accept nomination to represent Asia/Pacific. NZCOM to support current Board of Management reps and London as continuing venue for Head Office.

Regions to discuss remit regarding partnership with consumers being constitutionally expedited. Also remits to be formulated on nuclear testing and cultural safety comments to National Office by 20 December.

Direct Entry Midwifery Fund

The Direct Entry Task Force has generously donated funds to the College to establish a Hardship Grant of $500 for direct entry students for text books, part fee payment or clinical placement expenses. Applications (through P O Box 21106, Christchurch) close on 31 January 1996.

There is also the Joan Donley Trust Fund available for female babies "caught" by Joan Donley who wish to undertake direct entry midwifery courses. The same criteria applies to all applicants.

Post Graduate Education

Report back on College Meeting with Massey and Victoria Universities Midwifery Departments and Nursing Council on postgraduate education policy and direction. All masters level papers to include practicum and an increase in research papers.

CALVIN and HOBBES

EVENTS CALENDAR

EMPOWERING WOMEN

Palmerston North & Christchurch

A 2 day workshop on teaching Active Birth
Led by **Andrea Robertson**, ACE, Australia

DATE: December 12th & 13th, 1995
VENUE: Awatea Park Motel
Palmerston North

DATE: December 14th & 15th, 1995
VENUE: Commodore Airport Hotel
Christchurch

TIME: 9.30 - 4.30pm both days
COSTS: $135 Australian Dollars

CONTACT: ACE
PO Box 366
Camperbdown
NSW 2050
AUSTRALIA
Ph: (02) 660 5177
Fax: (02)660 5147

BIOETHICS RESEARCH CENTRE SUMMER SEMINAR

9 - 14th February 1996
Knox College, Dunedin

Areas to be addressed include:
Research Ethics
Teaching & Learning in Bioethics
Moral Management in Health Care

Contact: Aiden Stenton
Bioethics Research Centre
PO Box 913
Dunedin
Ph: (03) 474 7977
Fax. (03) 474 7601

LOW DOSE FOLIC ACID AVAILABLE TO REDUCE THE INCIDENCE OF SPINA BIFIDA

- Prescriber Update Ministry of Health No. 10, October 1995

> Folic acid 0.8mg tablets are now being marketed in New Zealand for the reduction of the incidence of neural tube defects in neonates. One tablet per day for 16 weeks, starting 4 weeks before conception is recommended. Higher strength folic acid 5mg tablets continue to be recommended for women who have had a previous affected pregnancy or who are considered high risk.

Prescriber Update No.3 November 1993 included an article entitled "Reducing the Chances of Spina Bifida by taking Folic Acid" based on recommendations of the Public Health Commission in consultation with the Ministry of Health.

Optimum results come from taking folic acid daily, starting 4 weeks before conception, and continuing daily through to the twelfth week of pregnancy. Initially, a dose of 5mg daily was recommended, as at that time the only medicine available for sale containing folic acid alone was a 5mg tablet.

Efforts were made to obtain a lower dose tablet, as overseas trials indicated a daily dose of 0.8mg folic acid was sufficient to reduce the incidence of neural tube defects in a woman's first pregnancy. In March 1995 consent to market a 0.8mg folic acid tablet was granted to Douglas Pharmaceuticals.

Women at high risk of bearing a child with spina bifida should, however, take 5mg folic acid daily, commencing 4 weeks before conception and continuing through to the twelfth week of pregnancy. Those women considered as high risk are those who: —

- have had a previous baby, or fetus, with spina bifida or related defect
- have relatives, a partner, or a partner's relatives with a history of spina bifida or a related birth defect
- are taking anticonvulsants
- are taking clomiphene
- are diabetic

Both strengths of folic acid can be purchased from a pharmacy.

Women should be reminded to combine folic acid supplementation with a diet containing plenty of fruit and vegetables.

A pamphlet containing information for women about the availability and benefit of taking low dose folic acid when planning a pregnancy (entitled "Folic Acid & Spina Bifida" — code 4147), can be obtained from local health promotion units.

If there is sufficient information for the committee to reach a decision on whether the claim meets the definition of medical misadventure or not, this is sent out to everyone involved as proposed advice. The involved parties receive copies of all the documentation to comment on. If no comments are received or additional comments offer no new information, this becomes final advice to ACC. This independent advice is then considered by the Corporation - who have the final say.

As the advice is based totally on written documentation (and sometimes photos as well), a detailed account from all involved is essential to enable a reasonable conclusion to be reached. Claimants need to document the effects of the adverse consequence as well as the length of time they have been unable to carry out their usual activities. Practitioners should provide a detailed account of what happened, including evidence relating to rarity and severity from a professional point of view. If the judgement of the practitioner is likely to be an issue, the reasons for the particular course of action should be provided.

The case will be revisited following any challenge to the proposed advice or if new information is provided.

- Judi Strid, September 1995

Continuing problems with the use of Augmentin for urinary tract infections

NZMJ 10/11/95

Augmentin has been widely used for the treatment of urinary tract infections in both general practice and in hospitalised patients. The use of clavulanic acid potentiated amoxycillin in the form of Augmentin was developed because of the increasing resistance of Escherichia (E) coli to amoxycillin. The latter continues to be a major problem and medical laboratories throughout the country routinely give in vitro sensitivity data relating to organisms that are resistant to amoxycillin, but sensitive to Augmentin. However, the theoretical benefits of the combination have not been substantiated in clinical practice as there is a high rate of treatment failure (at least 30% in our experience), particularly if Augmentin is used for the treatment of E coli urinary tract infections that are reportedly sensitive to Augmentin, but resistant to amoxycillin.

In 1992 I drew attention to the problems that we were seeing with the use of Augmentin.[1] This has increased. In our own experience,[2] Augmentin, like the other ß-lactam antibiotics, has been disappointing for the treatment of urinary tract infections.

In addition there is a slower resolution of symptoms compared with the response to drugs with a different mechanism of action such as trimethoprim, cotrimoxazole, nitrofurantoin or the quinolones. This slow resolution of symptoms frequently leads to patients being hospitalised with partially treated acute pyelonephritis, or what is now termed "Augmentin failure" in this department. Such patients have taken Augmentin for a few doses or up to a few days, but continue to have fever, loin pain and systemic symptoms. In addition, Augmentin has the highest rate of gastrointestinal side effects of any antimicrobial agent that we have used for the treatment of urinary tract infection. Despite the results of our study,[2] which was undertaken in 1981-2, we concluded at that time that "Augmentin would appear to have a place in the treatment of amoxycillin-resistant bacterial infections". Our views, however, have changed substantially after more than a decade of experience.

As suggested previously,[1] I "would caution all general practitioners about the use of Augmentin when they are given a laboratory report which shows that an organism is resistant to amoxycillin, but sensitive to Augmentin. The clinical outcome is likely to be the same". In addition the relapse rate of sensitive pathogens may be quite significant and the side effect profile troublesome.

Ross R Bailey
Department of Nephrology, Christchurch Hospital, Christchurch

1. Bailey RR. Augmentin for urinary tract infections. NZ Med J 1992; 105: 90.
2. Bailey RR, Bishop V, Peddie BA, et al. Comparison of augmentin with cotrimoxazole for treatment of uncomplicated urinary tract infections. NZ Med J 1983; 96: 970-2.

