SIAN BURGESS
17 Malvern Rd
Mt Albert
AUCKLAND 1003

POSTAGE PAID
CHRISTCHURCH NZ
PERMIT NO. 2843

SENDER: NZCOM BOX 21-106 CHRISTCHURCH

NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

NATIONAL NEWSLETTER

September / October 1995

AGM Report

President's Annual Report

Cerebral Palsy
Consensus Statement

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

National Office : P O Box 21-106 Edgeware Christchurch 906-908 Colombo Street
Telephone (03) 377-2732 Fax (03) 365-2789

NATIONAL COMMITTEE

Board of Management

Karen Guilliland	**National Co-ordinator**	C/- National Office (as above)
Sally Pairman	**President**	90 Cannington Road, Dunedin - Phone 03-467-5046
Linda Collier	**Assist Co-ordinator/ Treasurer**	C/- National Office (as above)
Julie Richards	**Newsletter Editor**	81 Caledonian Road, Christchurch - Phone 03-377-2732
Judy Henderson	**Secretary**	C/- National Office (as above)

Regional Chairpersons

Auckland
Sandy Grey
827 Te Atatu Road
Te Atatu Peninsula
AUCKLAND
Ph/Fax: 09-834-5704

Canterbury/W Coast
Jacqui Anderson
Lincoln Maternity Unit
Lincoln Hospital
Lincoln CANTERBURY
Ph: 03-332-9088

Central
Ruth Martis
467 Church Street
PALMERSTON NTH
Ph/Fax: 06-356-2354

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: 02-2064-022

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

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

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

Maori Midwives - Nga Maia O Aotearoa Me Te Waipounamu
Ellen Tito
Harangi Biddle
Estelle Marment
Ranui Parata

Consumers

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

---

conclusion

demonstrate midwifery outcomes.

Conclusion

It has been another very busy year for us all and the expectations we all have of the College seem to grow daily. It is difficult to remain pro-active and responsive to individual midwife needs as well as national and international needs. It is increasingly obvious to me that as members we have to review our commitment to the College in both financial and participatory terms. A member-led organisation relies on the active involvement of its members and we also must consider the financial commitment we are prepared to make to ensure enough employed people to carry the workload.

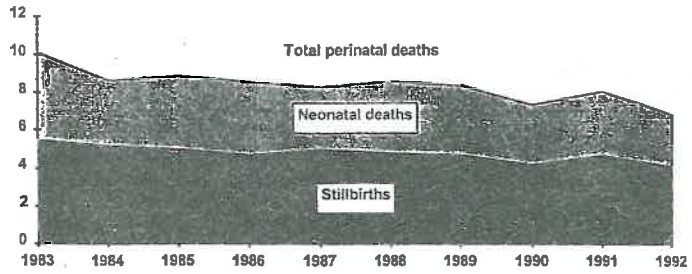
The coming year will be another challenging year as we begin to experience the changes imposed by the Maternity Project. We have to individually review our practice and consider how best to fit into this new system. Choices will need to be made for midwives as well as women and working within a capped budget will require changes from us all. Our ongoing challenge is to ensure that within this new system, midwifery continues to develop and provide a strong service which truly meets the needs of women.

I would like to thank the National Committee and Karen for all their support over the past year. I am also very grateful to my husband and family for their support, encouragement and practical help which makes juggling work, family and College commitments so much easier.

I wish you all well for the coming year.

In respect of deaths of infants around birth, the evidence is quite clear that the rates of such events have been falling in recent years. The most recent confirmed figures are for 1992 and show a stillbirth rate of 4.1 per 1000 live births - the lowest figure ever in New Zealand. Similarly the early neonatal death rate (within seven days of delivery) at 2.8 per 1000 was also the lowest ever recorded. The total perinatal death figure was again the lowest ever recorded at 6.9 per 1000. The graph confirms the lowering trend over ten years. Provisional 1993 figures appear to confirm these findings.

Total perinatal deaths 1983-92



The article in the Sydney Daily Times claims that figures for perinatal deaths in Wellington have "doubled to 9 per 1000 since midwives took over". Data from births in Wellington Women's Hospital do not confirm this but rather point to improving rates there as in the rest of the country.

I am confident from this information that there is no evidence of worsening outcomes for mothers or babies over recent years and certainly not since 1990 when the Nurses Amendment Act was enacted.

Yours sincerely

Hon Katherine O'Regan
Associate Minister of Health

CONTENTS

National Committee Directory	fic
Editorial	2
Letter to the Editor	3
National Co-ordinator's Forum	5
Annual Report	9
Minute Summaries	17
Section 51 Update	28
Events Calendar	36
Current Issues	40
Articles of Interest	48
Media Watch	58
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:

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

Fetal productions warned **US**

The US FDA has alerted doctors about enterprises that are commercialising ultrasound videos of fetuses. In some cases the ultrasound was being used for as long as an hour to get a video of the fetus. The FDA said while routine medical use of ultrasound is safe, exposing the fetus to ultrasound for no medical benefit is not justified.

NATIONAL COMMITTEE MEETING CALENDAR 1995

17th and 18th November

Any contributions to the National Newsletter should be addressed to:
Julie Richards
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

NURSING COUNCIL NOMINATIONS

Nominations are being sought for the position of the NZCOMI representative on Nursing Council.

Jackie Gunn presently holds this position and will be standing down early next year at the end of her term.

Midwives who would be interested in this position, please contact your Regional Chairperson.

EDITORIAL

Welcome to the Spring issue of the newsletter. Isn't it great to feel warmer days and to see colour emerging in the garden.

The NZCOM National Committee and invited guests recently had the opportunity to share a day workshop with Professor Lesley Page. Lesley is the first Professor of Midwifery in the United Kingdom and has been closely involved with Changing Childbirth which is now policy throughout the UK. Lesley is also responsible for the establishing and evaluating of the One to One Midwifery Practice in London and Oxford.

The One to One Midwifery Practice is based on choice, control and continuity and Lesley's research reveals this must be continuity of caregiver and not just philosophy to be effective.

Congratulations to Christchurch Women's Hospital on the recent establishment of their One to One Midwifery scheme.

Section 51 Negotiations slowly proceed with little new information other than the RHA's acknowledgment for the need for a rural mileage allowance and this is presently being negotiated. A further meeting was to be held on the 8th September an update is included.

Don't miss the article on The Origins of Cerebral Palsy. This is the consensus statement of the Australian and New Zealand Perinatal Societies.

Planning for our 1996 Conference is well underway with an enthusiastic Conference Committee. Watch your mail box for the First Announcement and Call for Abstracts.

Karen's workload continues to expand far beyond the time and energy available and the National Committee has approved the ongoing employment of an assistant to the National Co-ordinator. Hence an increase in subscriptions to cover this and other services.

Karen has also had a very sad time with the death of her mother, Mary Chandler, during August. Mary was a wonderful woman with a clear sense of social justice and one of midwifery's strongest advocates. Mary always spoke her mind and could often be heard on radio talk backs defending attacks against midwifery.

Its not surprising that a woman of immense personal attributes would have a daughter such as Karen. Mary was one of Karen's strongest supporters and she will be sadly missed but with very fond memories.

Thanks for all the information and letters that you have sent into me for the newsletter.

Take care, *Julie Richards*

THE OFFICE OF THE
Minister of Health

31 AUG 1995

29 AUG 1995

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

Dear Ms Guilliland

At the end of July you spoke to Hugh Evans, my private secretary, and Dr John Marwick, senior professional adviser at the Ministry of Health, about claims made in Australian newspapers about perinatal and maternal mortality in New Zealand. The articles claimed there had been deterioration both in the number of maternal deaths and in stillbirths and attributed this to independent midwife controlled birth as allowed by the Nurses Amendment Act 1990.

Ministry of Health officials have now reviewed the latest available data. In respect of maternal mortality, I am advised that over the last ten years there is no clearly definable trend. Numbers are in any case small so that there can be quite marked variation from year to year. These deaths are all individually examined by the Maternal Deaths Assessment Committee which publishes reports on three year periods. Its last published report covered the years 1986 - 1988 and raised some concerns about high numbers in comparison to overseas data. The Committee has subsequently reviewed the 1989-91 data and found a much lower rate. Provisional data up to 1993 shows quite marked year to year variation.

Dr Marwick has spoken to Professor Aicken, who chairs the Maternal Deaths Assessment Committee. He confirms that the Committee's latest review shows a considerable improvement on previous levels. He also states that the reviews of individual deaths have not shown any evidence that there is an association between independent midwifery and maternal deaths. He points out that there are considerable difficulties in making international comparisons because of differences in what each country includes in its data and its completeness. New Zealand, being a small country, is confident of its data but concerns have been raised about the Australian figures especially the completeness of Aboriginal data.

MEDIA WATCH

"Daily Times" Sydney 25/5/95

....."In public pronouncements since International Midwives Day earlier this month, the midwife movement in Australia has made clear it wants to take over control of birthing from obstetricians, as happened in New Zealand five years ago.

But in New Zealand, independent midwife-controlled birthing has been a disaster. Westmead Hospital perinatologist Dr Henry Murray, who left his native New Zealand in disgust at the new system, says the rate of deaths of babies at birth has doubled to 9 per 1000 in Wellington since midwives took over.

Maternal death rates also rose sharply to quadruple the Australian rate."

"Sunraysia Daily" Melbourne 26/7/95

....."Dr Bowditch said the team model was the only sensible option to ensure women would receive the quality of care they required and expect.

He referred to the New Zealand situation where, prior to the last election, legislation enforcing independent midwifery was passed.

He said the result of this move was to add $25 million annually to the health bill to pay for the midwives and a four-fold increase in the death of pregnant women.."

Lawrence criticises birth intervention

Melbourne Age 7 July 1995

By SONIA HARFORD,
Accent editor

The federal Health Minister, Dr Lawrence, yesterday accused some obstetricians of "overservicing" and criticised the medical profession's high rate of childbirth intervention in Australia.

Dr Lawrence, in Melbourne to launch a $1 million program of alternative birthing services for Aboriginal and Torres Strait Islander women, spoke out in favor of independent midwives.

She said Australia was one of a few countries where obstetricians devoted a lot of time to healthy women and normal births — eroding the role of midwives.

"I want to see that situation changed," she said.

At the launch of the national birthing services program at the Victorian Aboriginal Health Service, Dr Lawrence said the $1 million package would fund pre-natal classes, education for pregnant women to make their own birthing choices, and the employment of midwives to train Aboriginal health workers in some rural towns.

The Victorian Aboriginal Health Service would get $85,112 for a community birthing program, and $42,571 has been allocated to La Trobe Regional Hospital for a midwife's salary.

"Aboriginal concepts of birthing don't fit easily into the medicalised model that prevails in much of the Australian medical system ... our scientific knowledge and resources need to be adapted to understand different ways of giving birth," Dr Lawrence said.

The national program was a culturally sensitive approach to improving Aboriginal health, she said.

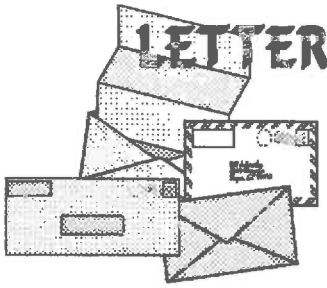
Dr Lawrence's ministry took over Aboriginal health only a week ago from the Aboriginal and Torres Strait Islander Commission.

Aboriginal pregnancies are more likely than others to result in premature births, complications and underweight babies. "As a result, Aborigines are at a greater risk of illness and death, and not only as infants. Low birth weight can lead to serious implications in adulthood," Dr Lawrence said.

She said the program would employ midwives in their own right and would have agreed accreditation in hospitals.

Victoria's Health Minister, Mrs Tehan, said this week the state had too few obstetric services in rural areas due to rising medical indemnity insurance. A spokesman for Dr Lawrence said she was also concerned about the impact of rising insurance on country doctors, but it was a separate issue from the high rate of intervention in child birth.

LETTERS TO THE EDITOR



26 JUL 1995

27 Kildare Street,
Waikiwi,
Invercargill.

19th July, 1995.

Dear Linda,

As a new member I have just received my first copy of the N.Z.C.O.M newsletter which I found most informative. The articles on sheepskins and on immunization have come a little later for me, my three children having been born during the era when every caring mother used a sheepskin and put her baby to sleep in the prone position!.

I would, however, take issue with you over the comment on page 20 referring to God as 'she'. As a Christian I am deeply offended (as I am sure will be many other Christian midwives) as this is in direct contravention of the first of the ten commandments. I feel that if we, as midwives, are to have credibility with our medical colleagues and the public such comments are unnecessary and counter-productive.

Yours faithfully,

Phoebe

Mrs. Phoebe Anstice.

PARENTS CENTRES
New Zealand Inc.

P.O. Box 17-351
Wellington
Ph/Fax (04) 476 6950

21 August 1995

Dear Editor

I refer to your reprint of an article by Royal Elfast in the June/July NZ College of Midwives Newsletter.

Parents Centre has had a number of letters from Royal Elfast who is implacably opposed to the use of sheepskins in infant bedding. Naturally we took his concerns seriously and sought further information from researchers connected with the Cot Death Study. The replies confirm that an infant lying face down on a sheepskin is at higher risk of SIDS where there are factors leading to the infant's lack of response to the "rebreathing stimulus" - this is true of any soft surface where the infant is placed prone.

It was however stated that analysis of the cot death information suggested that babies lying on their backs or sides were in fact at lower risk of SIDS if they slept on a sheep skin. It is thus essential that parents are advised that babies should be placed only on the back or side with respect to sleeping on any surface but this is even more crucial on soft surfaces.

Royal Elfast also draws links between sheepskins and atopic asthma. Research is being carried out in Wellington presently on links between dust mite allergy and the development of asthma. No data has yet been published from this study but it is known that sheepskins that are not regularly washed and aired do become mite-infested. It is therefore essential that parents are reminded to wash the sheepskin regularly but even more importantly, hang the sheepskin in the sun to air at least once a month and preferably, more frequently. Exposure to sunlight and low humidity kills dust mites.

It has been difficult for Parents Centre to know what information to pass on to new parents with respect to SIDS, especially when there are so many theories as to possible causes. As well as the modifiable factors identified through the Cot Death Study, there are also theories that related SIDS to suffocation, insufficient selenium, immunisation, ammonia from urine-soaked nappies, fire retardant chemicals used in baby's bedding, particularly mattresses, as well as other causes. There is no doubt that those who hold these views are genuine in their concerns and their views may in time, be proven to be scientifically valid.

However, because of the sheer volume of bewildering but plausible theories, Parents Centre has decided that it can best serve the needs of its members by educating them in the factors that are scientifically proven with respect to the prevention of SIDS. This is not to discredit or ignore the alternative theories but rather to recognise that however deeply felt, they are at present still anecdotal and without scientific validation.

Sharron Cole

Sharron Cole
National President

THROUGH A GLASS DARKLY

Midwives should stop deluding themselves about their skills and responsibilities and recognise the true nature of their profession, argues Rachel Clarke

ACCOUNTABILITY

BEING on the inside of the midwifery profession often results in the unquestioning acceptance of rhetoric as valid reality. Statements such as 'Midwives are independent, autonomous practitioners in their own right' and 'Midwives are highly skilled' are empty, particularly in view of the very limited sphere of decision-making to which midwives are restricted. Being on the inside often means we cannot see what it is like on the outside, because of the mud on the windows. All too often we accept the rhetoric as representing reality and fail to see the truth through not asking questions or scrutinising research findings.

Why has the RCM never successfully protected our working sphere? Most trade unions would react explosively if the jobs of their members were threatened by a rival group, as in the case of a plumber doing the work of an electrician. But the RCM has allowed obstetricians to undermine, define and control our working practices. Why are copies of the *Midwives' Rules* and the *Midwives' Code of Practice* sent to the Royal College of Obstetricians and Gynaecologists? Is it to gain approval and reassure them that the midwives are being 'good girls' and not stepping out of line? What business is it of the RCOG how we govern our practice?

Midwives' inclination to block out difficult situations occurs because we are ill prepared to deal with the reality of women's lives

If midwifery is as wonderful as the rhetoric would have us believe, the National Childbirth Trust would be redundant as a pressure group, the recommendations of the Maternity Services Advisory Committee would not have been required, *Changing Childbirth* would be a work of imaginative fiction and the Association of Radical Midwives would not be trying to get back to basics. Their existence shows we are not getting it right. If midwives are so 'highly skilled', why are the statistics on successful breast-feeding such a damning indictment of midwifery practice? Research confirms that what lies beyond our perception of ourselves is the reality of midwifery practice.

Some months ago, I learnt of a situation in which a student working with a midwife encountered a woman with a bruised pubic and vulval area. The student anticipated that the midwife would open a conversation, giving the woman the opportunity to discuss the bruising or any problems she had. To the student's dismay, the midwife failed to do this, continuing the routine aspects of the examination. Any potential for the midwife to be truly 'with woman' was lost. Midwives' inclination to block out difficult situations occurs because we are ill prepared to deal with the reality of women's lives. We lack the skill to initiate 'dangerous conversations'. Real midwifery involves intimacy and emotional commitment, but too many of our interactions with women are superficial, and we terminate nine months of care knowing hardly anything worth knowing about their lives.

Surprisingly, many midwife teachers and clinical midwives still believe the only skill students need to learn is how to deliver a baby. This is a foolish and naïve belief, for there is little skill in this. Babies emerge naturally, heading for the only exit available to them. In most cases there is no need for any hands to manipulate the infant. Having created a reality in which women believe they need someone to deliver their babies, midwives have become victims of their own myth. Yet if we face up to being redundant in this role, it may provoke us to ask: 'What are midwives for, then?' This may lead us to discover the real nature of midwifery. We need to do this with some urgency because midwifery needs to be reinvented.