1996 : MIDWIFERY TODAY INTERNATIONAL CONFERENCE

Weaving a Global Future II

29th February - 3rd March 1996
Pacific Beach Hotel Hawaii

Contact : Midwifery Today
P O Box 2672-4002
Eugene Oregon 97402
Ph (503) 344-7438 Fax (503) 344-1422

1996 CONFERENCE & ANNUAL GENERAL MEETING of the NZ LACTATION CONSULTANTS ASSOCIATION

Lactation Consultants : Meeting the Challenges Toward the Year 2000
29th - 31st March 1996
Latimer Lodge Conference Centre, Christchurch

Further Information available December 1995
Conference Co-ordinator : Marcia Annandale Ph (03) 323-7124

BREASTFEEDING : REFRESH, RENEW & REVITALISE
PLUS
BREASTFEEDING UPDATE - IBLCE EXAM PREPARATION SEMINAR

9th - 11th March, Perth
13th - 15th April, Melbourne
18th - 20 May, Brisbane

Seminar to be conducted by Mary Lantry, Angela Smith and Ruth Worgan

Registration Fee: $185
Enquiries: Capers
P.O Box 567
Nundah
Queensland 4012
Ph: (07) 3266 9573 Fax: (07) 3260 5009

ICM 24th TRIENNIAL INTERNATIONAL CONGRESS OF MIDWIVES

Oslo, May 1996

Pre-Congress Workshop, 23-26 May

(TO BE CONDUCTED IN ENGLISH)

Experienced Midwives who wish to become Consultants/Advisors, primarily in developing Countries, are invited to attend this workshop. Apply early - only 40 places are available. Registration Fee : 125 Further details from ICM Headquarters, 10 Barley Mow Passage Chiswick London W4 4PH UK

NEW ZEALAND COLLEGE OF MIDWIVE (INC)

1996 National Conference

28th August - Pre Conference Workshop

29th - 31st August - Conference

Lincoln Conference Centre, Canterbury, New Zealand

Theme : *Midwifery : The Balance of Intuition & Research*

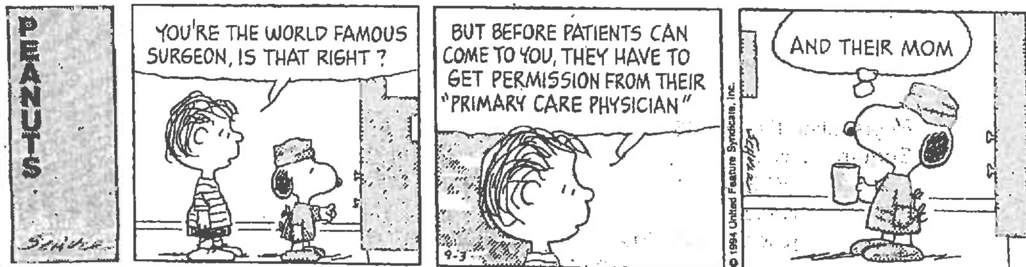
Keynote Speaker : Barbara Katz-Rothman

Contact: Judy Henderson Phone (03) 377-2732

NATIONAL HOME BIRTH CONFERENCE

1996

1 September 1996
Christchurch



Recent Amendments

Recent amendments to the Act allow the Medical Misadventure Unit to make decisions about medical mishap without having to seek independent advice. This means that very obvious situations, or cases where a clear precedent has been established can be dealt with very quickly without involving a committee process. All error claims are dealt with by a committee.

Another amendment allows ACC discretion to accept claims lodged more than 12 months after the injury. The 12 month deadline had previously caused eligibility problems in situations where the adverse consequence hadn't become a problem until after 12 months or people had been unaware of the time restriction.

Failed Sterilisation

Although women received compensation under the old Act, for an unwanted pregnancy as a result of a failed sterilisation procedure, there is no entitlement under the new Act. A pregnancy is not considered to be a personal injury so even if the procedure has been carried out incompetently, the requirement for a personal injury to have occurred means the medical misadventure criteria have not been met.

Medical Misadventure Committees

There are two Medical Misadventure Committees; one in Wellington and one in Auckland. The purpose of the committees is to provide independent advice to ACC, although the Corporation makes the final decision. The committees each have a lay member, a lawyer and a member of the particular specialty involved. As well as maternity and gynaecology cases, the committees consider matters on a range of other specialties such as radiology, physiotherapy, neurology, surgery, dental, orthopaedics, nursing and general practice.

The Committee Process

Any ACC M46 claim form involving treatment or some form of health care is sent to the Medical Misadventure Unit in Wellington. Case managers at the Unit seek background information from all parties involved. This information then goes to a Medical Misadventure Advisory Committee meeting for consideration.

The committee first of all determine whether there is a personal injury. A disappointing or unsuccessful outcome, for example, is not a personal injury. They then have to agree that there is evidence of a casual link between the actions of the health professional and the adverse consequence. A ruptured breast implant is an injury, but the rupture is generally due to a manufacturing fault, not the actions of a health professional. The matter of error or mishap is then investigated.

ARTICLES OF INTEREST

MEDICAL MISADVENTURE

Section 5 of the 1992 Accident Rehabilitation and Compensation Insurance (ARCI) Act, outlines the provisions for a person to make an ACC claim for compensation for an injury received as a result of medical misadventure.

Medical misadventure is defined as a personal injury resulting from medical error or mishap. Many practitioners and consumers are not aware that unlike any other ACC claim, a medical misadventure claim is subject to either an error or a rarity and severity test. Error just applies to the actions of a registered health professional, whereas mishap applies to treatment by or at the discretion of a registered health professional. This means that the actions of a student midwife, for example, would be seen as being at the direction of a registered health professional.

Medical Error
Medical error is the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances. It is not medical error solely because desired results are not achieved or because subsequent events show that different decisions might have produced better results.

A failure to obtain informed consent is medical misadventure only if the registered health professional acted negligently in failing to obtain it. Medical misadventure does not include a failure to diagnose correctly the medical condition of any person, or a failure to provide treatment unless that failure is negligent. Therefore, for an error claim to be accepted under these provisions, the practitioner has to be found to be negligent. These are the only error situations where the practitioner can lodge an appeal against the Corporation's decision (not the committee's advice to ACC).

Mishap
Mishap is when the adverse consequences of the treatment by or at the direction of a registered health profession are ***both*** rare and severe. Rarity is defined as a probability level of one percent. Severity criteria can only be met if the consequences result in death, hospitalisation as an in-patient for more than 14 days (over and above what would normally be expected) or significant disability for more than 28 days. Severity can also be met if a person can demonstrate their entitlement to an independence allowance.

Put simply, mishap is an injury from treatment ***properly given*** (includes known side effects and recognised risks of a procedure or treatment). Error is when the injury is from treatment ***not properly given***.

Clinical Trials
People injured in clinical trials are also subjected to the medical misadventure rarity and severity criteria, if the adverse consequence was as a result of the actions of a registered health professional.

CURRENT ISSUES

Midwives Prescribing Rights

Some midwives in different areas of the country have had prescriptions turned down by pharmacies. This has been extremely frustrating and often very inconvenient for women.

The prescriptions have generally been for less commonly prescribed medication such as antibiotics and oral contraceptives.

The reason this has occurred is that when the pharmacist has put in a claim to Health Benefits Limited the claim has been turned down and the pharmacist has been left with paying for the medication. Therefore when further prescriptions have come in from midwives they have either been turned down or the woman has been charged the full price for the medication.

HBL are acting on outdated information and the following two letters from the Ministry of Health clarify the prescribing rights of Midwives i.e.

"there is no legal prohibition on the prescription by midwives of antibiotics or oral contraceptives..."

As it may take some time for the changes to filter through the system, the following guidelines are suggested:

- when prescribing antibiotic or oral contraceptives give a clinical reason for the prescription.
- get to know your local pharmacist and discuss the issue and familiarise them with the Ministry of Health decision.
- find out whether the cost of the medication will be shifted back to the woman. Women need to know this as there may be a cheaper option for them.
- Some midwives are choosing to be charged for the medication until the issue is resolved.
- carefully consider what and why you are prescribing and ensure this is within your scope of practice.

REMEMBER

RECORD YOUR NZCOMI NUMBER ON THE PRESCRIPTION FORM AND NOT YOUR NURSING COUNCIL NUMBER.

THE NURSING COUNCIL NUMBER IS NOT COMPATIBLE WITH THE MINISTRY OF HEALTH COMPUTER PROGRAMME.

MINISTRY OF HEALTH
MANATU HAUORA

133 Molesworth St
P.O. Box 5013
Wellington
New Zealand
Phone (04) 496 2000
Fax (04) 496 2340

Ref. No ________

11 OCT 1995

10 October, 1995

Karen Guilliland
National Co-ordinator
New Zealand College of Midwives
PO Box 21-106
CHRISTCHURCH

Dear Karen

PRESCRIBING RIGHTS FOR MIDWIVES

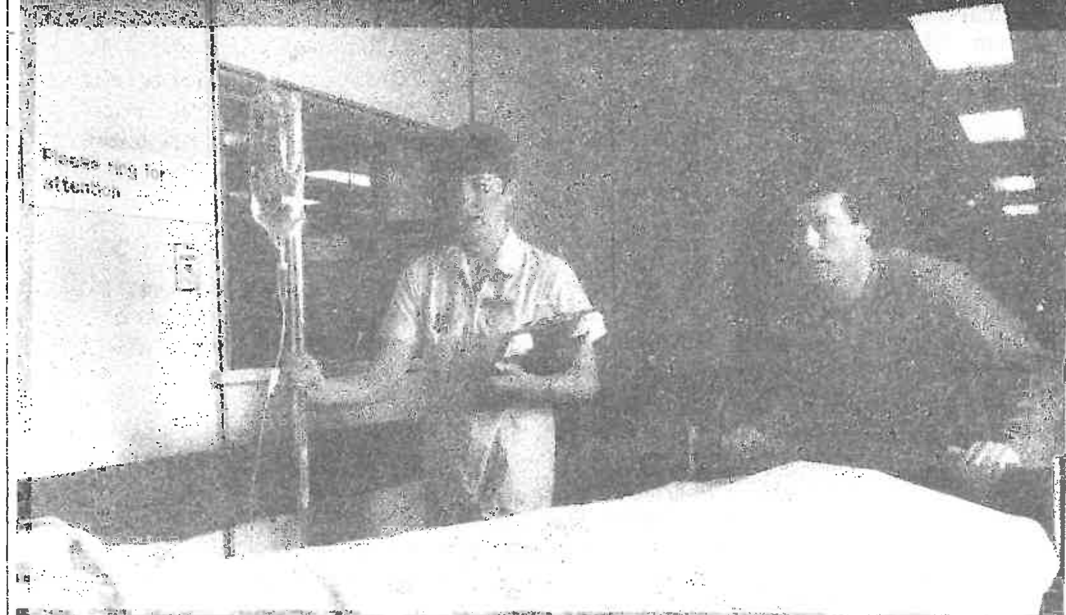
I apologise for the delay in responding formally to your 30 May 1995 letter in respect of this matter.

As you are of course aware following the passage of the Nurses Amendment Act 1990 (which included amendments to the Medicines Act 1981 and the Misuse of Drugs Act 1975) midwife prescribing of prescription medicines and the controlled drug pethidine has been lawful for antenatal, intrapartum, and post natal care.

Following the law changes referred to above the (then) Department of Health published a guide to the amendments entitled *Nurses Amendment Act 1990: Information for Health Providers* and made reference to the 1990 amendment in a Circular Memorandum (No.64) dated 12 November 1990. The 1990 publication *(Nurses Amendment Act 1990: Information for Health Providers)* suggested that it would be appropriate for midwives to prescribe medicines such as iron tablets, antifungal agents, oxytocin, vitamin K, antacids and the controlled drug pethidine. As you know this publication went on to suggest that prescribing by midwives would not include the treatment of underlying medical conditions such as asthma or hypertension and also not include "the prescribing of medicines such as antibiotics or oral contraceptives." Circular Memorandum No.64 expressed the view that "it would be expected that a midwife would only be prescribing for normal, low risk pregnancies."

The Ministry agrees that there is no legal prohibition on the prescription by midwives of antibiotics or oral contraceptives and that it indeed may be appropriate for these to be prescribed by midwives in the course of providing antenatal, intrapartum, and post natal care.

Who cares for the care givers?



HSWS Health Care does

8 good reasons to acquire affordable exclusive health care developed for all health sector personnel:

1. Birth, bereavement grants, sick leave without pay, home aid, oral surgery, optical benefits all available, plus many more.
2. Comprehensive cover for both medical expenses and hospital admissions.
3. A non-profit organisation run for the benefit of its members.
4. A premium refund for being healthy when you have Hospital Cover.*
5. Up to $50,000 available per operation with Hospital Cover.**
6. Quality health care for an amazingly affordable cost.
7. Direct debit of premiums available. No hassle or extra costs.
8. Health plans fully portable should you change vocation.

Call us on 0800-500-237

Health Care

* Hospital Cover premium refund less claims, fees and G.S.T. after 15 years in the scheme. ** Hospital Cover is a policy of National Insurance Life & Health and available through HSWS Health Care

HSWS Health Care, Level 2, 163 The Terrace, P O Box 10075, Wellington, Freephone 0800 500 237, Wellington callers use 473 6181, Fax: (04) 473 6187.

HSWS Health Care -

on track to become a major provider of services to the health sector

Health care and health insurance are now issues of critical importance to a growing number of New Zealanders, none more so than those employed in the health sector, who are generally more aware of the need for quality health care than others.

That's why, in 1971, a non-profit organisation called the Health Service Welfare Society was formed specifically to look after the needs of health personnel in the public sector.

Now known as HSWS Health Care the Society provides health care services to all personnel employed in the health sector, whether public or private, including those engaged in specialist health areas such as pharmacy physiotherapy, dentistry (etc), and includes all professional, administrative and maintenance staff.

HSWS offers two core plans - the Basic and Advanced Plans which cover a variety of core medical expenses, including GP visits, prescription charges, physiotherapy, ambulance and much more.

In addition to this, members can also access Hospital Cover. This policy provides cover for major surgical care and hospital admissions. Its unique advantage, apart from a generous $50,000 per operation cover, is a premium refund for being healthy. After 15 years in the scheme, a large percentage of the premiums can be refunded back to the policy holder.

Members of HSWS Health Care also enjoy a host of other special advantages. For example, HSWS members can include their partners and dependent children. All plans are fully transferable should a member retire or transfer to another occupation outside the health sector.

Increasingly, organisations representing those employed in the health sector are recognising the benefits offered by HSWS Health Care.

The New Zealand Nurses Organisation is conscious of the role a non-profit company such as HSWS can provide. National Director Brenda Wilson explains: "With the advent of health sector restructuring, nurses have lost many unique health care services previously available to them, especially in public hospitals. The primary health plans available through HSWS Health Care, covering GP visits and prescription charges are reasonably priced and assist in redressing the loss of previous benefits."

Take a close look at HSWS Health Care. In every area, the Society can deliver high quality health protection for a very reasonable and affordable outlay.

It would seem useful for the Ministry to write to regional health authorities, Health Benefits Limited and PHARMAC clarifying the Ministry's views in relation to the prescribing by midwives of oral contraceptives and antibiotics. I have, therefore, recommended to the Director-General of Health that she do so and a copy of her letter is attached.

In considering the issue of prescribing by midwives I found the NZCOM Consensus Statement Guidelines for Prescribing (enclosed with your letter of 30 May 1995) very helpful. I note that the contents of the Consensus Statement accord with the Ministry view that prescribing by midwives should be within the level of their knowledge and expertise and would not include medicines for the treatment of underlying medical conditions such as hypertension and asthma. I note and agree with the statement in the Consensus document that midwives are "not expected to prescribe for all antenatal, labour, birth and postnatal situations" and note that this is in line with the accepted view that there are clearly some situations during the antenatal, intrapartum and postnatal care period where specialist medical or obstetric care or advice is required.