At present, care in labour is characterised by charting physical and technological information every 15 or 30 minutes, using a 'flight plan' preordained in procedures, which encourage us to wring urine from recalcitrant bladders, to dart in and out of the vagina and spend the rest of the time in the office gossiping and discussing how difficult the 'patients' are. Many of us fail to see that the 'flight plan' is a device that alienates us from women. We service the notes and partogram and ignore the pain and fear of the woman. The reality of the care we offer has been perverted. What we do each day is 'damp-dust' our clients and tell ourselves that the work has been done.

Students write of giving a woman support and reassurance but, when pressed, cannot articulate how it is done or identify the skills that separate midwifery from the care the woman's mother or partner may give. If caring is skilled and has therapeutic value for women we must be able to articulate how that skill differentiates us from unskilled lay people, and woman who receive real care with an impact on their experience of childbearing must be able to identify its value.

The rhetoric supports a false reality that does not exist outside the party-line propaganda. Women experience the reality obscured by the muddy windows and midwifery research exposes it, but the majority of the workforce refuses to acknowledge it. Reality may come as a shock, but it is not half as dangerous as the docile acceptance of a false belief system. Playing 'Let's Pretend' is for children. It is time midwifery grew up and perceived the world clearly. **NT**

Rachel Clarke, MA, RM ADM, MTD, CertEd, is a freelance writer and lecturer

38 NURSING TIMES NOVEMBER 30, VOL.91, NO 48, 1995

19. Shields JR, Schifrin BS. Perinatal antecedents of cerebral palsy. *Obstet Gynecol* 1988; 71: 899-905.
20. Nelson KB, Ellenberg JH. Antecedents of cerebral palsy. *N Engl J Med* 1986; 315: 81-86.
21. Blair E, Stanley FJ. Intrapartum asphyxia: a rare cause of cerebral palsy. *J Pediatr* 1988; 112: 515-519.
22. Nasya R, Peters E, Bartholomew M, Landis JR. The origins of cerebral palsy. *Am J Dis Child* 1989; 143: 1154-1161.
23. Soothill PW, Nicolaides K, Campbell S. Prenatal asphyxia, hyperlactacidemia, hypoglycaemia and erythroblastosis in growth retarded fetuses. *BMJ* 1987; 294: 1051-1053.
24. Scheller JM, Nelson KB. Does caesarean delivery prevent cerebral palsy or other neurologic problems of childhood? *Obstet Gynecol* 1994; 83: 624-630.
25. Stanley FJ, Blair E. Why have we failed to reduce the frequency of cerebral palsy? *Med J Aust* 1991; 154: 823-826.
26. Blair E. The obstetric management of fetal distress and its association with cerebral palsy [letter]. *BMJ* 1994; 309: 1229.
27. Fleischer A, Schulman H, Jagani N, et al. The development of fetal acidosis in the presence of an abnormal fetal heart rate tracing. The average for gestational age fetus. *Am J Obstet Gynecol* 1982; 144: 55-60.
28. Low JA, Simpson LL, Ramsey DA. The clinical diagnosis of asphyxia responsible for brain damage in the human fetus. *Am J Obstet Gynecol* 1992; 167: 11-15.
29. Matsuda Y, Patrick J, Carmichael L, et al. Recovery of the ovine fetus from sustained hypoxia: effects on endocrine, cardiovascular and biophysical activity. *Am J Obstet Gynecol* 1993; 170: 1433-1441.
30. Field DR, Parer JT, Ayelender RA, et al. Cerebral oxygen consumption during asphyxia in fetal sheep. *J Dev Physiol* 1990; 14: 131-137.
31. Davis S. Foetal distress negligence cases. *Aust Health Law Bull* 1994; 2: 117-125.
32. *Sapley v Gypsum Mines Ltd* (1953) AC663, 681 per Lord Reid.
33. *March v E+MH Stramare Pty Ltd* (1990-91) 99 ALR 423 at 424.
34. *F v R* (1983) 33 SASR 189 at 190.
35. *Rogers v Whitaker* (1992) 175 CLR 479
36. *F v R* (1983) 33 SASR 189 at 194.
37. Hirsch D. Medical negligence. A litigation crisis? *Aust Health Law Bull* 1993; 2: 105-112.
38. Compensation and professional indemnity in health care. Interim report. Canberra Commonwealth Department of Human Services and Health, 1994.
39. Cochrane pregnancy and childbirth database (devised from the Cochrane database of systematic reviews). Cochrane updates on disk. Oxford: Update Software, 1994.
40. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994; 343: 1609-1613.

!!STOP PRESS!!

DIRECT ENTRY MIDWIFERY

Wellington, Waikato and Christchurch Polytechnics have been approved as institutions to run Direct Entry Midwifery.

We are expecting an announcement from the Minister shortly that the Departmental Status will be lifted and all direct entry degree programmes will be established as the mainstream entry point for midwifery education.

Stillbirth Anomaly

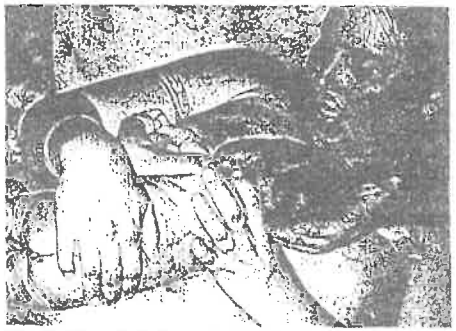
NZ DOCTOR 28/4/95

Concern has been raised that allowing the coroner no jurisdiction in incidences of stillbirth means cases of medical misadventure or those which could advance medical science can slip through the net.

In the wake of two stillbirths in one night on Auckland's North Shore recently, Auckland coroner Stephen Osborne said he is worried that there is no statutory requirement to have such cases investigated.

Midwives and paediatricians contacted by *New Zealand Doctor* have expressed confusion and frustration over grey areas in the law.

The decision to label an infant death as a stillbirth is generally made by clinicians and subsequent involvement of the coroner is not a legal requirement. Rather it depends on the discretion of the clinicians and what is accepted local practice.



The first breath defines whether the baby is a "person"

A paediatrician who was involved in the two Auckland cases said he believes there has to be some sort of review that applies to all births that end with a death.

"Stillbirth" is specifically excluded from the coroner's jurisdiction under the Coroners Act 1988, though Dr Osborne suggested that some cases of so called "stillbirth" should not be excluded.

Dr Osborne said the term is ambiguous and he has met with paediatricians recently in an attempt to resolve the issue.

"I have always looked on the baby who has fully emerged from his [or her] mother's womb with no signs of life as stillborn, though in a number of cases it is now possible to resuscitate."

Cases where stillborn babies were demonstrably dead in the womb are clearly not for a coroner to investigate but those where the baby was very recently alive are another matter.

"I believe it is in everyone's interests to ensure births of this type are investigated. At the moment it seems this will not happen if neither the police nor [the coroner] have an opportunity."

Medical law expert David Collins said in order to qualify as a "person" under Section 4 of the Coroner's Act a baby has to have been born "alive", which in common law means to have gasped at least one breath. *SB*

Further story on page 2

NATIONAL CO-ORDIANTOR'S FORUM

- Karen Guilliland

A TYPICAL WEEK IN THE NATIONAL OFFICE

It was made clear to me the other day that members are not always sure about the workings of the National Office or the comings and goings of the National Co-ordinator!!

In order to make this office more visible I thought it might be useful to outline a typical week. I have chosen to look at my diary for September 4-8th.

Monday 4th September

0730 Telephone call from a regional chairperson checking that information she had sent to me about a local CHE access issue had arrived. Discussed strategies to deal with the situation which involved a midwife employed by the CHE who wanted to have an independent caseload but had been denied access as our employee.

0800 Rang the midwife concerned.

0830 Picked up Sally Pairman President of the College from the airport. Sally, Julie Richards and I met with the four RHA maternity representatives from Southern and North Health to discuss Section 51 regarding rural services, mileage and postnatal midwifery care. (See progress made at the meeting further on in newsletter).

1445 Took Sally back to the airport summarizing the notes from the meeting at the same time!.

1510 Back in the office. Judy my patient and highly competent secretary brought me up to date on telephone messages and mail that she had actioned in my absence. Today's included 2 young school children wanting information for their school project - one 10 year old had heard we did 'good works', a Canadian midwife wanting a copy of our Breastfeeding Handbook, a manager from the Plunket Society telling us their breastfeeding policy paper is nearly finished and did we want to comment, a computer software developer from Auckland with a programme for midwives and a PhD student from Waikato wanting information on midwifery in relation to economic and health policy changes.

I read the rest of my mail and sorted it into the ever increasing action pile. Answered several letters to individual midwife queries and drafted the submission on Cultural Safety to the Education and Science Select Committee.

Several regions had sent in comments to be incorporated into the submission. It was heartwarming to recognise that midwifery's commitment to cultural safety and partnership was so widely held.

1730 Had a session on the computer with Marita (finance/membership clerk) as we grappled with the new membership software programme and its gremlins. Becoming computer literate has been a huge time commitment for all three of us here.
1830 Sent Marita home miles past her paid hours and we'll try again tomorrow with the computer programmer. Rang and made an appointment with him.
1845 Rang a midwife to discuss her ACC claim report - once again her CHE employer had not supported her. This is the fourth time an employed midwife had been badly advised by her managers.
1900 Lockup the office and home with the fax still churning out messages!.

Tuesday 5th September

0830 Returned several phone calls to individual midwives in relation to membership, education and discipline matters.
0930 Marita and I met with the computer programmer. He promises he will make the program faster but blames our 'old' machinery. (All of 2 years old!!).
1000 Read and sorted mail - 20 items today. Fax from a midwife regarding students and Mentoring. Did an interview with a journalist doing a freelance article for a National magazine.
1300 Visiting midwifery students wanting to talk about practice issues.
1400 Further work regarding an indemnity claim. Phoned the indemnity underwriters legal consultant for second opinion. As I will act for the midwife I started to prepare the case. Proofed the midwife's first draft report and discussed with her. Arranged hearing dates and process with the Nursing Council.
1700 Caught plane to Hamilton.
1930 Meeting with College members in Waikato over a variety of issues.
2200 Home to a local midwife's house for the night - plenty of discussion.

Wednesday 6th September

0900 Meeting with Midland's Midwifery Practice Organisation (MPO) Steering committee in Hamilton. Members had driven from New Plymouth, Tauranga, Thames and Taupo for the meeting. Strategies and progress planned for the feasibility study report to the RHA - looking good.
1525 Caught plane back to ChCh.
1900 Home finally after weather delays in Wellington. Wrote letters while waiting between planes.
1915 Back to the office to pick up messages and sign letters and collect files for tomorrow's trips. Meanwhile Marita and Judy back in the office, had recorded nineteen telephone calls and 12 mail items dealt with. These were mainly individual member enquiries. All involved sending out information which is a major part of Judy's day and very time consuming. Marita now handles all membership issues for the College as well as all our accounts. An average of 12,000 photocopies of information is mailed out of this office monthly. The correspondence in and correspondence out in the last 3 month period covered 24 typed pages.

Alternatives to litigation

Studies suggest that patients initiate litigation partly to seek compensation, but also to seek explanations and accountability and to improve standards of care for other patients.[40] The public may have been given unrealistic expectations about pregnancy. Many may be unaware that, based on current Australian data:

- More than 15% of pregnancies will miscarry;
- 6%–8% of babies will be born preterm;
- 1% of babies die around the time of birth;
- 5% will have a notifiable birth defect; and
- 0.2%–0.25% will have cerebral palsy.[1]

There is a great need to educate health professionals and the public that the origins of cerebral palsy are usually hidden and almost always occur during the pregnancy, only to become apparent after birth. Existing neurological problems may result in the fetus showing signs of distress during labour, but existing brain damage may not be prevented or reversed by earlier delivery or by caesarean section. The belief that cerebral palsy is often due to birth asphyxia is erroneous, and expectations that monitoring in labour might prevent many cases of cerebral palsy have not been met.

Friends, relatives and caregivers may wish to offer simple explanations for complex problems and resolve typical grief reactions of anger, guilt and depression by attributing cerebral palsy to suboptimal care. In most cases there is no blame and there should be no guilt on the part of the parents or the caregivers. Early recourse to litigation tends to isolate the parents and child from those who could help and give explanations. Maternity staff are often unaware of the subsequent development of cerebral palsy and may not be asked to help in counselling. It is recommended that mechanisms should be available to encourage interviews between parents and the perinatal team that cared for the pregnancy and the baby with cerebral palsy. Independent expert advice should be offered when requested by parents. If the explanations are not satisfactory, or other issues are of concern, a hearing by a Complaints Tribunal[39] may prove a quicker, cheaper and more satisfactory method of providing accountability and of checking standards, rather than resorting to prolonged and expensive litigation. Only when complaints are upheld by these tribunals should the details be made public and the necessity for further legal action be considered.

Long term support services

All children with disabilities, and their parents, deserve appropriate long term support, including counselling, within the economic capabilities of the country. Parents of children with cerebral palsy should not have to risk expensive litigation to obtain financial help. As soon as possible, parents should have access to a comprehensive support service which includes paediatric rehabilitation, physiotherapy, occupational therapy and speech therapy. In Australia these services are provided to children with a disability at no cost to parents. Equipment is available through various government schemes such as Domiciliary Care. Respite for parents is also available through Home and Community Care and Community Support. In spite of the general availability of these services in most cities, there is a need for more services and more comprehensive services for all children with disabilities, without the need to prove causation or fault in their perinatal care.

Conclusions

There is no evidence that current obstetric practices can reduce the risk of cerebral palsy. The origins of many cases of cerebral palsy are likely to be antenatal. While obstetric interventions in the presence of signs of possible hypoxia may prevent fetal death, there is no evidence that they will limit the prevalence or severity of cerebral palsy. The antenatal signs of hypoxia and the methods to monitor hypoxia in labour are still imprecise. This can lead to overdiagnosis of severe hypoxia and, even when correctly diagnosed, early delivery by caesarean section may not change the risk of cerebral palsy. All expert witnesses and the public should recognise that the belief that caesarean section will prevent many cases of cerebral palsy is incorrect. There is a great need for further research into the antenatal origins and the prevention of cerebral palsy. This will include more cerebral palsy registries, improved methods of assessing the development and well-being of the fetus throughout pregnancy and labour, and better methods of assessing the neurological integrity of the baby before and after birth.

References

1. MacLennan AH. Who will deliver the next generation? *Med J Aust* 1993; 159: 261-263.
2. Blair E, Stanley F. Aetiological pathways to spastic cerebral palsy. *Paediatr Perinat Epidemiol* 1993; 7: 302-317.
3. Stanley FJ. The aetiology of cerebral palsy. *Early Hum Dev* 1994; 36: 81-88
4. Low JA, Robertson DM, Simpson LL. Temporal relationships of neuropathic conditions caused by perinatal asphyxia. *Am J Obstet Gynecol* 1989; 160: 608-614.
5. Steinlin M, Good M, Martin E, et al. Congenital hemiplegia — morphology of cerebral lesions and pathological aspects of MRI. *Neuropediatrics* 1993; 24: 224-229
6. Truwit CL, Barkovich AJ, Koch TK, Ferriero DM. Cerebral palsy: MR findings in 40 patients. *AJNR Am J Neuroradiol* 1992; 13: 67-68 [see comments]. Comments in: *AJNR Am J Neuroradiol* 1992; 13: 73-83.
7. Grant A, O'Brian N, Joy M, et al. Cerebral palsy among children born during the Dublin randomised trial of intrapartum monitoring. *Lancet* 1989; 1: 233-236.
8. Umstad MP, Permezel M, Pepperell RJ. Intrapartum cardiotocography and the expert witness. *Aust N Z J Obstet Gynaecol* 1994; 34: 20-23.
9. American College of Obstetricians and Gynecologists Committee on Obstetric Practice. Committee Opinion 137. Washington: American College of Obstetricians and Gynecologists, 1994
10. Coldtz PB, Henderson-Smart DJ. Electronic fetal heart rate monitoring during labour: does it prevent perinatal asphyxia and cerebral palsy? *Med J Aust* 1990; 153: 88-90.
11. Low JA. The significance of fetal asphyxia in regard to motor and cognitive deficits in infancy and childhood. In: Tejani N, editor. Obstetrical events and development sequelae. Boca Raton, Fla: CRC Press, 1990: 43-58.
12. Illingworth RS. A paediatrician asks — Why is it called birth injury? *Br J Obstet Gynaecol* 1985; 92: 122-130.
13. Earn AA. The effect of congenital abnormalities of the umbilical cord and placenta on the newborn and mother. A survey of 5,676 consecutive deliveries. *J Obstet Gynaecol Br Emp* 1951; 58: 456-459.
14. Blair E. A research definition for birth asphyxia? *Dev Med Child Neurol* 1999; 35: 449-455.
15. Stein PJ, Eigbe F, Lessauer TJ, Beard RW. Inter-relationships among abnormal cardiotocograms in labor, meconium staining of the amniotic fluid, arterial cord blood pH and Apgar scores. *Obstet Gynecol* 1989; 74: 715-721.
16. Ellenberg JH, Nelson KB. Cluster of perinatal events identifying infants at high risk for death or disability. *J Pediatr* 1989; 113: 546-552.
17. NHMRC Expert Panel on Perinatal Morbidity, 116 Session of Council. Canberra. NHMRC/AGPS, 1993
18. Levene MI, Sands C, Grindulush H, Moore JR. Comparison of two methods of predicting outcome in perinatal asphyxia. *Lancet* 1986; 1: 67-69

mild ischaemic hypoxia before any signs of mild damage to vital systems.[29] These fetuses can maintain oxygen delivery to the brain over a wide range of blood oxygen concentrations. Once the lower limit of compensation is reached, however, the fetus tends to decompensate very rapidly and this may quickly lead to death.[30]

Causation and fault

To determine causation, Australian courts have had regard to what is known as the *but for* test, where a plaintiff seeks to establish that, without (or *but for*) a defendant's breach of duty, he or she would have remained uninjured. It is recognised that applying this test becomes difficult when there are a number of events which may have influenced an outcome.[31] There must also be an application of common sense to the facts of each particular case.[32] Causation will be a very difficult matter to determine in cerebral palsy cases because most are caused by an antenatal condition which often may not have declared itself before or immediately after birth. An absence of major risk factors, such as intrauterine growth restriction, extreme prematurity, twin gestation or known antenatal viral infections, does not exclude congenital or acquired neurological deficit during fetal development.