I commend the College on the development of the Consensus Statement and suggest that the College promote this document widely. The Consensus Statement very properly emphasises the importance of midwives identifying any deficit they may have in knowledge or skills and suggests participation in education programmes. In promoting the Consensus Statement to midwives it would also be useful to identify where such educational programmes might be available.

Yours sincerely

John Marwick
Senior Advisor (Health Professional)
Personal Health Services

MINISTRY OF HEALTH
MANATU HAUORA

133 Molesworth St
P.O. Box 5013
Wellington
New Zealand
Phone (04) 496 2000
Fax (04) 496 2340

Ref. No ________

9 October, 1995

COPY FOR YOUR INFORMATION

PRESCRIBING BY MIDWIVES

As you may be aware the Ministry of Health has been approached by the New Zealand College of Midwives who have complained that pharmacists in some areas (mainly the Waikato and Palmerston North) are refusing to fill prescriptions written by midwives on the basis that Health Benefits Limited has declined to pay out on claims by pharmacists in respect of such prescriptions. Dr John Marwick, of the Ministry of Health in Wellington, has contacted Health Benefits Limited to discuss this issue. Dr Marwick has been advised by Nan Miller of Health Benefits Limited that the company is in fact adopting the stance complained of by midwives and that this stance is based on the (then) Department of Health publication entitled *Nurses Amendment Act 1990: Information for Health Providers*. I understand that Ms Miller has now suggested to members of the Pharmacy Policy Advisory Committee (for Health Benefits Limited) that it would be appropriate for "a full policy debate" on prescriptions written by midwives to now take place. I am not aware of whether that suggested "debate" has begun.

This seems, therefore, an opportune time for me to clarify any misunderstanding which may have arisen as a result of statements made or views expressed in Ministry publications or circulars in 1990, or subsequently, in relation to prescribing by midwives. I refer in this regard and in particular to the statement in the abovenamed publication to the effect that prescribing by midwives would not include "prescribing of medicines such as antibiotics or oral contraceptives".

I wish to now confirm that the Ministry of Health agrees that there is no legal prohibition on the prescription by midwives of antibiotics or oral contraceptives and agrees that it may indeed be appropriate for these to be prescribed by midwives in the

Rivalry, Legal Threat is Maternity Plan Legacy

Penny St John

NZ Dr. 29/9/95

GP obstetricians and midwives are waiting to see what is contained in the new Section 51 notice relating to maternity services being drawn up by the RHAs.

After months of negotiation the RHAs are now drawing up a Section 51 notice which GPs fear will not address any of their major concerns about the new maternity contract. Some GPs have already indicated that they may leave obstetrics if these concerns, particularly over the level of fees, are not resolved.

Negotiating committee chair Phillip Rushmer took advice from the September NZMA Council meeting and the negotiating committee has agreed to wait for the release of the Section 51 notice before deciding what action should be taken.

"We can't reject the document before we see it," he said.

Dr Rushmer says the RHAs have agreed to some minor changes relating to specialists but GPs' main concerns remain unanswered.

He says the NZMA has four legal options open to it if necessary although he will not disclose what these are.

"The RHAs can not just drive a stake in the ground and push these changes through," he said.

In the meantime CHEs have agreed on a figure of $350 for midwifery services per hospital delivery, and independent midwives are unhappy that this is being seen as a benchmark figure.

National coordinator for the College of Midwives Karen Guilliland says the amount is "insulting" and she believes that the CHEs must be cost shifting to come up with this sort of figure.

Ms Guilliland says an arbitrator is probably needed as there is no agreement between the RHAs and doctors and midwives.

Both midwives and GPs are increasingly worried that infighting could break out if GPs and midwives are contesting what they see as inadequate payment.

Karen Guilliland questions whether GPs should get the bulk of the money as of right and she says the situation "does not bode well for cordial relationships between the providers".

Dr Rushmer says he is also fearful that "the good relationship that has built up could be jeopardised".

Ms Guilliland says that some midwives and IPAs have been trying to negotiate packages of services for women to choose from and she says this could help by depersonalising aspects of the negotiations.

"This could avoid care-givers fighting it out about who gets paid what."

But Dr Rushmer says some IPAs seem to be negotiating packages where women are referred to midwives as the lead caregiver.

This appears to be happening in cases where the woman's GP does not practise obstetrics and Dr Rushmer says it is essential women are given very clear choices about what is available right at the start of pregnancy. ■

Cut fetal monitor use *(from page 36)*

The American College of Obstetricians and Gynaecologists holds a more moderate view on fetal monitoring during labour. In a technical bulletin released recently, the group maintained that stethoscopes and electronic monitors are equally effective.

A test that measures the pH level of the fetus' blood, when combined with the electronic monitoring, can reduce Caesarean rates by providing a better picture of whether the fetus is in distress, according to ACOG.

One of the main impediments to reducing the use of electronic monitors is the fear of a lawsuit, he said.

Midwives set to sign home birth contract

Lois McTaggart

12 Ov. 29/9/95

Central RHA is negotiating ι contract with home birth nidwives to set up a pilot egional Community Home 3irth Trust, based on the new naternity schedule.

Midwives and consumers ıave set up a home birth colective, Community Birth ervices (CBS) as a precuror to the trust, which is ne:otiating for funding more han 100 births a year.

Current contract proposals nclude funding over a three ear period to cover an exected home birth growth ate to about 125 births a year y 1998.

The trust will also monitor ome birth practices accordıg to guidelines set by the lew Zealand Obstetrics tandards Review Committee nd College of Midwives.

Home birth consumer, lelen Griffin, says that while 30,000 of RHA transitional ınding has already been ranted to CBS to set up ofce space, and appoint a part me office, the contract is ot yet signed and sealed.

The original target start-up ate of October 1 now looks ery unlikely.

Some of the proposed maernity services to be funded y the trust, as outlined in ıe draft maternity schedule, ıclude free antenatal classes, free nappy service, and free home help as necessary.

Where women choose to have a doctor present at a birth, GPs will be contracted by midwives, through the trust, to work in home birth settings.

Local GP obstetrician Michael Short says, "GPs cooperating with home birth midwives, in support of a commitment to provide women with birthing choices, will come on board as maternity providers working alongside midwives."

Negotiating committee member, Joy Christianson says that while negotiations progress "final funding amounts, firm sign up dates and starting times, and emergency back-up services need ironing out before a Community Home Birth Trust becomes a living entity."

Contract agreements with the trust regarding providing access to secondary maternity services at the Palmerston North Maternity Unit in the event of an emergency home birth transfer remain on the negotiating table, as Central RHA declines to pay twice for one service.

Central RHA maternity services manager Gillian Bishop indicated that funding for transport and intervention in cases where the mother has to be taken to hospital would be funded by the CHE. ■

Cut fetal monitor use

- NZ Doctor 29/9/95

Canadian obstetricians are being advised to cut down on their use of fetal monitors during labour, as experts there believe that the practice needlessly raises Caesarean-section rates.

In an evaluation of 16 clinical trials, continuous electronic fetal heart rate monitoring did not provide any health improvements in newborns, compared to simply using a stethoscope, according to a group of Canadian experts who have drawn up new guidelines for fetal heart monitoring.

Caesarean rates were 30 per cent to 50 per cent greater when electronic monitors were used, according to Dr George Carson, head of maternal-fetal medicine at the Grace Hospital in Vancouver, British Columbia, and one of the authors of the guidelines.