The Chief Justice of the Australian High Court, Justice Mason, has talked about important conceptual differences between causation in law and causation in science.

> ... [In] science, the concept of causation has been developed in the context of explaining phenomena by reference to the relationship between conditions and occurrences. In law, on the other hand, problems of causation arise in the context of ascertaining or apportioning legal responsibility for a given occurrence ... a person may be responsible for damage when his or her wrongful conduct is one of a number of conditions sufficient to produce that damage. [However,] ... it is for the plaintiff to establish that his or her injuries are "caused or were materially contributed to" by the defendant's wrongful conduct. ... Generally speaking, that causal connection is established if it appears that the plaintiff would have not sustained his or her injuries had the defendant not been negligent.[33]

Given our understanding of the rarity of preventable intrapartum causes of cerebral palsy and the difficulty of detecting antenatal causes before labour, it should not be necessary for a defendant to prove the likelihood of neurological abnormality of the fetus before labour or birth. The inability of a defendant to provide such details in retrospect should not allow the assumption that the origins of the cerebral palsy began in labour. It is for a plaintiff to prove the causative link between a putative breach and injury, not for a defendant to prove, in hindsight, the precise antenatal cause and timing of this condition.

The standard of care required of health professionals is "... that to be expected by an ordinarily careful and competent practitioner of the class to which the practitioner belongs".[34,35] Whether a medical professional has acted in accordance with a standard of reasonable care "... is a question for the Court [to decide] and the duty of deciding cannot be delegated to any profession or group in the community".[36] Standards of care will be determined by the courts, not in isolation, but with regard to the evidence of expert witnesses who should give opinion based on scientific evidence.

2: Outcomes of neonatal encephalopathy[18]

Mild encephalopathy	
Minor disturbances of tone Hyperalertness Slight feeding difficulties recovering by 48 hours.	76 children had a favourable outcome
Moderate encephalopathy	
Lethargy More pronounced abnormalities of tone Poor feeding Convulsions recovering by seven days	Out of 24 infants, 18 had a favourable outcome, five had severe handicap and one died
Severe encephalopathy	
Coma Failure to maintain adequate ventilation Profound hypotonia Convulsions	Out of 21 infants, five had a favourable outcome, three had severe handicap and 13 died

Expert witnesses

Medical negligence litigation is mostly expert driven and a plaintiff unable to procure good expert evidence to demonstrate fault is unlikely to succeed.[37] Equally, it is important to have expert witnesses available to give evidence about the standard of care to assist plaintiffs to present claims in the courts. Problems arise when plaintiffs' advisers seek multiple verbal (and untraceable) medical opinions, eventually selecting minority views which may be expressed by those who lack recent or real expertise in the particular area in question. Opinion on obstetric management should be sought only from practising obstetricians endorsed by their Colleges. Those giving care to the child in later life should not make assumptions about causation. The inappropriate use of phrases such as *fetal distress* or *birth asphyxia* should be avoided.

This conference supports the concept canvassed in the 1994 interim report from the Review of Professional Indemnity Arrangements for Health Care Professionals:[38] that the courts appoint acknowledged medical experts from lists chosen by the relevant Colleges. Medical evidence presented about best practice should rely on evidence-based medicine; for example, from randomised controlled trials which, in perinatal medicine, are easily accessible from the databases of the Cochrane Collaboration.[39] The publication of these trials dates the information available at the time in question. Legal practitioners should be conversant with the medical issues involved before embarking on medical negligence litigation.[37]

Providing a service for 1650 members and all other interested parties is increasingly demanding.

Thursday 7th September

0630 Back to airport for 7am flight to Wellington for the Competencies Writing workshop with Nursing Council. It was wonderful to see the responses sent in by a significant cross section of consumers, midwives and managers. Almost all were congratulatory and pleased to have been consulted early on in the process. Bronwen Pelvin, Ruth Martis, Alison Chappel (Nursing Council) and myself redrafted the Competencies talking in all the comments made. We'll look forward to your next responses. (Beryl Davies and Sally Pairman as also involved on this committee).
1830 Met up with Sian Burgess from Auckland Region and together went to a meeting with Professor Jill White from Victoria University and Professor Lesley Page from the UK. We discussed the possibility of establishing a joint clinical chair of Midwifery with the Medical School, the CHE and the University. Very early days but all the fishhooks and bouquets were canvassed. We were lucky to have the advise and wisdom of Professor Page as an outside expert on these matters.

Friday 8th September

0930 Sian and I set off to Wellington Airport's Conference Room for meeting with the 7 RHA representatives, and the RHA's 12 Medical Association representatives to discuss Section 51 once again. Nothing new for midwives since Mondays meeting (see further pages for details).

It was for our part an extremely difficult and time wasting meeting with little movement from the RHA's on prices. The meeting finished early and Sian and I were stuck at the airport because all flights were booked up. Fortunately we had both brought work to do. We critiqued the depressingly proscriptive access agreement written up for North Health Hospitals. Rigid criteria and lack of trust in midwives abilities are evident in almost all CHE documents. These attitudes impinge all midwives employed and self employed.

I also read the CHE midwives concerns over the RHA/CHE negotiations for midwifery services prices in CHE's with some alarm. These negotiations have no College or NZNO representation for midwives and the policies set will impact directly on CHE continuity of care schemes and consequently hospital midwives pay scales. Will have to arrange a meeting with NZNO. Rang Sally Pairman to report back on the meeting.
1200 I have been having a long correspondence with a number of midwives who are battling for independent practice in Australia. Two newspaper articles recently reported 2 obstetricians saying NZ midwifery was 'disaster' with maternal mortality quadrupling and perinatal mortality increasing. They are using this to discredit midwifery autonomy in Australia.

I wrote to their professional organisation, Medical Councils, Australian College of Midwives, and the Australian Federal Health Ministers providing evidence to refute these scandalous claims and seeking an apology to NZ midwives from those involved.

1830 Landed back in ChCh and taken home by my lovely supportive husband to a meal cooked by our 18 year old son and several phone messages which will wait for tomorrow.

There it is - a slice of life at the office. It is difficult to be precise about my role as it seems to change and grow by the minute. My overall philosophy for prioritizing when there's only me is generally in this order.

- the individual member urgently needing advice and action.
- the individual member with a pressing problem needing advice
- the preparation, writing up and acting as council for individual midwives appearing before the Nursing Council
- ACC reports, Coroner's enquires, midwifery opinions to statutory and employing bodies.
- informing national committee members, sending out information, collating responses and reporting back.
- official mail from Consumer bodies and Government Departments
- submissions to various Government bodies on issues effecting midwifery.
- contracts - employment, Section 51, MPO's, access. Researching, consulting and writing up national papers and contracts. Critiquing local contracts for individuals.
- midwifery consultation on practice, education and political issues. Responding to the media.
- liaison and networking with other health agencies and related professional groups. This includes information giving to a wide variety of students and international enquiries.
- talking to midwife groups, running workshops, guest speaker at conferences, promoting midwifery.

And then priorities begin to get a little gray with all the rest being slotted in as is possible. Altogether the College's growth has been phenomenal and the ability to be visible, reactionary and pro-active in all things midwifery is sorely tested at times.

However I remain forever confident midwifery is set for a positive future.

distress and instead describe the observed signs or the variation in the test results.

A normal fetal heart rate is generally predictive that there is no acute hypoxaemia, but variations from the normal pattern are not good predictors of hypoxaemia: Even prolonged late decelerations with reduced variability have a less than 50% chance of being associated with major fetal acid–base changes, which themselves are only poorly correlated with cerebral palsy.[11] Similarly, meconium-stained liquor is a common finding in labour, but only a minority of babies from these labours are born with a low umbilical arterial blood pH. Finally, Illingworth has suggested that there is an undue readiness to ascribe brain damage to umbilical cord problems.[12] Earn found a loop around the neck of the fetus in 23% of 5676 consecutive births, without significant effect on fetal outcome, except for one neonatal death where the cord was wound eight times around the baby's neck.[13]

Birth asphyxia

Birth asphyxia is not a well-defined term.[14] It implies some sort of dysfunction resulting from a lack of oxygen supply to the baby's tissues during the birth process. The term should not be used clinically because of the difficulty in ascribing clinical signs and symptoms in the neonate to an event during birth. Low pH and/or low Apgar scores at birth are supportive evidence of asphyxia but should not be used alone to make the diagnosis.[15,16] Until more information is available, perinatal asphyxia is the preferred term to describe a neonate in whom there is:

- An event or condition during the perinatal period that is likely to severely reduce oxygen delivery and lead to acidosis (e.g., major antenatal haemorrhage or cord prolapse); *and*
- A failure of function of at least two organs (usually the brain and kidneys) consistent with the effects of asphyxia.[17]

However, even these criteria are not specific for recent hypoxia and can be the result of any of the antenatal causes of cerebral palsy. They are minimum requirements to suggest the possibility of asphyxia but do not prove its intrapartum origin.

Neonatal encephalopathy

Neonatal encephalopathy is a clinical syndrome of signs suggesting neonatal neurological abnormality. It has many causes and intrapartum hypoxia cannot be considered as a possible cause unless encephalopathy is evident within 24 hours of delivery. The extent of encephalopathy is a reasonable predictor of neurological outcome. Levene et al. graded the signs and recorded the varied outcomes as shown in Box 2.[18]

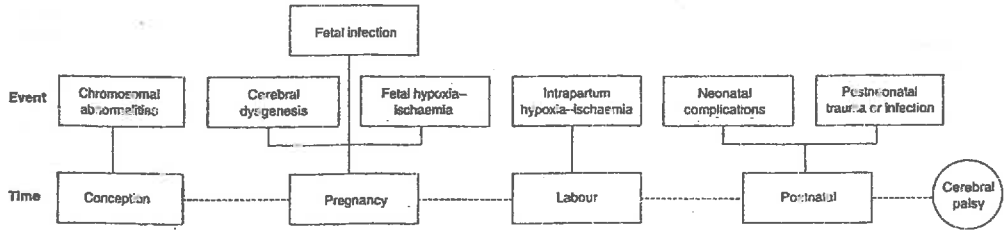
Does cerebral palsy ever originate in labour?

Most infants who develop cerebral palsy are born from uncomplicated pregnancies and are delivered without signs of fetal heart rate abnormalities. They do not have low Apgar scores or acidosis at birth or any abnormal neurological signs in the neonatal period.[19,20] Two major studies of children with cerebral palsy have been reported in which their labour, delivery and neonatal records were in agreement in finding that, for 90%–94%, their disability could not be related to intrapartum hypoxia.[20-22] This does *not* mean that in 6%–10% of labours hypoxia beginning in labour is the cause of cerebral palsy. In cases in which severe intrapartum hypoxia was documented, it may not have been preventable and earlier delivery may not always have been possible. Pre-existing neurological deficit can contribute to intrapartum hypoxia, or be associated with chronic hypoxia.[23] It is our opinion that the lesions causing cerebral palsy are rarely initiated in labour and are rarely preventable.[24,25] What little evidence exists suggests that less than 2% of cerebral palsy could be attributed to suboptimal intrapartum care.[26] It is the opinion of this conference that this figure could be lower.

Fetal response to acute hypoxia

The healthy fetus has some remarkable defence mechanisms to cope with reductions in oxygen that might occur in labour. The human fetus may have longstanding mild or moderate hypoxaemia[24] and, in hypoxic conditions, can sustain life without neurological damage for much longer periods than an adult. This is principally because fetal haemoglobin releases more of the available oxygen to the fetal tissues than adult haemoglobin and, secondly, when acutely stressed the fetus can redirect nearly all its blood supply to its brain and the placenta. It is difficult to estimate the duration of hypoxia before birth. There may be a period of up to several hours with cardiographic changes without acidaemia in cord blood.[27,28]

In experiments, the sheep fetus has been found to adapt to prolonged hypoxaemia, tolerating up to eight hours of



The timing of events causing cerebral palsy.

canal. If these reductions are too great, a normal fetus is more likely to die than survive with cerebral palsy.[4] These normal reductions of blood supply and oxygen can compound the detrimental effects of any chronic hypoxia already experienced during the antenatal period.[4] Cerebral palsy occurring after birth is also uncommon and is caused by, for example, complications of prematurity, untreated rhesus disease (kernicterus), meningitis, accidents or near-drowning.[3]

Timing the onset of pathological brain lesions

It should be clearly stated that, currently, fetal brain development (or maldevelopment) cannot be monitored during pregnancy. Only examination of the brain at autopsy can identify the full extent of injury in some cases. In other cases of cerebral palsy no pathological lesion is identifiable. The neuropathological lesions leading to cerebral palsy are various and include maldevelopments (cerebral dysgenesis), germinal matrix–intraventricular haemorrhage, cerebellar haemorrhages, grey matter damage, white matter damage (periventricular leukomalacia), hypoglycaemic neuronal injury, thromboembolic injury (including vasculitis secondary to infection) and kernicterus.

The immature brain has only a limited number of ways of responding to acute or chronic injury and these essentially consist of neuronal and white matter loss and glial proliferation. These changes occur over many days and weeks. They may later be modified by secondary changes such as posthaemorrhagic or postinflammatory hydrocephaly or white matter atrophy. By the time a child presents with cerebral palsy during the first years of life, the neuropathological effects of any hypoxic–ischaemic injury or other injury will have become modified by these changes and by further postnatal brain development. Even if that child were to die during its first year and the brain was made available for expert examination, it would be impossible, on this basis, to determine the exact timing of the original neurological insult.

Recent suggestions that the condition of the placenta could be used as a surrogate marker of antepartum fetal injury are based largely on anecdotal argument and have not yet been fully evaluated; such techniques are fraught with observer and sampling bias.

Imaging of the brain

Antenatal ultrasound scans may detect gross brain changes, but a normal scan does not exclude antenatal neuropathology. Few infants undergo brain imaging, either because there is no clinical suspicion that cerebral palsy may develop or because there are no imaging facilities available. A neonatal ultrasound examination may not demonstrate longstanding microscopic changes but can detect major acute lesions or secondary changes. Acute lesions may appear as periventricular flare, oedema and intracranial haemorrhage. Periventricular and caudothalamic notch cysts, porencephaly, parenchymal calcification and intraventricular adhesions may also be demonstrated in the early neonatal period and imply events occurring more than two weeks previously.

The period from 26 to 34 weeks' gestation is critical for neurodevelopment. The patterns of brain injury, and therefore imaging features, are similar in fetuses and neonates, and late investigations cannot separate brain injury occurring *in utero* from perinatal or postnatal events. Magnetic resonance imaging of limited numbers of cerebral palsy patients[5,6] suggests that the adverse neurodevelopmental event occurs prenatally in up to 50% of cases.

Can obstetric care prevent cerebral palsy?

If better obstetric care could prevent cerebral palsy the lower rates of cerebral palsy would be associated with good obstetric care rather than with bad obstetric care. There is very little good evidence for this supposition. Several decades ago, new technologies such as electronic fetal monitoring were introduced into obstetrics, without adequate assessment by randomised trials. It was assumed that early detection of fetal distress would allow early delivery (e.g., by caesarean section), thus avoiding damage to the fetal brain and cerebral palsy. Although it is probable that some perinatal deaths have been prevented by such techniques, there is no evidence that they have reduced the prevalence of cerebral palsy, despite increased use of fetal monitoring and rising caesarean section rates.[7] In view of the likely antenatal origins of most cases of cerebral palsy, this is not surprising. However, the mistaken belief that birth injury is a major cause of cerebral palsy may have stemmed from:

- The high rate of non-specific fetal heart rate aberration detected by electronic fetal monitoring;[8]
- The lack of tests which are specific for damaging levels of intrapartum hypoxia, and;
- The more intense medical observation during labour and delivery than antenatally. Thus, any signs of possible fetal distress resulting from antenatal neurological injuries may not be detected until the commencement of labour or until the normal stresses of labour uncover signs of a compromised fetus.

These factors may lead to the assumption that the fetus was healthy before labour and that it was only in labour or at birth that problems occurred. However, events causing a predisposing to cerebral palsy may occur from conception onwards, as shown in the Figure. Any one event or any combination of events could be the cause of the cerebral palsy.