Increased Caesarean rates associated with electronic monitors are the result of a high number of false-positive readings. But doing away with the monitors may be unpopular, said Dr Carson.

The guidelines, released by the Society of Obstetricians and Gynaecologists of Canada, urge that in low risk pregnancies, doctors use a stethoscope to listen to the fetal heart rate.

..... *concluded on page 37*

course of providing antenatal, intrapartum and post natal care. The Ministry has received a copy of the NZCOM Consensus Statement *Guidelines for Prescribing* and finds that document helpful. We note, that the Consensus Statement accords with the Ministry's view that prescribing by midwives should be within the level of their knowledge and expertise and would not include medicines for the treatment of underlying medical conditions such as hypertension and asthma.

It would seem appropriate given the Ministry's current views for regional health authorities to review with Health Benefits Limited the current stance being adopted by that company in relation to prescriptions by midwives.

This letter is being sent to each of the four regional health authorities, PHARMAC and HBL. A copy will also be sent to the College of Midwives. I enclose for your information a copy of a recent letter from Dr Marwick in reply to the NZ College of Midwives.

Yours sincerely

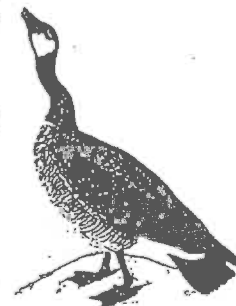
Karen O Poutasi
Director-General of Health

CC: Karen Guilliland
National Co-ordinator
New Zealand College of Midwives

Lessons From Geese

Fact 1: As each goose flaps its wings it creates an "uplift" for the birds that follow. By flying in a "V" formation, the whole flock adds 71% greater flying range than if each bird flew alone.

Lesson: People who share a common direction and sense of community can get where they are going quicker and easier because they are travelling on the thrust of one another.



Fact 2: When a goose falls out of formation, it suddenly feels the drag and resistance to flying alone. It quickly moves back into formation to take advantage of the lifting power of the bird immediately in front of it.

Lesson: If we have as much sense as a goose we stay in formation with those headed where we want to go. We are willing to accept their help and give our help to others.

Fact 3: When the lead goose tires, it rotates back into the formation and another goose flies into the point position.

Lesson: It pays to take turns doing the hard tasks and sharing leadership. As with geese, people are interdependent on each others skills, capabilities and unique arrangements of gifts, talents or resources.

Fact 4: The geese flying in formation honk to encourage those up front to keep up their speed.

Lesson: We need to make sure our honking is encouraging. In groups where there is encouragement the production is much greater. The power of encouragement (to stand by one's heart or core values and courage the heart and core of others) is the quality of honking.

Fact 5: When a goose gets sick, wounded or shot down, two geese drop out of formation and follow it down to help and protect it. They stay with it until it dies or is able to fly again. Then, they launch out with another formation or catch up with the flock.

Lesson: If we have as much sense as geese we will stand by each other in difficult times as well as when we are strong.

"Lessons from Geese" by Angeles Arrien, based on the work of Milton Olson.

HEALTH BENEFITS LTD

MATERNITY AUDITS

HBL have now completed a number of audits of midwives and doctors as part of the newly established Maternity audit programme. Currently HBL is developing a midwife protocol for audit with the NZCOM. In the meantime the procedures largely follow the Medical Trial Audit Protocols established with doctors in 1994.

The sole purpose of the audits are to establish that claims made on HBL have been done so properly and within the terms and conditions of the MBS Section 51 Advice Notice.

We have found that generally the standard of records examined to be very high and in a number of cases we have worked through claiming conditions and difficulties with midwives.

It is vital for claimants own protection that comprehensive records are kept to support each service claimed.

Some common areas of concern identified have been:

- No records of mileage to support mileage claims. We would expect that each trip claimed would be supported in a log book or running sheet identifying start and finish mileage for each service claimed.
- Urgent attendance's claimed which are not in response to an "urgent request" or not within the specified time periods to be eligible for an urgent request.
- Hours for conduct of labour differ on claim forms to those shown in hospital and birthing records. As a COL can be claimed only from the time of established labour, we would expect the terminology of established labour to be consistent both on the claims and in the hospital records. Any services provided prior to the established labour should be claimed as antenatal. The medical definition of established labour applies, ie when strong, regular, painful contractions occur and there is a change in the cervix.
- Claiming for COL when the audit shows the claimant has been absent for periods throughout the labour and birth.
- Duplicate claiming.
- CHE/HBL overlap of payment.

While there are other issues that have been identified, these are the main ones.

If we believe the errors are a genuine mistake and relatively small in nature, we will assist the claimant with suggestions of how to claim and recover amounts for any overpayment.

Where systematic and ongoing improper claiming is discovered, the matter will be referred to an RHA Advisory Committee who may also refer the matter to Disciplinary Committees and take a variety of courses of punitive action.

In the unusual case that of deliberate cheating of the claiming system exists, the matter will be treated as a "formal investigation" and investigated with a view to criminal prosecution.

Part of the audit and investigation procedures may involve speaking with clients to clarify issues and to confirm that the claiming was accurate and appropriate. The midwife will always be notified of an audit and its results.

Dennis Black
Desk Manager

Alcohol advertising and Maori

GALA NZ Inc. Newsletter 17, Nov., '95

On first contact with alcohol, Maori called it waipiro, 'stinking water'. This 'stinking water' has become a scourge as "Once Were Warriors" so graphically and tragically illustrated. The legacy of its introduction to Aotearoa is for my people ill-health, premature death, criminal activity, domestic violence, broken homes and family deprivation.

Many Iwi health groups, working on shoestring budgets, are promoting participation in sport and other physical recreation in the hope of developing in their youth positive images of good health and a drug-free life style. They are frustrated by liquor advertising often blatant, sometimes subtle and always persistently insidious. Cleverly contrived messages target the most vulnerable in society, our youth, often massaging dreams of wearing the silver fern.

It is a sad paradox that the major male sports, both rugby codes, and cricket, are sponsored by brewery giants whose logos are plainly visible on the uniforms of national teams.

The latest proposals by the liquor industry supported by some Members of Parliament on the specious grounds of greater freedom of choice, are to lower the legal drinking age to 18 and to remove some of the few remaining restraints on the sale of alcohol. Instead of permitting more channels for encouraging the consumption of a potentially dangerous and addictive substance, our politicians should be enacting legislation to curb this nation's number one drug problem, and releasing resources to Iwi health groups working to counter the effects of 'stinking water' and its promotion among youth.

Dr Erihapetie Murchie, Patron

The Ten Commandments For Reducing Stress

1. Thou shalt NOT be perfect, nor even try to be.
2. Thou shalt NOT try to be all things to all people.
3. Thou shalt leave things undone that ought to be done.
4. Thou shalt NOT spread thyself too thin.
5. Thou shalt learn to say "NO".
6. Thou shalt schedule time for thyself, and thy supportive network
7. Thou shalt switch off, and do nothing regularly.
8. Thou shalt be boring, untidy, inelegant and unattractive at times.
9. Thou shalt NOT even feel guilty.
10. Especially, thou shalt NOT be thine own worst enemy, but be thy best friend.

A HUMAN ASSISTED REPRODUCTIVE TECHNOLOGY BILL OR NOT?

Dianne Yates, MP for Hamilton East, writes:
I have discussed with and written to the Minister of Justice, Hon. Doug Graham, and the Minister of Health and Women's Affairs, Hon. Jenny Shipley about the possibility of this bill, which is virtually non-partisan, becoming a government bill.

The bill is in the private members' ballot, but has only a small chance of being drawn, as there are over 15 bills in the ballot. It is too important, however, to languish in the ballot for months, and possibly never see the light of day.

I seek your support, and that of kindred organisations and people. Please write urgently to the above-named Ministers, and ask for them to not only support, but to consider adopting the bill as a government bill, in order for it to pass a first reading and get sent to Select Committee for public submissions, input and consideration.

The bill has the support of the Labour Caucus, and I have canvassed government members and other parties but letters from you to any Members of the other six parties in Parliament would be appreciated.

<u>A brief summary of the bill:</u>
AIMS:
- To formulate a legal framework for restrictions and controls on assisted reproductive technology in New Zealand - in line in particular with British and Canadian laws, and to prevent some of the problems and court cases experienced in the United States of America.
- To protect the rights of children, and the rights of women (birth mothers) as well as donors (men and women).
- To guide medical professionals.

MAIN POINTS:
- To license clinics
- To keep centralised records
- To prevent cloning
- To outlaw the sale of babies and body parts/tissue/fluids

The bill does not forbid, but controls
- *In vitro* fertilisation and
- Surrogacy (largely covered by the Adoption Act 1955 and the Status of Children Act 1969).

The following letter is in response to comments purportedly made by Henry Murray in the Sydney Daily Times 25/8/95.

These were printed on Page 58 of the NZCOM September/October 1995 Newsletter

Westmead Hospital and Community Health Services

(A Unit of the Western Sydney Area Health Service)

Address all correspondence to:
The General Superintendent
Westmead Hospital
Westmead NSW 2145
Australia

Telephone 633 6333 61, 2, 633...
Facsimile 6334984

SYDNEY 2000 SUPPORTING

o/r

y/r

Date 31 OCT 1995

27 October 1995

Ms Karen Guilliland
National Coordinator
New Zealand College of Midwives
PO Box 21 106
CHRISTCHURCH

Dear Ms Guilliland

I very much appreciated our conversation by phone about comments that I was supposed to have made to the media both here and in New Zealand about Obstetric services. As regards the Australian article you will now be aware the I was totally dismayed at the outcome in terms of what was attributed to me and the way it was reported. The conversation I had with the author was on Cesarean section. It was extremely aggressive in that she had had a birthing experience that was unsatisfactory and she had ended with a section that she had wanted from the start. She was enquiring of Westmead why our rate is low, and the implications of that.

Some of her concern was about midwifery attitudes and as she knew about the New Zealand situation of care there was some conversation about that topic. Out of that conversation came statements (note there were no quotation marks) that were neither said or implied. I understand that other comments have been attributed to me that do not originate with me. The statement in the article about maternal mortality comes from a ?NZ Sunday times article of September 18 1994. The perinatal mortality statement came from an obvious misunderstanding of a detailed explanation of corrected and uncorrected perinatal mortality. I explained about the difference and how the Wellington uncorrected perinatal mortality was double that of the corrected rate and reasons for that. This somehow got construed as it did in the article which leaves me in dispair. As you know I am following the matter through as best I can on this Side of the Tasman.

Although you did not refer to the statements about my reasons for resignation and Independent midwifery being disastrous in your letter, I think that you should be aware that they are incorrect also. I left New Zealand for a number of reasons, the most important being the funding of the universities and the Wellington clinical school in particular. The Department of Obstetrics in Wellington was to be given enough money for half a secretaries salary in 1996 which left us underfunded for any teaching or research. The situation was intolerable. My letter of resignation to the university enumerated many

problems underlying my unhappiness, Independent midwifery was not one, and was not mentioned in the letter. Similarly, although the author of the Australian article was keen to know about disastrous Obstetric situations that had arisen in Wellington, not only did I not provide her with any, I went out of my way to say that the rate of Obstetric problems was no different to those in Australia. I hardly think that my wife and I would have an Independent midwife look after our first delivery if I felt that the care could be disastrous. I can only hope that our conversation and this letter go some way to clarify things in New Zealand...

If you wish to discuss anything further or hear of further statements that I am supposed to have said please feel free to challenge me at any time. As you know, being misrepresented is a very unhappy experience.

Kindest regards

Yours sincerely

H G Murray

cc Australian College of Midwives

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**

NZCOM DIRECT ENTRY MIDWIFERY EDUCATION FUND

EDUCATION GRANT

Purpose: The Direct Entry Midwifery Education Fund was established to provide an Education Grant to students undertaking Direct Entry Midwifery registration Courses within New Zealand, to assist in payment of the course fees, clinical training fees or purchase of required text.

Amount: Up to $500 per applicant, per year. The amount of funding available is dependent on the finances available each year and will vary accordingly.

Conditions for Application

The Applicant:

- is a student undertaking a Direct Entry Midwifery Course leading to registration as Midwife.
- has made formal application and has been accepted in the course of study.
- is a current financial member of NZCOM.

The Application is assessed on:

- degree of financial hardship
- level of income
- presentation of application
- preference will be given to applicants who have not previously received a financial grant from this fund or a like fund.

Application Closing Date:

31 January each year

Applications Forms available from:

National Treasurer,
New Zealand College of Midwives
P O Box 21106
Edgeware CHRISTCHURCH
Phone: (03) 3772-732

Christine Barbour, Hamilton, discovered the following information in the Kent Family Magazine 1994. Please note this "Midwife" established a comprehensive database and had an annual caseload in line with the NZCOMI recommendations. He attended his last birth at 87 years.

William Waylett (1728-1815) was a surgeon-apothecary who spent almost the whole of his working life in Lydd. He was also a male midwife and kept a casebook in which he recorded all the births he attended (from 1757 to 1815). These total close on 3,000 and I have now indexed them; the information given is: Date/ Parent's name/ Location/ Duration of pregnancy/ Type of birth/ Sex of child/ Number of pregnancies (the record is 15)/ Fee charged. Illegitimacies are distinguished by the omission of *Mrs* and give the mother's christian name instead of the usual *Mrs John Smith*. The father's occupation is sometimes stated, for example, *'Veteran Soldier's Uxor', 'Comedian', 'Soldier', 'No.2 Barracks', 'Mrs Major Gibbons; she died 1st Dec'.*

Yours sincerely,
John Douch

Tel: (0933) 224038
6, Roberts Street,
Wellingborough, Northants NN8 3HY.

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

DEPARTMENT OF NURSING AND MIDWIFERY

THE MIDWIFERY PARTNERSHIP

A model for practice

Karen Guilliland & Sally Pairman

MONOGRAPH SERIES: 95/1

DEPARTMENT OF NURSING & MIDWIFERY
VICTORIA UNIVERSITY OF WELLINGTON

Available from:

NZCOMI
P O Box 21-106
Christchurch

or

Dept of Nursing
& Midwifery
Victoria University
of Wellington
P O Box 600
Wellington

COST
$16.00
(incl P&P)

The Cochrane Pregnancy & Childbirth Database

The new 1995 Issue 1 of the *Cochrane Pregnancy and Childbirth Database* contains:

- Over 30 new Cochrane reviews relating to pregnancy and childbirth
- 500 pre-Cochrane reviews of interventions in pregnancy and childbirth from previous issues
- The complete text of *A Guide to Effective Care in Pregnancy and Childbirth* (2nd edition) from Oxford University Press
- The specialised register of controlled trials assembled by the Pregnancy and Childbirth Group

and is available now in Windows, DOS, Macintosh and CD formats.

- Subscriptions to *The Cochrane Database of Systematic Reviews (CDSR)*, on disk and CD-ROM, are available through the BMJ Publishing Group, PO Box 295, London WC1H 9TE, UK. Tel: 44-171-383-6185/6245; Fax: 44-171-383-6662. The pilot database for CDSR, *The Cochrane Pregnancy and Childbirth Database*, is also available from the BMJ Publishing Group.
- *A Guide to Effective Care during Pregnancy and Childbirth* (1995, 429 pages), *Effective Care of the Newborn Infant* (1992, 650 pages) and *Effective Care in Pregnancy and Childbirth* (1989, 2 volumes, 1500 pages) are all available through Oxford University Press, Walton Street, Oxford OX2 6DP, UK. Tel: 44-1865-56767; Fax: 44-1865-56646.