Fetal distress

The term *fetal distress* is imprecise and non-specific.[9] No antenatal or intrapartum monitoring technique can clearly tell whether a fetus is unhealthy or whether the condition is acute or chronic. Tests such as electronic fetal heart rate monitoring poorly predict fetal outcome. Up to 79% of fetal heart rate traces during labour show some type of variation that has been described as *abnormal*,[8] but the vast majority of such infants are born without signs of perinatal asphyxia or cerebral palsy.[10] Clinical signs and test results predict only the possibility of *distress* and, as distress has no agreed definition in this context, it is preferable to avoid the term fetal

ANNUAL REPORT

- Sally Pairman

August 1994 - August 1995

National Committee				
President	-	Sally Pairman		
Board of Management	-	Karen Guilliland	-	National Co-ordinator
	-	Linda Collier	-	National Treasurer
	-	Judy Henderson	-	Secretary (From April 94)
	-	Marita Perini	-	Finance/Membership Clerk
	-	Julie Richards	-	Newsletter Editor
Consumer Representatives	-	Sharon Cole	-	Parents Centre
	-	Rea Dallenbach	-	Maternity Action Alliance
	-	Glynette Gainfort	-	Home Birth Association
Nga Maia O Aotearoa	-	Harangi Biddle	)	
	-	Estelle Marment	)	2 representatives from group
	-	Ranui Parata	)	of 4.
	-	Ellen Tito	)	
Consultants to National Committee	-	Bronwyn Pelvin		
	-	Joan Donley		
	-	Judi Strid		
Regional Chairpersons				
Northland	-	Jane Fox		
Auckland	-	Sandy Macaulay until July 1995 - now Sandy Grey.		
Wanganui/Taranaki	-	Tricia Thompson until May 1995 when this Region's boundary changed.		
Waikato/Bay of Plenty	-	Violet Stock (Tauranga), Lyn McCroskery (Hamilton) until May 1995 when the regional boundary changed to Waikato/Taranaki and Bay of Plenty/East Coast Regions.		
Eastern/Central Districts	-	Ruth Martis		
Wellington	-	Rosie Aspin until May 1995, then Sue Culvert.		
Nelson/Marlborough	-	Marianne Duncan until July 1995 now Kirsty Prichard.		
Canterbury/West Coast	-	Jacqui Anderson		
Otago	-	Adrienne Mulqueen until May 1995, now Mary Gamble.		
Southland	-	Jo Mawdsley until March 1995, now Jenny Humphries.		
Life Members to College Nationally:	-	Kathy Anderson		

Honorary Members to College Nationally:
- Helen Clark
- Joan Donley
- Karen Guilliland

Complimentary Members -
- Helen Manoharan (Journal Editor)
- Irahapeti Ramsden

Total Membership as at 30 April 1661

National Committee

The National Committee continues to meet quarterly in Christchurch. Friday evenings are eith workshops or regional reports and Saturdays continue as all day business meetings. Workshop topics have included a day long Midwifery Standards Review National Meeting and Consensus Statements for the College. There has been one teleconference.

I would like to thank all members of the National Committee for their hard work and commitment to the College and for the very good job they do in sharing information back to their regions. The College is dependent on these lines of communication remaining strong and accurate. We were pleased to welcome our Maori midwifery colleagues to National Committe and are delighted Nga Maia O Aotearoa has been formed to help address the specific needs of these midwives. We are keen to work to work with them.

Several midwives have stepped down or ended their term as representatives this year. We farewell them all with many thanks for their work on behalf of the College.

Board of Management

Karen Guilliland continues to carry a huge workload as the National Co-ordinator and almost weekly the College is needing to develop its scope to address the fast changing requirements of the health system. A rapidly growing area is unfortunately, is indemnity. We are very fortunat that Karen has such well developed skills in this area and has consequently been able to curb ou legal expenses. Karen continues to provide a very professional and credible public profile for the College and we are indebted to her for her ability to be pro-active and recognise the need f developing the scope of the College. The responsibilities continue to be far beyond reasonable expectations for one person and whilst Karen is supported by a very good team in the Board of Management, we have not yet developed a structure which will enable the College to continue run effectively when any key person is sick or on leave. This is an area we must continue to work on. I would like to thank Karen for the support and guidance she continues to give me. Her ability to share information is great and vital when the President is outside Christchurch.

Linda Collier took over as National Treasurer from Kathy Anderson and she is doing a terrific job in restructuring the membership of the College. Hopefully the new system will streamline both membership and finances. Linda is ably assisted in this by Marita Perini. My thanks to you both for undertaking this huge task.

Position Statements

The origins of cerebral palsy — a consensus statement*

The Australian and New Zealand Perinatal Societies

There is a crisis affecting maternity care in many countries. Both caesarean section rates and medical defence premiums are increasing. New options for the care of pregnant women (e.g., birthing units) may fail because midwives, general practitioners and smaller hospitals may be unable to afford adequate insurance to continue their services.[1]

The crisis is fuelled by widespread beliefs that cerebral palsy is often caused by injuries sustained during labour and birth and that cerebral palsy may therefore be the result of inappropriate obstetric care. There is now considerable evidence to suggest that these beliefs are unfounded. A conference of Australian and New Zealand specialists in this area was convened to review the relevant literature and offer a consensus statement to help parents, counsellors, lawyers and health professionals understand what is known and what is not known about the origins of cerebral palsy.

Definition

Cerebral palsy is not a single entity but covers neurological impairments characterised by abnormal control of movement or posture resulting from abnormalities in brain development or an acquired non-progressive cerebral lesion.

Prevalence

Cerebral palsy is the most common physical disability in childhood, occurring in about 2–2.5 per 1000 children born. The frequency of cerebral palsy has not changed over the last 40 years, despite a fourfold drop in both perinatal and maternal mortality. In some countries there is an increase in the occurrence of cerebral palsy, attributable mostly to the increased survival of very low birthweight infants.

Causes

There are many antenatal factors that may lead to cerebral palsy and often there may be several contributing factors.[2,3] Examples are shown in Box 1. There are also strong associations between cerebral palsy and intrauterine growth restriction, antenatal death of co-twin/triplet and extreme prematurity.

The fetus is designed to withstand the stress of labour, which usually involves a reduction in the amount of oxygen in the blood (hypoxaemia) and the amount of blood reaching the brain (ischaemia) during passage through the birth

1: Known antenatal causes of cerebral palsy

Developmental	Cerebral dysgenesis
Vascular	Hypoxic–ischaemic Haemorrhagic Embolic
Infective	Rubella Cytomegalovirus Toxoplasmosis Listeriosis Other viruses
Genetic	Autosomal X-linked Associated with other syndromes Chromosomal abnormalities
Metabolic	Iodine deficiency
Toxic	Lead Mercury

*This statement follows a consensus conference held in Adelaide, South Australia, on 26 August 1994 and sponsored by the South Australian Health Commission.

The Australian and New Zealand Perinatal Societies.
Alastair H MacLennan, MD, FRACOG, Associate Professor of Obstetrics and Gynaecology, University of Adelaide, Consensus Conference Chair. No reprints will be available. Correspondence: Professor A H MacLennan, University of Adelaide, Women's and Children's Hospital, 72 King William Road, North Adelaide, SA 5006.
Panel members: Fiona Stanley (Epidemiology), Institute for Child Health Research, Perth; Eve Blair (Epidemiology), Institute for Child Health Research, Perth; Greg Rice (Fetal Physiology), Royal Women's Hospital, Melbourne; Peter Stone (Obstetrics and Gynaecology), University of Otago; Jeffrey Robinson (Obstetrics and Gynaecology), University of Adelaide; David Henderson-Smart (Perinatal Medicine), University of Sydney; Victor Yu (Neonatal Intensive Care), Monash Medical Centre, Melbourne; Michael Harbord (Paediatric Neurology), Flinders Medical Centre, Adelaide; Leon Stern (Paediatric Rehabilitation), Crippled Children's Association of South Australia; Helen Chambers (Perinatal Pathology), Women's and Children's Hospital, Adelaide; Margaret Furness (Radiology), Women's and Children's Hospital, Adelaide; Tina Hayward (Radiology), Women's and Children's Hospital, Adelaide; Kerena Eckert (Midwifery Research), Women's and Children's Hospital, Adelaide; Christopher Boundy (Barrister and Solicitor), Adelaide; Susan Merrett (Medical Administration), South Australian Health Commission; Mark Kenny (Medicolegal Services), Women's and Children's Hospital, Adelaide.

after a doctor sharply informed Roz she would be in labour for at least another three hours.

"It just wasn't what I needed to hear at that time and when Hannah was born a short time later I was so druggy and unaware."

Roz was also not happy with her first few days with Hannah in the maternity annexe.

"You have to leave your dignity and privacy at the door. I was in an open ward and as I was having problems breast feeding, everyone else knew. I am glad to see that this aspect has changed and that the annexe is more private these days."

However for Roz at that time, it wasn't a good atmosphere.

"There was nothing special or personal about such a significant event. I was young and did everything I was told. But when you are having your first child you don't know what to expect or what to do.

"My decision to have a home birth was an informed choice. I researched all aspects and prepared myself fully, but it was also an approach taken by our whole family."

Preparation for the birth began early in her pregnancy. As well as doing a lot of reading about her options, she began classes with the Home Birth Association.

"There was no pressure to have a home birth. The biggest issue is to choose a place where the mother feels safest. The association stress that if she feels safest in a hospital, then that is the best place for her to give birth," she said.

The decision to have a home birth was the combination of her hospital experience and personal preference.

"I wanted people who are close to me, who I could be myself with and relate to me on a level I could cope with during labour."

All of the support people were prepared for what would, and could, happen during the birth and were told what to bring with them when the time arrived.

Roz decided to use the birthing pool for the second stage of labour as a form of pain relief. If the birth was at night Roz wanted soft candles and a leadlight lamp to create a soft glow in the room. Music chosen for the birth ranged from Van Morrison and James Taylor through to spiritual, mediation and classical styles.

A vegetarian for five years, Roz was aware of the importance of nutrition through the pregnancy. She returned the highest iron counts her midwife had ever seen and increased her regular regime to include raspberry and nettle tea for toning the organs, cell salts for tissue elasticity, Five W for vitamins and under much protest, molases. Roz also ate natural foods such as puha, dandelions and water cress, all which provide valuable vitamins and minerals.

Preparing physically involved yoga from six weeks into the pregnancy, which taught breath control and relaxation.

"Yoga helped me to breathe through the pain while exercises strengthened the hips, legs, back and pelvis."

No tea, coffee, smoking, drinking or drugs were taken during the pregnancy.

To keep the pelvis tipped forward, and therefore encouraging better birthing position, Roz used a rocking stool.

Being prepared was not only reserved for Roz. Karl also had ideas for the birth.

"Karl has attended a hospital birth and is pretty 'anti' to the standard approach. He has made his suggestions, but mainly is nervous for me and what I will be going through."

As Roz's main support person, Karl attended classes and also gained a lot of knowledge. To ensure Karl would not miss the birth, the couple invested in a mobile phone.

By selecting a home birth, Roz and Karl want to achieve a sense of togetherness.

"I hope to feel empowered. I do not want any drugs or machines that go ping. And if anything goes wrong I am only 15 minutes from hospital. I want time for our family to be together as a family when our new baby comes - time for us all to form a bond with our new person."

Roz said the home birth is also about control.

"It is knowing that you have the power within yourself to achieve a drug free,natural birth. This is something I genuinely feel I can achieve without the pressure of intervention."

Two days after the birth both Roz and Karl are still 'high' from the experience. Roz said there is no comparison to the two birthing techniques and is thrilled with how everything went.

"It is just as we wanted. I felt safe, supported and totally at ease with the whole process."

Support always there

THE services offered by the Home Birth Association are available to all home birthing women at no charge.

These include providing support people to assist at the birth and a nappy service which supplies clean, laundered nappies delivered to the home.

Ante natal preparation workshops are open to all women, partners and support people and cover a wide range of topics.

Workshops include birthing options, the birthing environment, healthy eating, natural remedies, self responsibility, stages of labour, roles of the partner and support people, contraception, practical preparation or siblings at birth, and facts and myths.

Statistics from the Tauranga HBA for August 1992 to July 1994 record 103 home births, of which nine were single mothers. Various reasons resulted in 17 transfers to hospital, with a further two unplanned home births.

Thirty-one mothers were having their first pregnancy while four were having their fourth or fifth child.

Before the birth a midwife will make ante natal visits and discuss the kind of birth wanted. Practical requirements are outlined and general organisation is discussed.

When labour starts the midwife is contacted and arrives as soon as is wanted. She brings with her a full kit including drugs and equipment for controlling bleeding and resuscitating the baby.

The woman is free to walk, stand or lie during labour and give birth in whatever position feels most comfortable.

Afterwards the midwife stays with the family for at least two hours to ensure the comfort and safety of both mother and child. She is on hand to give support when the mother first breast feeds her baby.

The midwife then leaves the family to the privacy of their home but returns later for a check. She continues to visit daily for the next two weeks.

"What happens in Pregnancy, Birth and the Early Weeks of Life is of the utmost importance to all of us."

brother only minutes after his birth.

Linda is also now employed on a one year contract to provide assistance to Karen, particularly in the areas of Standards Review, indemnity issues, the MPO and educational issues. The aim is that Linda will provide cover for Karen when she is away.

Judy Henderson continues to work long hours as Secretary and we are fortunate she has skills to pick up some of the routine enquiry work and letters from Karen. It is always nice to be greeted by her friendly voice on the phone and we are grateful for her organisational abilities.

The Midwifery Resource Centre continues to provide a positive focus for the National Office of the College, and whilst getting a little small now, is still an ideal location for our National Meetings.

Publications

Helen Manoharan continues as the Journal Editor and I am constantly amazed at her dedication and skill in putting together two issues each year. Helen has worked hard to obtain advertising and has been able to increase the number of pages in the Journal. Each issue is of a very high standard and it is so important for the College to have this professional focus. Our grateful thanks to Helen for her untiring efforts and ongoing commitment.

Julie Richards as the National Newsletter Editor, is doing a great job in collating the Newsletter and distributing it every 8-12 weeks. Many thanks to those of you who send in items and to Julie for producing this interesting and informative Newsletter.

The Handbook for Practice was reprinted this year as demand continues to be high.

Section 51 Negotiations

As I read the last AGM Report I can hardly believe we are still in negotiation with the RHAs over Section 51. Meetings over the past year have involved discussion in the modular system and accompanying service specifications. At times the referral guidelines and Well Child Schedule have been addressed, but only through submissions rather than frank and open discussions

We are near the end of the process and after some optimism earlier in the year, it now seems that the new structure along with the accompanying prices will do little to enhance women's choice or strengthen midwifery services. Independent midwifery care for women wanting total midwifery care will probably remain a viable option. Shared care is in more jeopardy but until we see the prices released by CHEs for midwifery services, this is still not clear. In addition, we have serious concerns about services for rural women, home visiting and women with particular needs.

The Referral Criteria issue also remains unresolved as does the place of the six week check. The RHAs have attached the Referral Criteria to the Section 51 Advice Notice and the College along with the NZMA continues to object to this. The RHAs do seem willing to allow NZCOM and NZMA one more opportunity to come to agreement over these. A meeting will be held between all the Colleges to facilitate consensus.

One interesting spin-off to this negotiating process has been our improving relations with the NZMA. They seem to understand that we are not the enemy and we now regularly meet with them prior to Section 51 meetings to discuss our joint areas of concern.

The Negotiating Committee has consisted of Karen, Sian Burgess, Julie Richards, Joy Christison and myself, with Gill Down attending one meeting as our Accountant.

Access to CHEs

The issue of access to CHEs for midwives continue to be a problem throughout New Zealand. We have looked to the RHAs and to Jenny Shipley to take a stronger part in resolving these. Unfortunately this has not yet happened and CHEs continue to act, we believe, in an anti-competitive manner.

Karen and I did meet with all the Women's Health Managers this year to try and present the College's vision for midwifery services to them. It was a useful meeting and led to greater understanding of our separate and collective issues. Hopefully this communication will continue.

Education

We are still awaiting approval from the Minister of Health to remove the experimental status from the Direct Entry Programme. The evaluation has been completed and it is positive. We expect an announcement shortly to lift the experimental status. The first graduates from the two Direct Entry Programmes graduated last December and are out in practice now. Many of them are working independently.

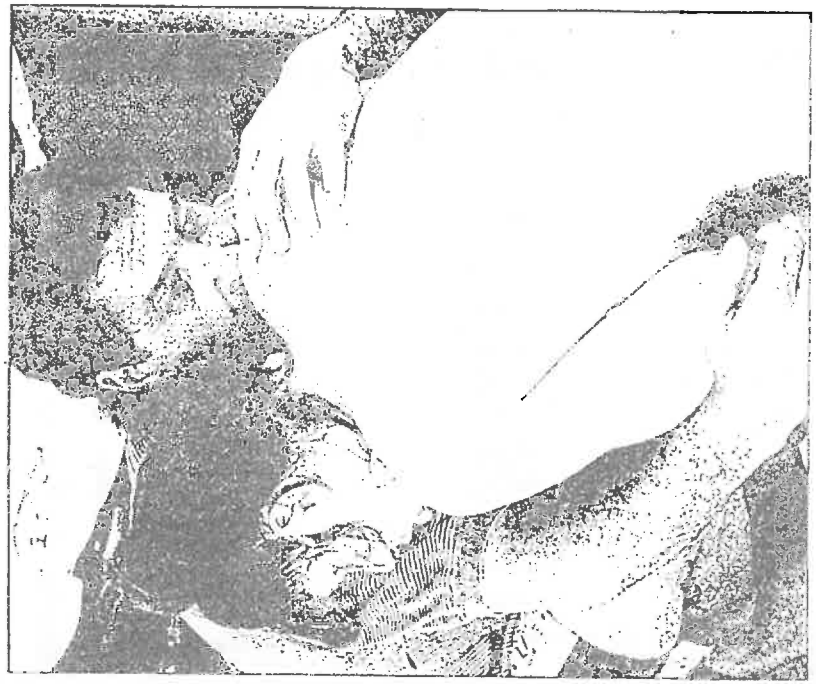
Waikato and Wellington Polytechnics should be ready to run with a three year degree next year and Christchurch the following year. This will bring a uniform education system throughout New Zealand for all midwives, either Direct Entry or Post Registered Nurse.