FETAL WELFARE AND THE LAW

John Seymour, BA, LLB, PhD (AK)
Barrister & Solicitor of High Court of NZ
& Supreme Court of ACT

A 249 page Australian Report of an Inquiry commissioned by Australian Medical Association and sponsored by RACOG, National Ass'n of Specialist O&Gs, Australian College of Peadiatrics and Medical Protection Ass'n of Australia.

The purpose of the Inquiry was to find answers to where responsibility should lie for the provision of the best possible care for the fetus before and during birth.

Some excerpts:

"When a competent, properly advised pregnant woman has clearly communicated her decision to decline a particular form of treatment, there are no circumstances in which the law should seek to override this decision. The principle that her wishes should be respected should prevail regardless of the degree of risk either to herself or the fetus".

"Both women's groups and health care professionals should concentrate on improving education and communication, so that doctors and midwives are fully informed of women's views and concerns, and women are willing to consider medical advice in an open-minded manner. The invocation of coercive legal procedures will not serve the interests of pregnant women or their fetuses: Australian society would be far better served by programs which foster high-quality antenatal care and thorough education".

"There is no place for legal intervention designed to impose controls on the behaviour of the pregnant woman, when this behaviour is potentially harmful to the fetus. Whether it is criminal law or the child welfare law which is being considered, resort to coersive measures in an attempt to protect the fetus is inappropriate. At best, invocation of the law is ineffective, and at worst, counterproductive".

"The rejection of legal intervention to control antenatal behaviour is consistent with adoption of the principle of respect for women's autonomy. When a woman's behaviour presents a risk to the fetus, the law should not intervene in such a way as to curtail her freedom of action. The pregnant woman must remain free to decide how to live her own life. When making decisions, however, she would have access to full information on the harm which her behaviour might cause the fetus".

"It should be appreciated that not all maternal behaviour which is potentially harmful to the fetus is the result of free choice. The behaviour is frequently the product of a variety of personal and social factors over which the woman has little or no control. Society should take this into account and make available counselling and support services directed towards alleviation of the problems underlying the woman's behaviour".

"Australian common law does allow a child to sue for damages in respect of injury negligently caused during pregnancy. There are however some unsatisfactory features in courts' decisions, and some uncertainty in theoretical grounds for allowing children to sue in respect of antenatal harm. It is difficult to escape the suspicion that in some cases compensation has led to questionable statements of principle. Further clarification of the law is needed".

In view of NZ's C.E.R. with Australia and our recent 'harmonisation' of food standards with Australia - in the interests of 'free trade' - it would be a good idea to obtain and read the full report.

GENETIC SUPPORT COALITION

During the Health Research Council conference ***Whose genes are they anyway?*** held in Wellington during July 1995, a number of groups and individuals expressed interest in forming a coalition of people with genetic conditions. Since then an interim committee has been established and the commitment given to make this coalition a reality.

The purpose of this coalition is to:

- ensure that all people with genetic conditions and their supporters have a voice on genetic issues affecting them - public policy, ethics committees, genetic testing, life and health insurance, discrimination in employment, genetic research, privacy, cultural appropriateness, etc
- increase public awareness and acceptance of diversity
- find out about new and positive developments in the field of genetics
- facilitate networking between genetic support groups

Interim committee Howard Esler - Apert Syndrome, Jennie Giles - Genetic Counsellor/Little People of NZ, Barbara Holt - Breast Cancer Action, Craig Jones - Diabetes Youth, Sandy Johnson - Breast Cancer, Anne Mellsop - Huntington's Disease Assn, Ruta Nonu - Pacific Island Health and Justice, Jane Shackleford - Muscular Dystrophy Assn, Marama Wieldraaijer - Adrenoleucodystrophy.

For further Information please contact:
Howard Esler, Coordinator Ph/Fax 09 6279137 Auckland
6 Peter Mulgrew St, Avondale, Auckland 1007

PACIFIC ISLAND POSTNATAL DISTRESS AND DEPRESSION LINK

This group has developed due to concern amongst the Pacific Island women regarding increasing Postnatal Distress.

Enquiries about the group should be addressed to:

The Pacific Co-ordinator
Pacific Island Distress & Depression Link
P O Box 79130
Royal Heights
Auckland

Phone (09) 833 8251

FOR SALE

SONICAID

as new

$1000

Please contact
Diane Howick-Smith
12 Hamana Street
Devonport
Auckland
Phone (09) 445-7292

Notice of Birth

There is a new regulated form BDM 9 Notice of Birth. In all cases Notice of Birth should reach a Registrar of Births within 5 working days.

In the case of hospital births, either:

- the Notice of Birth should be filled in and signed by the person in charge of the premises for every live birth and still birth.
- other arrangements to give notice of birth (for example, a computer printout) may be made with the Registrar of Births.

In the case of home births, the form must be filled in and signed by the doctor or midwife responsible for every live birth or still birth. If no doctor or midwife was present at birth, the form should be filled in and signed by the person in charge of the premises where the birth took place or where the mother was admitted after the birth.

Notification of Birth for Registration

For parents, there is a revised form BDM 27 Notification of Birth for Registration and a new informal booklet. These should be provided together to the parents as soon as it is practical after the birth.

Where it is possible, your assistance in providing this material to the parent(s) of every birth is gratefully appreciated.

If you have any questions about birth registration and the new Act, please contact this office.

Registrar of Births

Request from NZ Homebirth Conference

Would Independent Midwives attending home births please send in the Homebirth Stat Forms to **Linda McKay, P O Box 7093, Wellesley Street** .... along with $3.00 for each form. Forms can be obtained from Linda by phoning 09-378-0599

NB: Could Independent Midwives who have consumer-friendly handouts please send a copy so they can be assessed and included.

DEPARTMENT OF
JUSTICE
NEW ZEALAND

Registrar Births, Deaths and Marriages
48 Peterborough Street
Private Box 25211
Christchurch
Telephone (3) 379 6006
Facsimile (3) 366 9141

In reply please quote:

What maternity care providers need to know about the Births, Deaths and Marriages Registration Act 1995

The registration of birth is guided by new legislation from 1 September 1995.

While the basic principles relating to birth registration remain unchanged, there are three key changes that providers of childbirth care should be aware of.

1. There is a new, wider definition of a still-born child.
2. For providers of maternity care there is a revised form to give notice of birth to the Registrar of Births.
3. For parent(s) there is a new information booklet to accompany a revised Notification of Birth for Registration form.

Definition of a Still-Born Child

Both the Notice of Birth (completed by the doctor or midwife or other person in charge of the premises where the birth took place) and the Notification of Birth for Registration (completed by the parents) require a statement whether or not the birth was a still-birth.

The definition of a "still-born child" has been widened in the new Act, reflecting the increased threshold of foetal viability.

The new definition of a still-born child is a dead foetus that:
- (a) weighed 400g or more when it issued from its mother; or
- (b) issued from its mother after the 20th week of pregnancy.

For the purposes of registration:
- A still-birth is registered as a birth, not registered as a death
- A baby that died following birth is registered as a birth and also as a death.
- A miscarriage is not registered at all.

TO: NEW ZEALAND COLLEGE OF MIDWIVES
MINISTER OF HEALTH
OPPOSITION SPOKESPERSONS FOR HEALTH
NEW ZEALAND PRESS ASSOCIATION
REGIONAL HEALTH MANAGERS OF MATERNITY SERVICES
MINISTRY OF WOMENS AFFAIRS
NATIONAL COUNCIL OF WOMEN

REMIT ONE:
The Home Birth Associations of New Zealand/Aotearoa are concerned that the dollar amounts allocated to the maternity modules in the latest Maternity Benefit Schedule Section 51 are insufficient to provide women with quality maternity care.