Communication and consistency between the five schools will be important and to this end the College is holding its first Educators Workshop on the Sunday following the AGM. This will provide an opportunity for educators to agree on issues in undergraduate education.

The Education and Research Council was disbanded last year after the Co-ordinator, Chris Hendry took up a new position and no replacement could be found. A successful mechanism for dealing with a whole variety of education issues is yet to be found. Possibly a regular educators meeting would be a good start.

The National Committee with the help from the regions has developed consensus statements on a variety of practice issues. These are available as guidelines for midwives in each region. Guidelines for independent practice have also been developed in this way.

Ongoing issues for education are around whether the College needs to develop an accreditation process, post graduate education and Midwifery masters Programmes. Certainly it would be preferable for the College to accredit midwives in an ongoing basis for such skills as resuscitation and cannulation.



Karl supports Roz during the final stages of the birth. As the main support person, Karl offered Roz both physical and emotional assistance.

WHAT makes a woman shun the standard approach to giving birth and choose a technique with the myth of being dangerous or harmful? Do home births deliver what mothers expect? Bay of Plenty Times reporter VICTORIA CUSHING talks to a Tauranga couple who last month welcomed their new son in the security of the place they feel safest — the family home.

OCEAN music plays on the stereo. From the lounge drifts the faint smell of incense. Between the woman's shouts of pain, support people attend to her with hot towels and drinks of cold water.

This is not some wacky, secretive ritual, but home birth, a safe, supportive alternative to the tradition of hospital labour. As hundreds of New Zealand woman are finding out, when it comes to having a child, there is a difference between giving birth and being delivered.

Last month Isaac made his entrance into the world in the bedroom of his parents, Roz and Karl. Watching the experience was his sister, four-year-old Hannah, and close at hand were independant midwife Anne Sharplin (later accompanied by Veronika Muller) and two support people.

Such a private moment was only brought into the public arena to break down the myths of giving birth at home. Unlike a hospital, there is no bleeping machines or medical staff popping in or out - just words of encouragement and a background of music.

The niggling pains that signalled labour was on its way began almost 20 hours ago, however Roz managed a good night's sleep and intense labour did not begin until 1pm the next day.

During early labour Roz sat with her support people in the lounge, but by 3.45pm had moved to the heated birthing pool for pain relief. Set up in the couples bedroom, the pool gave Roz a weightlessness, easing pressure on her back and pelvic area.

Soonafter Roz is in full labour, kneeling over the edge of the birthing pool. Her focus is intense and Karl is right beside her rubbing her back. Also lending her support is Hannah, who rests her hand on her mothers shoulder. The atmosphere is calm, peaceful and special - exactly what Roz and Karl wanted.

By 4.10pm Roz's waters have broken and her pain intensifies. Her shouts fill the house and the only other voices to be heard are encouraging words from Karl or Anne.

Hannah is totally captured by the whole process. She whispers that her baby will soon be here and that she thinks it's going to be a boy. The birth has been fully explained to her and Hannah knows what her mum is doing and that this is how their family gets a new brother or sister.

Anne reminds Roz to use her breathing techniques to ease through the pain. Roz feels the need to push and stands up from the pool.

Within the space of what feels like seconds, a head appears, quickly followed by the rest of Isaac's 4000gm (8lb - 13oz) body. Anne's philosophy is hands off, but hands ready, and when Isaac appears, she is ready to pass him through the Roz, and the new mother and baby sink back to the heated water.

What happens next is considered one of the most important aspects of birth - the time to bond. However, this time it is not only a mother-son bond, but time for Karl and Hannah as well.

Roz and Karl's decision to have a home birth was made for a variety of reasons.

With Hannah's birth, Roz said she went through all the required procedures, as instructed by her doctor.

"Women having their first baby do not know what to expect, or what to do. Some doctors say what they want to say and don't really provide a lot of information," she said.

Roz said she had two scans with Hannah, but after reading material from the World Health Organisation opted to forego scans with her second child.

"Scans were never originally intended as routine procedure, only if evidence suggested something may be wrong with the baby."

Roz admits she is a bit cynical about the standard approach to birth, probably because her first birthing experience was not as pleasant as she would have liked.

To start with her doctor did not make it to the birth, although several student doctors whom she had never met before or been told would be present, attended. She was given the drug pethadine half an hour before Hannah's birth,

ARTICLES OF INTEREST

Picture: Ross Brown

HANNAH listens to the beat of her baby brother during a visit with Roz to independant midwife Anne Sharplin (back).

Mother's safety most important

THE most important aspect of a home birth is the safety of the mother and baby, believes Tauranga Independant midwife Anne Sharplin.

A former domiciliary midwife, Anne works with both the Western Bay Health and Home Birth Association, attending home and hospital births.

"It is vitally important for the mother to feel in control, and when she is in control, she is safe," she said.

"For some women the hospital is where they feel safe, and for those who don't want to leave their home or family, a home birth is the best option."

Anne said a home birth helps ease the transition for a family welcoming a new child into their house. It is also good for the husband or partner.

"It gives the partner time to bond and get to know his new son or daughter."

No chemical pain relief is administered during a home birth.

"Pain relief drugs can compromise the health and wellbeing of mother and baby and we advise that if this is what a mother wants, she is best to be in a hospital environment."

However, pain relief is offered in the form of heated water (when in the pool), hot or cold towels, homeopathics or relaxation techniques.

CHILDBIRTH in the Home

All funding for post graduate short courses has now been shifted from the Polytechnics to the Clinical Training Agency who are responsible for purchasing courses. The College has made an initial approach on two fronts - one is to develop a post graduate course for midwives in conjunction with the Women's Health Managers which could be run by the College or Polytechnics throughout New Zealand. The second is to explore accessing funding for mentoring arrangements for new graduates, those returning to practice and those with identified needs.

Masters in Midwifery Development is occurring at Victoria and Massey Universities. We are pleased by the consultative approach being taken by Victoria where they are working hard to fit Masters into a structure which fits within our under-graduate degrees. We hope Massey University will also enter into a collaborative approach with the College.

Many midwives continue their education through courses offered by local regions of the College, through Batchelor of Midwifery degrees and through the Masters Programme. This is to be commended and we need to work to ensure that these and other options remain viable.

Nursing Council

Jackie Gunn has continued as the lone midwifery voice on Nursing Council this year. It is a very time consuming task and often lonely. We have tried to offer Jackie support from the National Committee and we thank her for her hard work. Jackie intends to stand down when her term is up early next year.

An increasing number of complaints about midwives have been investigated by the Preliminary Proceedings Committee of Council. This seems to be a sign of the times as are complaints for all health professionals are on the increase. Fortunately the midwifery cases have not proceeded to a full Council inquiry.

The College has been working with the Nurses and Midwives Network (Umbrella group) to develop draft legislation for a new Nurses and Midwives Bill. We had hoped this would be introduced this year but this will not now happen. As MMP gets closer the politicians seem more wary of any new legislation and are mostly interested in what they perceive to be "non contentious". Jenny Shipley is also exploring an umbrella type of legislation whereby all occupational groups will be assessed to see whether they need to be regulated. Those which do will have combined legislation which follows the Medical Practitioners Bill and is then split into separate Bills at the third reading. It seems likely that this new initiative could now hold up a Nurses & Midwives Bill and may add several years to the process of changing our own Act.

The Nursing Council is also in the process of developing competencies for registration for both nurses and midwives. A small group from the College consisting of Beryl Davies, Bronwen Pelvin, Ruth Martis, Karen and myself have worked with the Council to draft these competencies for midwives. These are currently being circulated for comment and critique. When completed these competencies will be the standard by which all students are accessed for registration. The Council further intends to develop competencies for ongoing practice which will be linked to practising certificates in the future.

The College has tried to be supportive of Council in the current review of Cultural Safety with undergraduate education. We recognise the risk there is of this issue being high jacked by othe with a different political agenda.

Submissions

Over the past year the following submissions have been written:

- WHO International Code of Marketing of Breastmilk Substitutes
- Code of Conduct for Nurses & Midwives
- Code of Practice for Consumer Product Information
- Review of the National Policy for Cervical Screening
- Select Committee on Cultural Safety
- Fluoride & Oral Health
- Food & Nutrition Guidelines for Infants & Toddlers
- Health & Development Book
- Retention & Disposal of Health & Disability Information Discussion Documents
- Health Impact Assessment
- Select Committee on Medical Practitioners Bill
- Clinical Review of National Women's Hospital
- Prescribing Rights
- Consumer Safety in Health & Disability Support Services
- SRHA 1995/96 Purchase Plan
- NZCHS Draft Accreditation Standards (Maternal & Neonatal Service)
- Well Child Schedule
- Your Pregnancy

Thank you to the many midwives and consumers who contributed to the submissions, particularly to Joan Donley and Alison Stewart for their high standard of critique and impressiv knowledge base.

National Conference

The 3rd National Conference held in Rotorua last August was a resounding success. It also achieved a significant profit. Many thanks to Nita van Boven and all the Conference organiser: for their hard work.

The 4th National Conference will be held next year in Christchurch and I know that the Organising Committee are already hard at work. The theme of this Conference is "Midwifery - the Balance of Intuition and Research".

Liaison with Other Groups

Karen is a member of the ALAC Working Group to develop guidelines and information about alcohol in pregnancy.

Karen and I met with Jan Grant from the Ministry of Education to discuss the College's vision for midwifery education.

NZ Doctor 21 July 1995 PRACTICE

Antenatal HIV screens justified by research?

SEXUAL HEALTH
GORDON McKENNA

Recently in the newspapers, and on the radio, there was a story of young child that had been born in the US with HIV.

What made this so newsworthy was not so much the failure to prevent yet another case of vertical transmission, but that the child, spontaneously, sero-reverted to become HIV negative.

The baby boy had been born at 36 weeks by vaginal delivery to a 33-year-old woman who in the earlier weeks of gestation had had a relationship with an injecting drug user. At routine (sic) antenatal testing, she was found HIV infected.

In this case, reported earlier this year in the *New England Journal of Medicine*, it was considered likely that the infection had been acquired intrapartum, as opposed to in utero. This was because the cord blood initially tested was negative for HIV by virus culture, yet by day 19 the virus was present in the baby's blood. On follow up, however, and what made the headlines, was that by day 90 the baby was again clear of HIV.

This is a remarkable story on a number of levels. Although published in 1995, the baby is now five years old, so we can assume that this took place in 1990 or thereabouts. To date, both mother and baby are well, the mother with a still normal T-cell count and the boy still HIV negative, with no health problems of note.

The report authors comment that, in fact, this clearing of virus is not a new phenomenon, with a literature review of a number of cases of children infected perinatally clearing the virus. What made this one so special was the details virological follow up that ensued.

Finally, the writers were mindful of the fact that about 80 percent of babies born to HIV-infected mothers will be HIV negative at birth, and will likely remain so as long as they are not infected at a later date, e.g. through breastfeeding. The mechanisms protecting the unborn or newborn are largely unknown but are of extreme importance in understanding the nature of the HIV infection.

But these are not the real issues of this simple case report. The real issue is that the mother was tested for HIV routinely. It is now almost standard practice in the US to do HIV testing in pregnancy, along with syphilis, chlamydia and gonococcal infection screening.

Remember that about 1 percent of Americans between 16-45 years are estimated to be infected with HIV. Screening for disease which is this prevalent makes a lot of sense, although until recently not much was done once the diagnosis of maternal HIV infection was obtained.

There has been a debate about the relative benefit of offering caesarean section over vaginal delivery to slightly reduce the risk of transmission to the baby, but caesarean sections are unlikely to have been done often for this reason alone - think of the risk to the operator (high), and the benefit to the mother (none).

HIV transmission reduced

The other real issue is that in the same issue of the journal the results of a controlled trial were published which should radically change the management of HIV in pregnancy; and yet, despite being fundamentally more important than the isolated case report described earlier, it got little media attention.

In this clinical trial, 477 pregnant women with HIV were randomly allocated to either placebo or zidovudine being given during the delivery, and the neonates receiving it also for the first six weeks of their life.

The results were, quite frankly, staggering. The risk of transmission was reduced by two-thirds, from 23 percent of babies infected in the placebo group to 8 percent infected in the treatment group. The only side effect of note in the treatment group was a reversible anaemia.

This result must have profound consequences.

Firstly, it tightens up the rather dubious ethics of screening for a disease in pregnancy for which there was no real immediate treatment for mother or baby, carried out essentially on a good-to-know basis.

Secondly, it demands that in all countries, whether they have a high or low HIV prevalence, some active screening procedure for HIV be considered for the benefit of the unborn.

Involve women in screening moves

But what it also demands is that we face up to our responsibilities to women of the country and ask them what they think of these results.

The current prevalence in New Zealand of HIV in women is low at less than 8 percent of all cases diagnosed, or about 80 cases since testing first started in 1989. To date, there have been fewer than five babies who have acquired the infection perinatally.

But the results from this study imply that we should now be asking about HIV risk factors when challenged with a pregnant mother, offering her an HIV test if she wants one (cost is $12) and giving her the information to make an informed choice about the future if the test is positive.

In cities like London where 0.5 percent of pregnant women are HIV infected, this debate is slowly warming up. In this country, the debate has hardly started. If the medical profession alone pushes this issue

we will be accused of being paternalistic again, and looking upon women merely as vectors of disease to men and babies. What needs to happen is for us all to get involved, and to start talking about the real issues as a community.

Dr Gordon McKenna works at the Sexual Health Clinic, Christchurch

Transitional schedules

All children will move from the old immunisation schedule to the new schedule on 26 February 1996. Some children will need extra visits/vaccines to make sure that they have received the recommended number of doses for each antigen.

These proposed adjustments will be considered at the 14 September 1995 meeting of the Communicable Disease Control Advisory Committee (CDCAC):

- children aged between six weeks and five months will get a **third dose of oral polio vaccine** (OPV3) at 15 months (with the fourth dose of diphtheria-tetanus-pertussis-Hib (DTPH4) vaccine and measles-mumps-rubella (MMR) vaccine)
- children aged between five months and 15 months will get **OPV3** at 15 months (with DTPH4 and MMR) and a **third dose of hepatitis B** to be given at 16 months
- children aged 16-18 months will get **DTPH4** and **OPV3** at 18 months
- children aged 6-11 years will get a **fifth dose of OPV** at 11 years
- children aged 12-15 years will get **adult tetanus-diphtheria vaccine** age 15 years.

More detailed guidance will be included in the health professional educational material. ***Suggestions for the format of these would be appreciated.*** Please let me know by 23 August 1995 if there ***any points the CDCAC should be aware of in considering these schedules.***

Two injections for 11 year olds

The new immunisation schedule has three vaccines (two injections) scheduled at age 11 years. Persuading 11 year olds to accept two injections has been alerted as a potential problem. This could be alleviated by a good health education resource explaining need for both injections. This resource will be developed with the input of 11 year olds.

The MMR vaccine should be given first as it is more important and possibly less painful. Those who choose not to have a second injection at the same time will need a second visit by the public health nurses.

The school based delivery through public health nurses has achieved high coverage in the past and will need to demonstrate the ability to continue doing so with the new schedule. ***What coverage target be set?***

Immunisation Certificate

The new policy of requiring an Immunisation Certificate to be shown on enrolment is intended to benefit the community by increasing completion of a child's early childhood immunisations. Any extra burdens on vaccinators and the education sector can be minimised by devising a form of Immunisation Certificate which is easy to complete and to interpret.

A draft certificate has been developed with the input of the Certificate Advisory Group, the Minister of Education's Early Childhood Advisory Committee (ECAC) and the Health & Disability Commissioner. Consumer input on this draft is now being sought. There will be further opportunities for comment on the Certificate.

I attended the ECAC meeting on 21 June 1995. The major concern about the new policy is the extra burden imposed on the early childhood sector. The ECAC recommended that checks should be limited to the time when a child completes the early childhood immunisations at 15 months of age, and at entry.

The ECAC also recommended that those who oppose immunisation need to be able to have their child's certificate completed without extra costs or barriers.

Regards

Dr Ossi Mansoor
Public Health Medicine Specialist
Public Health Policy
Direct line: 04 496 2151
EMail:ossi.mansoor@mohwn.synet.net.nz

The following meetings were attended by Karen:

- *Meetings with Jenny Shipley, Katherine O'Regan, Helen Clark and Lianne Dalziel.
- *Medical Council/Nursing Council/Ministry of Health/College of O&Gs/O&G Society
- Professor Turner from Auckland School of Medicine
- NZNO
- *NZMA/NZGPA
- Pegasus Medical Group, Auckland Central GP IPO
- *Royal NZ Plunket Society
- National Council of Women
- Commerce Commission
- Midland Health Pharmaceutical's Manager
- HBL
- HBL Investigation Team.
- Terra Nova
- *Health Industry Training Organisation.
- Auckland National Women's Management.
- *NZNO Practice Nurse Section
- *Wellington Region Association of Midwives.

*. Also attended by myself.

Sian Burgess attended a Conference in Auckland on Case Management.

I have represented the College on the Nurses and Midwives Network, sometimes accompanied by Karen and sometimes by Beryl Davies.

I represented the College at the Nursing Council Strategic Planning Day.

I also represented the College on the Maternal Deaths Assessment Committee

Karen represented midwifery on the Nursing Council Professional Standards Committee.

Karen has visited midwives in:

- Dunedin
- Wellington
- Auckland
- Invercargill
- Palmerston North
- Tauranga
- Hamilton
- Rotorua

Karen was an invited speaker to Midwifery Conferences in Sydney, Townsville, Canberra and Melbourne.

Joan Donley was an invited speaker in Hawaii for Midwifery Today.

Lectures/Seminars/Workshops participated in:

- Professor Murray Enkin
- Head of Departments and Direct Entry Midwifery.
- Otago, Wellington, Christchurch, Waikato Polytechnics and Massey University.
- Nursing & Midwifery Social Force Conference
- Professor Lesley Page/Dr Mark Starr

Media

Karen has done 25 radio interviews, one television interview and numerous press releases/interviews. I have also done several radio interviews and press interviews.

Midwifery Provider Organisation

It has become increasingly obvious that in this new health system, midwives need to develop strategies which will maintain unity whilst the Government push is to competition. The College made the decision to form an MPO which is devolved into the four RHA regions. Initially, the MPO will collect data and liaise between midwives and doctors over subcontracting arrangements within the midwifery care modules. Eventually the MPO will contract with the RHAs for midwifery services and may well hold the budget for these services. The RHAs have given an undertaking that Section 51 will continue for 2 years once it is finalised. After that time they intend to contract directly with provider groups and midwives need to be in a position to do this by then.

The structure of the MPO has been agreed by National Committee and work is currently going on in each RHA Region to look at feasibility and establishment of regional advisory committees. Sian Burgess has been appointed by Northland Region to co-ordinate this stage for them. Linda Collier is doing the same for the Southern RHA. Region. A small group of midwives are working together on this in the Midland RHA Region as well with Michelle Fill as Co-ordinator. There are issues in Wellington Region as a group of Wellington-based midwives appear to wish to set up a separate structure to the College. This has yet to be resolved.

There is much work to do on the MPO. Whilst we were mostly successful in getting some transitional funding for the feasibility studies, we now have to obtain establishment grants to set up the structure. This whole way of working is new to midwives and we are on a fast learning curve. It is heartening though to see the overwhelming support for the MPO from midwives throughout New Zealand.

Midwifery Database

As decided by the National Committee, Karen is now working on the development of a data base for the College which will enable us to collate and work with the statistics of all midwives. As the maternity system restructuring begins it is increasingly important that we are able to demonstrate that midwifery care is of benefit to women and their families. Karen is keen to ensure that the data collection process will fit in with midwives preparation for Standards Review to decrease workloads. This will mean some changes to the data as the Standards Review information is not yet sufficient to allow the type of analysis we need to be able to

8 concluded on BIC

What is the session's edcuational content?

We will be preparing a syllabus with teaching aids for this syllabus, which will need to be ready by the end of October. ***All suggestions will be gratefully received.*** An initial outline of the content follows. Organisers will also course need to cater for local needs.

Immunisation

- basic principles: specificity, priming, memory
- relative importance of immunisation to child health
- vaccine efficacy
- vaccine safety
- anti-immunisation arguments
- population protection (herd immunity)

Immunisation coverage

- 1992 survey
- Plunket survey
- individual general practitioners
- targets - overall population and sub-populations

Outline of the National Immunisation Strategy

New immunisation schedule

- brief history of the schedule
- changeover & transitional schedules
- catching-up: principles and examples

Immunisation Certificate

- formalisation of current practice
- requirements on parents, vaccinators and pre-schools/school
- ante-natal preparation & informed choice
- help for getting previous immunisation history
- catch-up certification

Immunisation Standards

- status
- content

Local co-ordination (RHA specific)

Surveillance information developments (RHA specific)

Questions & Answers

Will participation result in accreditation?

This will be up to the relevant professional group to decide. There is no formal national accreditation system yet for vaccinators.

The *Interim Immunisation Standards*, (standard 1.1) states that "the vaccinator completes an appropriate training programme and has a current accreditation certificate" but recognised that these systems are not yet in place.

Accreditation is about maintaining competence and standards, it is unrelated to the medical officer of health's approval of a non-medical vaccinator. It may be more appropriate for such accreditation to be developed by the professional organisations than the Ministry of Health or RHAs. This is especially the case for general practitioners who already have an accreditation programme in place through the RNZCGP. ***What do you think?***

Educational sessions will also be needed for public health nurses, Plunket nurses, and community health workers who promote immunisation.

Health education materials

Pre-testing of the key messages, concept testing of the materials proposed and testing of the currently available material's appropriateness for the National Immunisation Strategy will be starting shortly. The health education material that we develop will be based on the results of this consumer input, which should be complete by mid-August. ***We are also keen to have your suggestions.***

Consent: written or oral?

The Certificate Advisory Group (health & education sector representatives helping with policy implementation) debated the pros and cons of written consent. Legal protection of vaccinator, and increased the likelihood of process being followed versus parent being overloaded with another form, whose signing does not signify any more than a verbal consent. The Certificate Advisory Group recommended getting the advice of the Health & Disability Commissioner, who suggested seeking consumer and professional input on this issue. Consumer testing for the health education materials will include a question on this issue.

A third option is to have a consent form available for those who wish to use it. Space for written consent could be included either in revised *Immunisation Choices* booklet or as part of the Immunisation Certificate.

MINISTRY OF HEALTH
MANATU HAUORA

31 JUL 1995

ImmuNews 2000

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

Ref. No. _____

***Immunisation 2000* implementation Newsletter #1 27 July 1995**

The purpose of this letter is to keep those involved and interested in the implementation of the National Immunisation Strategy informed of progress. I also hope that it will act as a forum for sharing views on the strategy and wider immunisation issues.

Please distribute this letter as widely as possible to others who may be interested. If you would like to have your name added to the mailing list, please let me know.

Previous information

Immunisation 2000 is a comprehensive National Immunisation Strategy which aims to improve the immunisation programme.

Health professionals have been informed about the *Immunisation 2000* strategy through a circular letter that was sent out in early July 1995. Please ask me if you would like a copy.

We also have available an earlier document entitled *National Immunisation Strategy: Questions & Answers* which includes background material on the nine diseases in the immunisation schedule.

Health professional education

The educational sessions will inform health professionals about the new immunisation schedule and new policy (Immunisation Certificate) and provide guidance on managing these as well as general immunisation issues.

The circular letter talked about health professional training, planned from mid-November 1995. This may be better described as educational sessions with the aim of ensuring a successful achievement of the *Immunisation 2000* milestone with at least 95% of two year old children having completed their immunisations.

The *Immunisation 2000* educational sessions will be organised by the relevant professional groups. I have made initial contact with the Royal New Zealand College of General Practitioners continuing medical education (CME) co-ordinators and the practice nurse network. Thank-you to those who have already indicated their willingness to help-organise a session in their area. Some questions raised may be useful to answer here.

Is there funding support for these sessions?

I will be exploring possible funding options and advise in next letter. The Ministry of Health will be providing the resources for the education with teaching aids and a syllabus for the educational sessions.

What about resource people?

The Ministry of Health will be providing the resources and with the RHAs will train the Medical Officers of Health, local immunisation co-ordinators/facilitators and nominated people to act as resource people for educational sessions.

If you are organising an educational session, think about who you would choose to be the resource people for your session.

When should the session run?

The resource people and supporting materials will be ready by mid-November to enable the educational session to be run any time from then. The educational sessions should be run before the end of the year to enable adequate practice preparation for the changes.

How long should the session be?

The education on *Immunisation 2000* should be covered in about two hours. You may wish to have some extra time for further discussion. An evening session for general practitioners and a Saturday morning session for practice nurses should provide adequate time.

SUMMARIES

NZCOMI Annual General Meeting held on Friday 25 August 1995 at the Midwifery Resource Centre 906 Colombo Street, Christchurch commencing at 6.20pm

GENERAL BUSINESS

a) Announcement of Office Bearers

i) President

As there were no other nominations received, Sally Pairman is elected unopposed as the President for a further term of two years.

ii) Consumer Representatives

The following nominations were received from consumer organisations as consumer representatives on the National Committee for a period of two years, with right of renewal:

Parents Centre (Diane Matsas), Maternity Action Alliance (Rea Daellenbach)

As there were no other nominations Diane Matsas and Rea Daellenbach are elected unopposed.

b) Remits

Proposed Amendments to the Constitution
Control of National Funds
Changes to Rule 15.5.1 - Capitation
Finance will be obtained on a per capita basis as determined at the AGM or SGM. This amount to be sent from the regions at a date set by the National Committee.

Sally Pairman Moved/Jacqui Anderson Seconded that the following be deleted: This amount to be sent from the regions at a date set by the National Committee. CARRIED UNANIMOUSLY

c) Remits to Bylaws

Proposed Changes to Bylaws:
i 2. A year's membership to the College shall be from the 1st May to the 30th April.

Sally Pairman Moved/Glenda Stimpson Seconded that the above be changed to read:

A year's membership to the College shall be from the date of joining.
CARRIED UNANIMOUSLY

ii 3. Capitation fees of those paying by direct credit should be paid no later than the end of the financial year.
Sally Pairman Moved/Bronwen Pelvin Seconded the above be deleted
CARRIED UNANIMOUSLY

iii 4. That each region of treasurer/membership representative forward on a monthly basis the standardised Membership Summary form complete with fully completed membership forms for any members who has joined or renewed their subscription that month.
Sally Pairman Moved/Sandy Grey Seconded that the above be deleted.
CARRIED UNANIMOUSLY

iv 5. That the regional treasurer/membership representative check all details on computer printout of membership list on a 3 monthly basis as issued at the time of each National Committee meeting.

Sally Pairman Moved/Kathy Anderson Seconded that the above be changed to read:

That the regional treasurer/membership representative check all details on a computer printout of membership list on a regular basis as determined from time to time by the National Treasurer.
CARRIED UNANIMOUSLY

d) **Remits - General**
Waikato & Taranaki Region
Submitted the following:

"To increase the NZCOM (Inc) annual subscription fees substantially"

To support this remit a report had been prepared and circulated prior to the Meeting by the National Treasurer consisting of a proposed budget estimating income and expenditure for the financial year 01/05/96 to 30/04/97 enabling sufficient funds to continue and to improve the existing service and also allow for further expansion as required. Linda advised that the proposed expenses are $381,962 and the expected income is $326,352 which would make an expected total deficit for the next financial year of $55,610.

Linda read out this Report which outlined the College's financial position as per the 1994 AGM agreement to increase regional capitations and subscription rates. Rate of capitation was previously set at a fixed levy, the amount varying between membership types where subs were increased and capition was set at 30%.

Women Talk Genetics

Auckland women interested in health research are invited to a discussion in October about the implications of genetic information for women.

The Health Research Council Women's Health Committee is organising the evening to bring together women interested in the Auckland-based Women's Health Research Network.

Panellists include -

- Marilyn Brewin, lecturer in Maori research at Unitec
- Moera Douthett, HRC Pacific Islands Health Research Co-ordinator
- Judi Strid, convenor, Federation of Women's Health Councils
- Dr Ingrid Winship, director of Northern Regional Genetic Services.

The four were either participants, speakers or organisers for the recent HRC national consensus conference *Whose Genes Are They Anyway?* held in Wellington.

The event involved people with a wide range of perspectives and raised many issues, including ownership of genetic material, colonisation, particular impacts on women, access to genetic services, civil rights, privacy, a voice for families with inherited conditions, screening and regulation.

The informal network first started after an HRC Grant Writing Workshop in Auckland in 1992, and meetings have discussed a wide variety of health topics. Themes included building links between women researchers, Maori and anthropological health research, and current research on bone, contraception and gynaecology.

The meeting will be held at the Marion Davis Library at Auckland Hospital, on Tuesday, October 10, from 5.30 to 8pm. A koha would be appreciated for drinks and nibbles.

Information - Sara Bennett, HRC, PO Box 5541, Wellesley St, Auckland 1, phone 09 379 8227 ext 840, fax 09 377 9988.

Cranberry Juice

Research has verified cranberry juice's ability to help cure urinary tract infections.

In a study conducted at Brigham and Women's Hospital, 153 elderly women drank about 10 ounces of cranberry juice cocktail daily. After six months, they showed about half as many infections and needed antibiotics only half as often as women who consumed a non-cranberry drink. Although the popular theory holds that cranberry juice works because it makes urine more acidic, the study suggests that cranberry juice contains a natural substance that interferes with the growth of bacterial colonies. ***(Eating Well Magazine, 1994)***

Expectant handling of first trimester abortion

A Royal Brisbane Hospital lecturer suggests it is time to re-evaluate the strategy of routine D&C for all miscarriages in the first trimester.

A recent trial indicated 80 per cent of women randomised to expectant therapy had no retained products according to ultrasound examination three days or more after spontaneous first trimester abortion.

There were similar numbers of complications in controls who underwent curettage, and conservatively managed patients. Although the best form of management is not yet clear, gynaecological units with ultrasound available may wish to reconsider their practice in the light of this and other studies.

Curettage was considered optimal management for incomplete and inevitable spontaneous abortions based on studies undertaken in the 1940s. Infection and bleeding related to back street abortion and anaemia, respectively, were problems that then sometimes had fatal consequences. Curettage was also thought to hasten recovery and avoid the need for further follow-up.

Because of this approach the natural history of first trimester spontaneous abortion has been unclear. However, expectant management proved successful in 81 of 103 patients undergoing first trimester spontaneous abortion in a recent Swedish study.

Nineteen patients with retained tissue measuring over 1.5 cm in AP diameter on day three underwent curettage.

Infection and bleeding rates, duration of convalescence, and packed cell volume two weeks later were similar for conservatively treated patients and those undergoing routine curettage.

Thus, in motivated and informed patients having a spontaneous first trimester abortion "a substantial proportion will avoid the need for curettage without additional risks in the short term".

The ability to follow up patients diligently is critical.

Forbes K. BMJ 310:1426, 3 Jun 1995

NATIONAL WOMENS HOSPITAL STATS 1994

Deliveries	-	8812 of which 3814 (43%) were nulliparous			
Babies	-	9257 PNMR - 9.3 Twins - 181 (PNMR 48.1)			
		Triplets - 4			
Providers	-	private specialists -	1690	(19.2%)	
	-	GPs -	2580	(29.3%)	
	-	Private midwives -	638	(7.2%)	
	-	team -	3024	(34.3%)	
	-	unbooked -to team--	880	(9.3%)	

Mode of delivery	**All women**		**Nulliparous**	
NVD	67.4%		56.1%	
Vaginal Breech	1.1%		1.0%	
C/section	19% n 1670		20.7% }	n 790
Forceps	10%		17.8% }	42.8%
Ventous	2.5%		4.3% }	
Epidurals	**n**	**%**	**NVD**	
Total	3281	37	13%	
Nulliparous	-	56		
Inductions	**n**	**%**		
Total	2033	23.1 }		
Nulliparous	1046	27.4% } c/s rate 19%		

Indications:

Post-dates	- 26%	Hypertension	- 27%	IUGR -	13%
Ruptured memb	- 10%	Diabetes	- 3%	<movement -	1%
Maternal distress	- 2%<	liquor	- 2%	fetal abnorm -	6%
Antibodies	- 1%	Unstable lie/abnormal CTG ea 0.5%			

Augmentation	**n**	**%**
Total	2484	27.5%
Nulliparous	1608	42.%

PPH 15.3% Episiotomy n 1496 (21%)

C/section - Indications

Failure to progress	- 33%	Fetal distress	- 23%
Repeat	- 16%	Malpresentation	- 15%
GPH	- 4%	APH	- 3%
Other	- 6%		

Admission to NNU (NICU & SCBU) - 1666

Perinatal loss classification:

Fetal abnormality	- 32%	Spontaneous prematurity	- 22%
Unexplained	- 15%	APH - 11%	IUGR - 7%
Infection	- 6%	Intrapartum asphyxia	- 4%
Hypertension	- 3%	Maternal disease	- 1%

Ultrasound scans - women scanned = 12,975 (1993 = 9,813)

Amniocentesis	526	437
CVS	209	237
Fetal transfusions	40	26

Linda had drawn a chart demonstrating what this increase would mean in dollar terms for the regions. This chart demonstrated revenue from subscriptions would not keep pace with services and expenditure of the College and explained it is reliant on income generated from profit margins from conferences and sales of stock to support its structure.

It was noted that the workload at National Office continues to increase and the need to employ an assistant co-ordinator full time on a permanent basis. It was agreed it is not be acceptable to reply solely on income generated from profits as this income is not guaranteed and that employed staff need to be paid from sustainable revenue.

Discussion followed regarding the possible increase in subscriptions. Karen asked those present what level of service should members expect from the College as she had noticed that expectations of members was increasing. It was agreed that the current workload must be financed.

Mary Gamble (Otago) said that with her dealings with the College over the past few days that she was impressed and to name your price as she thought it was the College that was the difference between the midwifery profession and extinction and if people wanted an expert service they have got to pay for it.

Beryl Davies (Wellington) questioned the College paying 30% of capitations to regions and asked if it had to continue with this. Linda replied that she thought with more money going to regions it would allow them to run a more financially secure region and allow more money for local requirements.

Sandy Grey (Auckland) said that there was some dissension from her members about the cost of subscriptions now let along increasing them more. She also said that her members are experiencing access problems and there was some dissatisfaction that their only avenue for them is to be referred to Commerce Commission.