Currently the majority of New Zealand women opt for shared care. There is insufficient money in the proposed modules to pay for quality continuity of midwifery care in a shared care situation.

We believe that there needs to be provision for payment for a second practitioner at a planned home birth.

The post natal module is seriously underfunded. Currently women who give birth at home have an average of 8 - 10 postnatal visits. Our statistics for these women show a high rate of exclusive breast feeding and extremely low rates of postnatal infections and other problems including postnatal depression. We believe that the low level of payment allocated to this module will prevent practitioners from providing adequate postnatal care regardless of the place of birth and that future health problems for mother and baby will increase along with postnatal depression.

Furthermore a quality postnatal service is dependent on the ability of the practitioner to visit women at home. The payment allocated to this module is totally insufficient to cover the time and travel expenses involved in providing quality postnatal care.

We acknowledge that there are currently women who receive less than optimum care during the childbearing cycle. However we believe that the proposed payment schedule will lead to far greater numbers of women being underserviced.

We are concerned that the proposed payment schedule makes no provision for the special needs of rural women. There needs to be provision for an additional payment to the practitioner who provides domiciliary care to these women.

We applaud the joint Regional Health Authorities commitment to a payment for home help services to women who give birth at home or take their option of early discharge from hospital. We urge that this payment reflect both the considerable cost savings being made for the maternity service by these women and their subsequent need for quality domestic services during the first few weeks of their baby's life. We would suggest that a figure in the vicinity of $500 is realistic.

REMIT TWO:

The Home Birth Associations of New Zealand/Aotearoa strongly support parents' right to make an informed choice about vaccination.

We urge that medical practitioners be required to report all adverse reactions to a national body which will make public this information in order to facilitate informed choices.

We strongly oppose any legislation or directive which enables education and childcare facilities to discriminate against unvaccinated children.

URGENT
MIDWIFE SURVEY REMINDER

Please return the self employed Midwife Register Survey form as soon as possible.

Thank you to all midwives who have returned their forms. However, we still need a higher return rate before the information we collect on midwives and their practice will be reliable.

Please return forms urgently.

Several midwives have returned their forms without their membership number and we are therefore unable to send the Birth Outcome Forms. If you think you maybe one of these midwives, please ring (03) 377-2732

CANNABIS & HEALTH IN NEW ZEALAND

CANNABIS USE IN NEW ZEALAND

Cannabis is the most widely used illegal drug in New Zealand. A 1990 survey showed that 12% of New Zealanders between 15 & 45 years of age had used cannabis in the previous 12 months. 43% of New Zealanders in the same age group report having used cannabis at some time in their life.

RISK TO OTHERS

Use of Cannabis during pregnancy

Evidence indicates that cannabis use during pregnancy causes health effects relating to foetal hypoxia similar to those associated with tobacco smoking. The effects include impaired foetal development and associated low birth weight. There is also evidence of the presence of THC in the feotus. There is a possible increased risk of abnormalities in birth or childhood abnormalities.

Passive smoking and cannabis

There is insufficient research to show whether there are health effects associated with the passive inhalation of cannabis smoke. However, evidence relating to the effects of passive tobacco smoke suggests that caution is appropriate.

Issues to be resolved include the possibility of adverse respiratory effects associated with long periods of exposure (particularly among children), and the possibility of a sedating effect on babies and young children.

John Hannifin, Chairperson, Drugs Advisory Committee
Community Health - Hygiene, March 1995

UPDATE ON THE OPEN POLYTECHNIC OF NEW ZEALAND DISTANCE LEARNING PAPERS FOR MIDWIVES

REPORT FROM: CHRIS HENDRY
NZCOMI REP ON TOPNZ ADVISORY COMMITTEE

TOPNZ is offering 5 distance learning papers specifically for Midwives. They are:

- Midwifery - Core Course
- Antenatal care
- Labour and Immediate Post partum
- Postnatal care
- Breastfeeding.

Each of the papers are worth "9 credits" (equal to 8 weeks work) and are available at any time of the year, to be completed at your own pace. The papers are very clinically focused and all the assignments relate directly to your clinical practice. Self reflection on practice, communication skills and consumer perception of care are emphasised. Some effort has been gone to by NZ Midwives to adapt the papers to the NZ midwifery setting. Further ideas on this would be useful from those who have completed papers. We have just redone all the assignments as some were too difficult to complete in the NZ clinical setting.

There are many other generic and Nursing papers that are available to compliment the 5 Midwifery papers, they are:

- Parenting Young Babies
- Cultural Safety
- Basic Statistics
- Stress - the Problem
- Health Management
- Physical Assessment

The completion of 90 credits leads to a Diploma in Clinical Practice from TOPNZ. If Midwives with a Diploma in Midwifery or the ADN from NZ Polytechnics complete 72 credits, they will gain a Bachelor of Health Sciences from Southern Cross University, NSW. Midwives who gained Registration from the Schools of Nursing Hospital Based Programmes would be best to discuss their options with Patricia French.

As the NZCOMI representative on the TOPNZ Advisory Committee, it is important that comments, suggestions and criticisms are passed on to me to take to Committee Meetings. I can be contacted at the Burwood Birthing Unit 03-3836844. For details on the papers, marking and supervisory information, Patricia French is the Coordinator of the programmes at TOPNZ the best person to contact at 0800 650200 (freephone).

TOPNZ also requires more assignment markers and clinical assessors, both of which are paid activities. Ideally a Midwife taking on the role would have a Degree and/or experience in assessment and marking processes. Anyone interested please send your CV to Patricia French TOPNZ Private Bag 31 914 Lower Hutt.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

MEMBERSHIP APPLICATION FORM

GST NO: 55-323-585

TO: **12 months Subscription to the New Zealand College of Midwives (Inc).**

TYPE OF MEMBERSHIP (Please indicate in Box)

☐ Self Employed $350

NB: Your membership is deemed Self Employed if you claim from the Maternity Benefit Schedule.

☐	Employed	$175	☐	Associate with Indemnity	$155
☐	Unwaged	$ 50	☐	Associate	$ 30
☐	Student	$ 50	☐	Affiliate	$ 30

METHOD OF PAYMENT (please indicate in box)

☐ Subscription payable to NZCOM ☐ (Cheque enclosed)

☐ Subscription from salary) Please contact National Office for a Direct Credit Advice to be sent

☐ Automatic Payment) to you (contact details at the foot of this page).

FIRST NAMES: .... (PLEASE PRINT CLEARLY)

SURNAME: ....

ADDRESS: ....Town/City.........................

DATE OF BIRTH:........../........../..........

PHONE: Work: .... (Ext: ....) Home: ....

PLACE OF WORK: (IF APPLICABLE) ....

ARE YOU A MEMBER OF NZNO? **YES/NO**

I AGREE TO MY NAME & ADDRESS (ONLY) BEING AVAILABLE TO ORGANISATIONS AS APPROVED BY THE NZCOM? **YES/NO**

REMINDER: *Professional indemnity insurance is included with NZCOM membership for financial members who are self employed, employed, unwaged, student and associate with indemnity.*

Your membership to the NZCOM will **expire** 12 months from the date of this payment being received. When your membership is due for renewal we will send you an invoice one month prior to the due date.

ADDRESS MAIL TO: Subscriptions, NZ College of Midwives, P O Box 21106, Edgeware, Christchurch
Phone: (03) 3772-732 Fax: (03) 3652789 Email Address: NZCOM.NAT.COORD@UNI.MASSEY.AC.NZ