Karen reiterated that the College's role is not that of a industrial union. Regarding access problems, lobbying can be done at RHA and CHE level but on an individual basis it is impossible for her to do. She suggested that members with access problems lobby as individuals with the College continuing to do so nationally.

Jacqui Anderson (Canterbury/West Coast) said on behalf of her region she would like to acknowledge Karen and the tireless work that she does contribute to the College and she should be compensated more for it. Karen declined an increase in salary.

Linda continued with the Report saying that the College currently pays honorariums to the National Treasurer, Journal Editor and Newsletter Editor. She proposed that the National President also receives an honorarium in recognition of the services provided to members. The honorarium to be set by National Committee. The Meeting agreed unanimously.

She also proposed that a new category for casual/part-time employed and self employed midwives with evidenced gross income below $10,000 reduce subscription rate to 50% of full fee and members living overseas have a package and postage levy added to their subscription rate.

Following the above Linda presented Proposals A,B,C and D for further discussion.

Karen spoke of indemnity insurance and how just one case could delete the College's accumulated funds. The individual cover for members is satisfactory in that it covered fines that may be incurred and costs of actual Hearing up to $200,000. However if there was any such claim lodged with the indemnity underwriters, the insurance premium for the following year would increase significantly. Current trends indicate that more and more complaints are being made about health professionals, eg, NZNO has had a 2,000% increase in complaints against their members.

The reason the College carries the costs of dealing with individual cases is to keep the premium price affordable. Most professional organisations work in this way.

Sally said that the College was fortunate that Karen had the expertise to be able to act as counsel when there were complaints against midwives with the Nursing Council as this alone saves the College thousands of dollars each year.

Judi Strid Moved/Lynley McFarland Seconded that Proposal C be adopted which increased subscriptions to 75% and 20% of capitations to regions.

Sue Calvert (Wellington) asked if this proposal could be taken back to the regions. The consensus was that it should have already been discussed at regional level and was to be voted on at this Meeting.

Jacqui Anderson (Canterbury/West Coast) suggested that perhaps the College could negotiate with the NZNO an acceptable subscription for CHE midwives to keep subscription at a minimum following an earlier comment that self employed midwives subscriptions are tax deductible. It was explained that the College had recognised the role of the NZNO for CHE midwives with its significantly lower subscription rate.

QUOTE OF THE MONTH

The following piece of information was given to a midwife when she approached a GP regarding shared care at the request of a woman.

The GP stated that he "didn't work with independent midwives" and suggested the following.

The midwife is categorised as the 'Maternity Support Person'!!

SUNNYBRAE FAMILY HEALTHCARE

Dr Christopher Boberg
General Practitioner
43 Sunnybrae Road
Northcote
Auckland

Telephone 4435076 Mobile 025959727
Fax 4431080

February 1995

NOTES FOR MATERNITY SUPPORT PERSONS

Dear support person

It is nice for a mother in labour to have a support person with her. There is a real benefit in outcome and in ease of labour for a mother to have someone who can hold her hand and rub her back and be there for her both physically and emotionally. It really does help perception of pain and positive progress in labour.

As you are health professional changing roles, you will find this transition interesting. A lot can be done to ease the outcome on the day by thinking through this issue before labour. There is a real skill in the support person letting the mother in labour talk directly with the hospital midwife and her chosen Doctor.

To be a support person, is in my view a valuable job. I must admit to enjoying this role in my wifes labours. It is wonderful for the previously professional support person to leave the role of leadership to someone else and enjoy being the support person.

CURRENT ISSUES

WORKING WOMEN'S RESOURCE CENTRE

PARENTAL LEAVE PAMPHLETS

Clear, concise, accurate and up to date, this pamphlet emphasises employment court decisions that jobs should be kept open unless it would be 'virtually impossible' to replace a worker with a temporary replacement. (The pamphlet was checked by the legal services board for legal accuracy).

The Working Women's Resource Centre also provides advice and advocacy on parental leave Ph. (09) 376 2156.

People wanting single copies should send a stamped, self-addressed envelope to:
Working Women's Resource Centre
Private Bag 68 905
Newton Auckland

If you would like multiple copies please send a donation to cover costs (20 cents each).

Pamphlets are available in:
English, Samoan, Tongan, Maori, Cook Island Maori, Nuiean

H E L P ! !

These members of NZCOM have all had mail returned to us. Do people who are reading this know any of the names below??? Or do you recognise your own name (if your reading someone else's newsletter)???

Robyne Bryant	**Hokitika**
Wilma Brady	**Auckland**
Kelly Allen	**Auckland**
Diane Burgoyne	**Auckland**
Fiona Bowman	**Auckland**
Patricia Carson	**Wellington**
Joan D'Ath	**Paeroa**
Anne Doherty	**Northland**
Glenis Gardner	**Hamilton**
Elizabeth Glynn	**Auckland**
Lisa Hodgson	**Auckland**
Jane Hooper	**Christchurch**

If you have answered 'yes' to any of the above, then please contact me at the National Office between 9.30am and 3.00pm, so I can let the lost souls have their own newsletters, and you have less grubby finger marks through your own!.

Thanking you. Marita

SOUTHERN RHA LABORATORY REVIEW GROUP

Following an immense amount of lobbying with very good rationale, the NZCOMI now has a representative on the SRHA Laboratory Review Group. She is:

Terryl Muir
Otapiri
RD 2 Winton

Any concerns re laboratory tests and investigations in the Southern Region, please contact Terryl.

Discussion is necessary with NZNI for them to also recognise the College's role for employed midwives.

Mary Gamble (Otago) said in her Region CHE midwives are paid $45,000-$50,000 per year and could well afford a new subscription rate of $350.

Sharon Cole (Parents Centre) commented that her organisation, which is a voluntary organisation pays their salaried staff far in excess to that of the College.

Motion for Proposal C withdrawn following this discussion.

A motion put forward by Jackie Gunn Moved/Sandy Grey Seconded that the following Proposal be adopted:

Proposal D: Subscription rates from 01/05/96 to 20/04/97:

Self employed	$700	Employed	$350
Student/Unwaged	$100	Associate	$ 60
Affiliate	$ 60	Associate with Indemnity	$274

30% of capitations going to regions.

Linda Collie moved / Julie Richards seconded to introduce a new category for casual/part time employed and self employed midwives with an evidence gross income below $10,000 reduced subscription rate to 50% of full fee.
CARRIED / 2 AGAINST (WELLINGTON AND CENTRAL)

e) Topics for Discussion

French Nuclear Testing in South Pacific

Sandy Grey (Auckland) Moved/Rea Daellenbach requested that the College make a public statement protesting France's proposed nuclear tests at Mururoa Atoll.

Letters of protest are also to be written to the French and Chinese Embassies as well as to Mr Bolger. CARRIED UNANIMOUSLY

f) Other Business

i) Annual Regional Reports
The Annual Regional Reports were tabled

ii) NZCOM Documents for Ratification:
The following Consensus Statements were ratified:
Prescribing - Vitamin K - Immunisation - Complementary Therapies
Ultrasound - Alcohol & Pregnancy

NZCOMI National Committee Meeting held on Saturday 26 August 1995 at National Office, 906-908 Colombo Street Christchurch commencing at 9am

BUSINESS ARISING
Section 51 (See enclosed update)

MPOs
Discussion initially centred on the confusion between NZCOM and WRAM (Wellington Regional Midwives Assoc) in relation to the setting up of a national MPO structure.

Kirsty Prichard reported back from the Meeting held in Wellington between NZCOM reps in the Central Region and WRAM. Nelson had understood that they wanted to run with a National IPO structure and had resisted and rejected Central RHA's small contract proposals. They were aware that CRHA had been courting small groups in the Central Region.

Sandy Grey (Auckland) said these tactics had been used everywhere but that no region had taken up the divide and rule tactic. Karen explained CRHA priorities as significantly more a separatist market model than the other RHAs and that Central had exhibited very clever and persistent strategies to divide people into small contracts. It was really a matter of collectivism versus individualism and both had followers. The National Committee's strategy however has always been overwhelmingly in favour of collectivism and this was the direction the MPO studies had confirmed. It was thought Wellington Region had understood that as no indication had been recorded otherwise.

Beryl Davies (Wellington) said she didn't believe WRAM had any intention of undermining the College and that there was no ulterior motive in its formation. It was a group which had been formed 2 years ago and reactivated. The Committee accepted the goodwill of WRAM towards the College and that the problem was a communication one.

The Committee agreed that they had believed from the Wellington Regional rep that Wellington was investigating the forming an IPO in the same way as other regions. It was their understanding that there was a Co-ordinator for that process nominated in Wellington. On discussion as to how these assumptions came to be, it was clear that there was a lack of communications between the National Committee and the Wellington Region with both groups believing the other to be on the same wavelength. Neither group was consciously misleading the other and it was resolved to move forward.

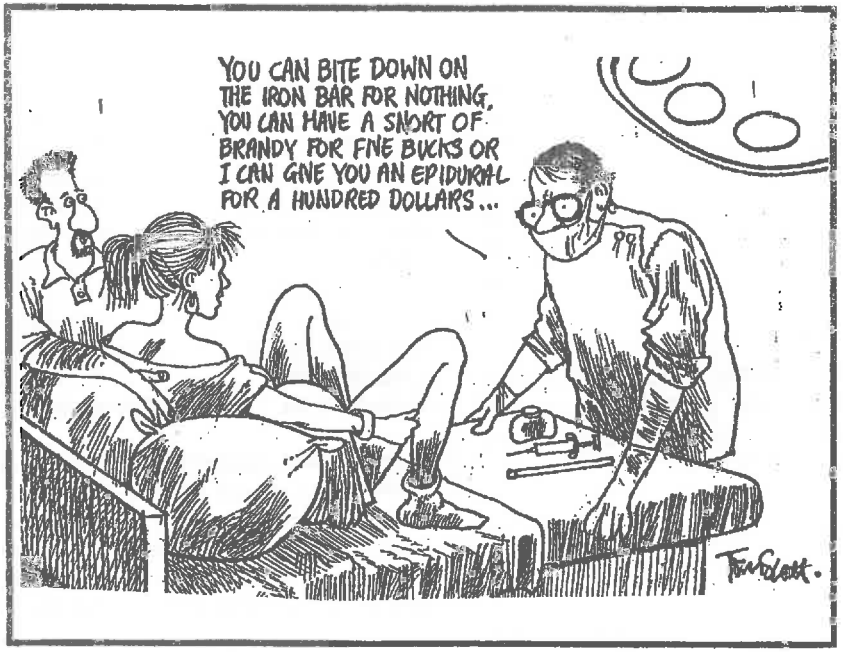
Wellington Region was requested to advise the College on their decision. Wellington Region was given a copy of all correspondence held between the National Office and Wellington on the Central MPO history.

Sue Calvert (Wellington) tabled a legal opinion sought by one of their members on the formation of a contracting agency. The advice was clearly in support of a collective approach. This opinion will be circulated to National Committee.

NATIONAL HOME BIRTH CONFERENCE 1996

NEW DATE

01 September 1996
Christchurch



Breastmilk and MS

An Italian study of the infant feeding patterns between cases of multiple sclerosis (MS) and healthy controls found that people with MS were less likely to have been breastfed, or were breastfed for a shorter duration than healthy people. It is suggested that since cow's milk-based baby milks have very low levels of unsaturated fatty acids they may weaken the nerves and allow an infective agent, such as MS into the nervous system.

(Compiled by The Geneva Infant Feeding Association - Switzerland)

ACKNOWLEDGEMENT

I wish to extend my apologies to the New Zealand Lactation Consultants Association for the lack of acknowledgement of the article *"World Breast Feeding Week"* reprinted from 'Issues'

The article appeared on pages 28 & 29 of the June/July issue of this newsletter.

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

24th TRIENNIAL CONGRESS OF THE INTERNATIONAL CONFEDERATION OF MIDWIVES

26th to 31st May 1996 Oslo, Norway

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

CALL FOR ABSTRACTS
Deadline 31st March 1995. Completed papers due 4th June 1995

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

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

The NZCOM while awaiting WRAM's decision is still committed to a structure for the Central RHA Regional midwives. An application for establishment funding will be lodged once WRAM's decision is known. Karen reiterated that our previous application had not been turned down. Gillian Bishop had simply failed to process it until she had successfully pressured smaller groups to form contracts.

The Meeting repeated its understanding of the process as a slow one and supported careful progression rather than reactionary response.

MPO progress reports were read by:
Judi Strid for North MPO
Linda Collier for South MPO
Glynette Gainfort and Ann Hopkirk for Midland MPO.

Those in Steering Committees were cautioned about the confidentiality of consultants reports and the College's MPO legal/accountancy/structural reports. These opinions are expensive and belong to the College and are not for release to private contracting parties.

The structure and process of the National Committee was discussed.

The National Co-ordinator explained her position as one of giving and sending out information and the National Committees to action it as necessary. The National Committee employed her to act on their behalf however they are the Board of Trustees and as such need to take responsibility for the College directions. She expected that all information received from the National Office will be assessed and responded to as the region sees fit. She welcomed direction and feedback.

It was agreed an information/guideline package for new National Committee members would be a good start. Sharon Cole offered to send the Parents Centre Executive handbook for new members.

Linda suggested chairpeople co-ordinate meetings regionally as soon as possible following National Committee meetings to ensure information goes straight out to members.

A summary of the National Committee Meeting will be printed in the Newsletter following the Meeting.

Karen said that response to calls for information for the Newsletter is improving.

All regions to exchange their region's Newsletters.
Ranui Parata explained they may be representing their own people on a national basis but she feels it will take time for them to fit into this structure and are presently concentrating on priorities. The main priority is to get together prior to each National Committee Meeting to discuss issues coming up at next meeting. The Committee accepted the need for it to address bnicultural issues.

This discussion reaffirmed the need for an orientation package which includes an outline of the culture of the Committee. Ruth Martis will draft something and send to Karen for circulation.

GENERAL BUSINESS

Conference Report

Julie Richards gave the meeting a report on the 1996 Conference (*Midwifery: The Balance of Intuition & Research*) to be held at Lincoln University from 29-31 August:

Accommodation

Cost of the accommodation will be around $30 per night which includes breakfast. There will also be a choice of accommodation at a backpacker hostel, motel and hotel in the City but will need to consider travel to Lincoln each day.

Pre-Conference Workshops (28 August)

These will consist of clinical skills, neonatal resuscitation, IV, Small Business information and will target midwives who don't have access normally to these types of workshops.

Home Birth Conference (28 August)

Home Birth Conference will be a separate cost to the NZCOM Conference.

Fundraising

Due to the ongoing cost of having a Conference Organiser we need to get our fundraising underway as soon as possible. We propose to offer for sale tights, T shirts, bike shorts and sweatshirts in the Conference colours (burgundy/ torquoise) with the NZCOM logo. These will be on sale from the first Call for Abstracts and Show of Interest flyer. These will be designed and produced by Jo Taylor, a local designer and consumer member of our Conference Committee. Jo is producing these for us for cost of fabric and labour only and we are immensely appreciative. There will be an initial financial outlay this year but we would hope to be generating income by early next year. The clothing would also be available at the Conference.

Invited Speakers

Barbara Katz Rothman (USA) has accepted our invitation and is very excited about coming to NZ. Professor Gill White (Victoria University) and Dr Jane Fisher (Australia) are presently being contacted.

Prescribing

The Ministry of Health has confirmed their acceptance of the statutory right of Midwives to prescribe antibiotics and contraceptives. The MOH will advise PHARMAC and the Pharmaceutical Society accordingly. If midwives continue to have problems with local chemists, they can contact their local chairperson for a copy of this advice.

NEW ZEALAND O&G SOCIETY BIENNIAL CONFERENCE

October 27th, 28th, 29th 1995
Palmerston North Convention Centre

Contact:
Sue Peek
P O Box 474 Palmerston North
Phone (06) 351-4469 Fax (06) 356-9841

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

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

EVENTS CALENDAR

PAEDIATRIC CONFERENCE

27th to 29th September 1995 - Sheraton Hotel, Auckland

Contact : Organising Committee
1995 Paediatric Conference
P O Box 12-736
Penrose, Auckland

11th Birth Conference

7 - 8 October 1995
Innovations in Perinatal Care : Assessing Benefits and Risks
Baltimore MD
Sponsored by the journal Birth & John Hopkins University
Speakers include Marc Keirse, Judith Lumley, Beverley Chalmers, John Kennell, Ruth Lawrence, Mary Renfrew, Charles Mahan, Bruce Flamm, Ellen Hodnett and Frank Oski.
Birth
43 Oak St, Genesoa
NY 14454 USA
Tel/Fax 716 243 0087

BIRTH, BABIES & BRIDGES IN THE 21ST CENTURY

October 21st, 22nd, 23rd 1995
Centra Hotel, Auckland

Issues :
- Sensitivity & Awareness of the Newborn
- Legal issues in obstetrics and paediatrics
- Maori and multi cultural birth traditions
- Sexuality and birth
- Women and power in the Birthplace

Contact : P O Box 52-065
Kingsland Auckland 3
Ph (09) 525-3437 Fax (09) 846-1801

Competencies
Nursing Council is in the process of developing these with the College. A meeting and workshop has been held with Nursing Council and a draft set of competencies circulated. It will be an ongoing process.

Regional comment to be sent back to Nursing Council via the National Office for the NZCOM reps. The Committee have used Standards for Practice Handbook as a baseline. Each education institution is expected to address how each individual organisation will measure the competencies.

The competencies have been developed as integrated statements, rather than behavioural task lists. We are moving towards a system where every 3-5 years practitioners will be measured against a set of competencies. The Midwives Standards Review Committee will monitor these competencies. NZCOM working toward recognition that majority of midwives in the CHE facilities be the consultants in the secondary care.

Consensus Statements
Cervical Screening
Review statement and reply to Cervical Screening Committee comments on consensus statement.

Media and Promotion Strategy
Karen has purposely not responded to the Metro article as it would just highlight the negative again. It needs a planned campaign and a journalist to do this. We need to take a positive approach - a national strategy then use regional networks to get information across. The role of consumer groups in promotion is essential.

Treasurer's Report
Linda Moved/Sandy Grey Seconded that the PresidentÆs position should be recognised with an honorarium. CARRIED UNANIMOUSLY

Sandy Grey Moved/Julie Richards Seconded that the honorarium be set for this year at $1500 and reviewed at the National Committee Meeting prior to each AGM.

Linda Moved/Sharron Cole Seconded that the Financial Statement be accepted.

Linda advised that regions should register for GST even if income not over $30,000 per annum so they can be paid GST inclusive capitation and claim GST back on their expenses. Each region is to notify National Office of their GST number.

Bounty Scholarships
Diane Matsas reported back on progress re feedback regarding the review of the content of Bounty. The May issue has been produced following discussion with Bounty representative. Need to look at each production and comment and feedback as a continuing process. Diane felt they are receptive. A video has also been reviewed and comment offered at the cost of a bromide.

Bounty want to offer a scholarship to $300 for travel/registration expenses related to midwifery. Central region opposed as publication not appropriate.

It was recognised that any inappropriateness was the fault of conflicting information.

Judi Strid acknowledged Bounty's effort to change the book and believed the College should accept scholarships along with the opportunity to keep commenting.

Joan's comments will be sent to Jenny Humphries so she can continue to liaise with Bounty.

It was proposed and accepted that we would write and acknowledge and request more information and express our interest.

Scope of Practice re Ventouse
Correspondence from Waikato that they do not believe scope of practice should be extended to include ventouse. It was reinforced that this was a discussion and not a position statement.

Northland emphasis was that it was a safety issue for them and that obstetricians are prepared to provide instruction for GPs/midwives so that they have the skills in an emergency situation. They wanted to know if this special needs area and its midwives would be supported. Midwives were seeking guidance that if they performed ventouse would they have the support of the profession.

Karen emphasised legal implications around appropriate scope of practice. This issue is in early discussion phase.

Karen will send out Waikato's information/letter as a starting point. Northland needs to outline reasons why this has arisen.

MSRC and Relationship to College - Nelson
The May Minutes were corrected to read MSRC has to be divorced from the College Complaints Committee. Kirsty asked whether midwives having a workload over the recommended College workload could be addressed. This will be the topic for next National Committee Workshop. Judi Strid said MSRC provides an overview of practice and a safe environment to be heard.

Need to continue with an educative process but we need a mechanism for committees to deal with difficult cases. Need further workshop for MSRC and Complaints Committees. Some CHEs are buying the service of the Review Committee. Who owns data & tool etc.

Position Statement re VBAC
Canterbury/West Coast questioned whether to work on a draft consensus statement on VBAC and forward to National Office. Regions to forward any comment/articles to Jacqui Anderson.

NORTHERN MPO FEASIBILITY STUDY

The Northern MPO feasibility study recently did a survey of 95 self employed midwives and their caseloads. The results indicate the increasing trend towards midwife only and home births as a choice for women. The majority of midwives surveyed offered both hospital and home birth services.

AUCKLAND CITY	
Midwife only	1590
Shared care	1245
Homebirths	478
CHE births	2159
No. of midwives	70

(data missing for 6 midwives)

NORTHLAND	
Midwife only	480
Shared Care	424
Homebirth	168
CHE births	586
Other birthplaces	79
No. Of midwives	25

(data missing for 5 midwives)

7. As project coordinator, Sian has provided a consultancy service to midwives in other areas as well as dental nurses who are investigating provider arrangements within the new health structure.

8. All members of the working group have been available to discuss areas of concern or where clarification is needed on the expected role of the MPO.

9. A small sub-committee has been established to research and compile the feasibility report. The report is nearing its final stages.

10. Have met with and maintained ongoing dialogue with RHA representatives.

11. Working group members have attended RHA and CHE forums to keep up to date with the health restructuring process.

12. Application for MPO establishment funding will follow the completion of the feasibility report.

Conclusion

Even though the process has been time consuming and we have needed to revisit some things several times, the working group is very pleased with the direction and progress being made. It has also been very heartening to receive such strong support from midwives for the MPO.

ANALYSIS OF THE AUCKLAND MIDWIFERY STANDARDS REVIEW COMMITTEES

An analysis of the Auckland Midwifery Standards Review Committees consumers evaluation forms shows the following interesting trends.

- ★ *That the midwives who provide an average of 12 postnatal visits per women have a breastfeeding rate at 6 weeks of 98%.*
- ★ *That midwives who provide an average of 12 postnatal visits per women never receive any negative feedback from the women.*
- ★ *That the level of satisfaction from women increases when they are visited every day for at least the first 7 days.*
- ★ *That there is a reduction in the number of breastfeeding difficulties if midwives spend an average of 1 hour with the women for the first 7 postnatal visits.*
- ★ *That midwives who visit women for 7 visits or less including primips have a reduced level of breastfeeding of 80%.*
- ★ *That midwives who visit women for less that 7 visits have a least 10 per cent of their consumer evaluation forms with negative comments in them.*

HBL

For audits by HBL, the College is setting up an audit profile or protocol based on the medical protocol currently in use. Karen has been through this and changed so that it is appropriate for midwives. Will be photocopied and sent out to regions for comment.

Regarding urgent attendance - are callouts in response to an urgent request, not routine visit in weekend and after hours etc.

Mileage - need to accurately document mileage between clients as individual amounts. Need to have supporting evidence, ie, logbook/diary. Documentation is vital - must document times/dates/place of visit/reason/routine/urgent/transfer etc. Establishment of labour time is an issue - CHE records and midwives documents are compared. Need to emphasis these issues to midwives.

Draft Code of Rights for Consumers of Health Disability

Karen advised number to phone to obtain a copy of this document. Each region needs to comment. Other groups comments will be forwarded to the Regions. Judi recommended attendance at public meetings re this document. Comments on this draft are due by 10 September.

OTHER BUSINESS

Handbook for Practice

Sandy Grey reported on the Standards for Practice and interpretation. Auckland had held a workshop where comments were made re standards and would like the standards to be reviewed.

SIDS Issue

Sharron Cole raised issues around SIDS re the need to be clear what the points are and what is anecdotal or personal opinion.

Sharron has written an article for Newsletter.

Sharon Cole tabled a booklet produced by Parents Centre about advocacy and lobbying. Have launched an advocacy and lobbying Co-ordinator. A How to Lobby Guide. Regions may purchase a copy for $10.

Karen raised awareness of new Parental Leave pamphlet.

Harangi Biddle travelling around the country talking to Maori Midwives/student midwives. Consulting with other for a programme to be run at the Waikato Polytechnic subcontracted with Maori SIDS. Would like to present this 1/2 day workshop on Friday at next National Committee meeting.

The next meeting of the National Committee is on 17 & 18 November.

STOP PRESS - SECTION 51 UPDATE

Unresolved issues for the NZCOM were:

- Rural service not included
- Home visits underfunded/mileage
- Second person fee underfunded
- Continuity and total care by a LMC underfunded
- Reduction of service to 28 days
- Six week check uncertain in relation to schedule
- Access agreements with CHE and other contracted facilities
- Post natal module/CHE costs
- Induction
- Significant increase in administration and data collection with no funding
- Referral criteria
- Separation of women and baby at 14 days

The RHA's responses are as follows:

Rural/Travel/Home Visits

There will be two extra payments to the modules with a focus on home visiting in the postnatal period. There is $1.4 million dollars to fund travel in two situations.

a) A woman living more than 30-60 minutes from a birthing facility.
b) A woman living more than 60 minutes from a birthing facility.

It is considered by the RHA that there is a travel loading already in the modules for women who live within 30 minutes of a facility. They declined to identify the amount they had loaded for travel or anything else for that matter! They gave no prices for the extra payments so we are unable to agree or disagree with this proposal until these prices are set. We doubt they will be adequate judging by the lack of movement overall in prices.

The Postnatal module/6 week check

The continuation of maternity services to 6 weeks was agreed. It is expected that the LMC will provide a discharge postnatal examination of both mother and baby. A further 6 week baby check linked to immunisation will be claimed for only from GMS. It's still not clear if midwives can access that.

NORTHERN MPO UPDATE

- by Sian Burgess 24 August 1995

The Northern MPO working group commenced formal operations on 4 June 1995 with four midwives and two consumers. Two additional midwives were added to the original working party. The members are

- Sian Burgess Project Coordinator
- Joan Donley
- Brenda Hinton
- Sandy Grey
- Lesley Hinson
- Joane Rama
- Suzanne Miller
- Judi Strid

The purpose was to undertake and complete a feasibility study on the MPO potential in the Northern RHA region.

PROGRESS TO DATE

1. brochure developed and distributed to all COM members in the northern region

2. regular updates provided in the newsletter

3. have received a $20 payment from 95 midwives, which will ensure them a copy of the final feasibility report

4. Sian Burgess has travelled throughout the Northern region meeting with groups of midwives to discuss ways the MPO could work for them, and the implications for their area of belonging to the MPO. Sian has also provided an MPO update at each monthly COM meeting.

5. Sian has attended 8 meetings (more to come) as the midwifery representative to develop an access agreement for the whole North Health region. This has included the four CHE managers, the RHA as well as GPs, obstetricians and a consumer. One of the most difficult areas to resolve continues to be the mentoring arrangements.

6. Developed a working relationship with an Auckland based IPA which has 400 member doctors. A mission statement and some principles have been mutually developed. The relationship is based on equal partnership and both parties have a strong commitment to providing quality maternity services for women.

Under the new proposals midwives and doctors will simply not be able to afford to provide such a comprehensive and cooperative service. The RHAs have obviously not given any thought to the underfunded CHEs having to pick up this service when they are already stretched to provide a satisfactory service.

Both Dr Rushmer and Mrs Guilliland say the proposed Referral Criteria will also have choice, safety and cost implications. "The RHA guidelines encourage minimum care rather than best care. If GPs and midwives are banned from caring for certain women regardless of that women's choice this will require women to seek obstetric care only available in cities. This increases costs, particularly to rural women and their families in travel and accessibility and to the maternity budget in unnecessary uptake of the expensive specialist facilities.

"Is this another way of closing small maternity units"? asks Mrs Guilliland.

Both the doctors and midwives are anxious that the guidelines will also make it very difficult for caregivers to maintain continuity of care "and that is yet another choice and safety concern", says Mrs Guilliland.

Dr Rushmer and Mrs Guilliland say that health professionals such as doctors and midwives work within high ethical and clinical standards laid down by their respective groups.

"Both are duty bound to strive to do their very best and both have to maintain their own standards. But this system can make it almost impossible to work within our professional guidelines", says Dr Rushmer.

The NZMA and the College of Midwives will meet with representatives of the combined RHAs on Friday 21 July and have asked for more information about safety and access issues in the contract as well as justification for the gross underfunding of the maternity service.

"It seems to us that this is yet another classic case where a management model for cost containment has been used to draw up a contract for health services. The proposals are simply a cleverly packaged cost cutting exercise designed to reduce the maternity service. The people driving this have no understanding of clinical practice and primary health and are not listening to those who do".

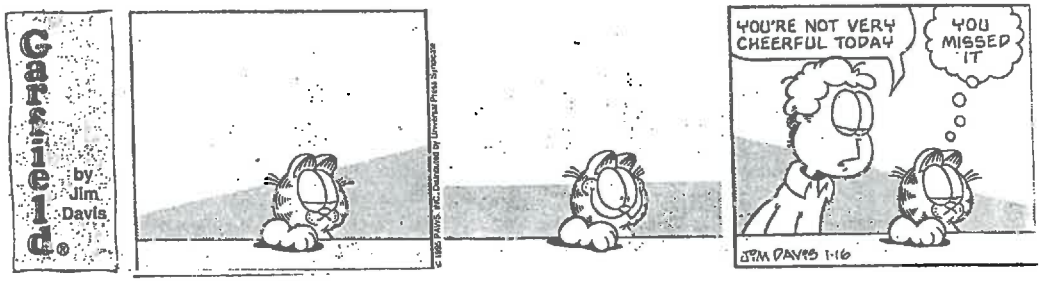
FOR FURTHER INFORMATION CONTACT:

Philip Rushmer
Chairperson
NZMA Maternity Services Committee

PH: 09-817-7453 (wk)
09-817-6704 (hm)

Karen Guilliland
National Co-ordinator, NZCOM

Ph: 03-377-2732 (wk)
03-355-9579 (hm)



The previous $80.00 home birth midwife supplement has now been added to the overall postnatal module bringing it up to $280.00.

A midwifery rural supplement to antenatal, postnatal modules to recognise time involved in home visits was agreed. The focus will be on postnatal home visits. The next draft will specifically require an LMC to provide midwifery postnatal care, including home visits. No price was put forward as yet.

Induction/CTG's/BPP's

Are all considered as being funded in the secondary care/CHE contracts and automatically available to the woman and her LMC. The LMC does not have to buy these services off the CHE.

There are only two situations in which a CHE can charge the self employed midwife/doctor, LMC.

a) for domiciliary midwifery services following discharge from the facility.
b) midwifery services for labour and birth.

Ultrasound

This debate between the RHA's and NZMA took up most of the very curtailed 2 hour meeting. (We had had a 10-3.00pm meeting time agenda).

The RHA's announced (unexpectedly from our point of view) that ultrasound will now be a notional budget. That is, they have funded 1.7 scans for every pregnancy but the LMC who exceeds this will be able to claim those costs back. There is no financial risk to the providers. The RHA's identified this extra money (and we wonder if they have any idea of the extra money which will be required) as coming from their risk management fund. We requested postnatal care and home visiting should also be considered under the same risk principle management since midwives carried all the financial risk in this area! It was noted but not with much enthusiasm. Draft 4 is heavy on rhetoric concerning choice, quality and primary health but in practice routine ultrasound without any supporting evidence of benefits is considered more of a priority than the whole midwifery service.

Access

The RHA's will not be producing a national access agreement but all four are endeavoring to produce their own RHA one based on the principles in Draft 4. Progress is slow but it seems the RHA's have

accepted the need for them to be more pro-active in sorting the issues.

Referral Criteria

In the absence of an agreed document by NZCOM, NZMA and the Colleges of GP & O+G the RHA's will release their referral criteria as guidelines only. The CHE will be required to use these criteria not produce their own. The doctors are meeting on the 7th October to discuss the criteria and will notify us following this date to arrange a consensus meeting.

Draft 5 will be released by the RHA's in 3 weeks time and will include all prices. Another meeting between all parties will be arranged to discuss draft 5. Ask your local chairperson when your region will be having a meeting to discuss this draft. Please forward any comments you have to the national office following that.

The RHA's expected the new Section 51 arrangements will be operational for all women by June 1st 1996 if the starting date is November.

The College put in a strong request for the Schedule to have an automatic review in 12 months.

An alarming feature of the CHE/RHA negotiations is Auckland CHE's price of $348.00 for midwifery services in labour and birth. This insulting price will not support the new hospital continuity of care teams and is to be strongly rejected. Hospital midwives deserve the same recognition of their worth when taking on continuity and caseloads as self employed midwives. The CHE's by putting this unacceptable price on their staff midwives are negotiating their way out of an independent midwifery service.

Under the modular service specifications continuity of midwifery care is a requirement. No midwives will be able to sustain the demands this places on them for less than they receive now. It is already difficult for CHE's to recruit midwives. These prices will make it impossible. The DRG's or unit prices for cesarean section or complicated delivery recognise and reward the obstetric salaries of those involved. Once again midwifery is in danger of becoming invisible in the employed setting.

SCIENTIA ET CONCORDIA

NEW ZEALAND MEDICAL ASSOCIATION

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

FACSIMILE TRANSMISSION

PRESS RELEASE TO:
All Health Reporters/Chief Executives/Press Officers

16 July 1995

JOINT STATEMENT FROM THE NEW ZEALAND COLLEGE OF MIDWIVES AND THE NEW ZEALAND MEDICAL ASSOCIATION

CONCERN FOR THE MATERNITY SERVICE

Doctors and midwives are unified in their concerns about the newly released RHA proposals for maternity services. They will reduce women's choice and compromise safety.

The New Zealand College of Midwives and the New Zealand Medical Association believe the agenda is to shift the costs of the public health maternity service onto the individual women's GP and midwife and away from the Government.

"Underfunding maternity services puts women's choices and safety in jeopardy and makes co-operative care difficult to achieve. The women's ability to choose both her own doctor and her own midwife will be under threat" says Karen Guilliland, National Co-ordinator of NZCOM.

Dr Philip Rushmer, Chairperson of the NZMA Maternity Services Committee, also believes the current proposal risks unnecessary disruptions to the maternity service. "We believe the contract will actually mean a step backwards in time to where there was no choice of caregiver and women received care under the CHEs terms rather than on their needs", he says.

"Over the last five years GPs and midwives have improved women's choices and family involvement in their own childbirth experience", agrees Mrs Guilliland. "This range of choices has forced hospital management to change the way they provide care to better reflect what women want rather than what suited the system", she said.