" Impedors + Facilitators "

THE DOMINION

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# Window dressing

NEW ZEALANDERS should feel relieved to know that at last they have their very own Bill of Rights.

It would be safe to conjecture that most do not. If anyone is giving the bill any thought at all, it will be to wonder why the Government went to so much trouble over the past five years to achieve so little.

The classic statements of rights and liberties have generally been forged in the heat of conflict as popular movements challenged despotic rulers. The British Bill of Rights, the United States Constitution, the French Declaration of the Rights of Man and of the Citizen — these documents changed the relationship of the citizen and the state.

New Zealand's Bill of Rights, by contrast, comes as the limp gift of an eight-vote majority in Parliament to a people who never asked for it, and who will be nonplussed to know what difference it makes. The elements that would have given it real teeth — its status as supreme law, entrenchment, and judicial power to strike down laws that contravene it — disappeared as the bill progressed through the House. So did all reference to the Treaty of Waitangi.

That will undoubtedly spare the country endless litigation. But the residue has all the sparkle of cold dishwater.

The bill solemnly assures us, for example, that we have the right not to be deprived of life — how grateful we must be — "except on such grounds as are established by law and are consistent with the principles of fundamental justice". What Parliament giveth, Parliament taketh away.

The right to life surely depends on the inherent dignity of the human being, which is beyond any Parliament to confer or remove. The bill would have made a more useful contribution if it had come to grips with the contemporary concern about the right to die.

But this bill is not about breaking new ground. The disabled, the aged and homosexuals hoped in vain to be added to the list of groups it is illegal to discriminate against. The bill simply rounds up such existing laws as conveniently fit — like freedom of association, the right of New Zealand citizens to leave the country, freedom to impart information and opinions "of any kind in any form".

If the words mean what they say, the bill would end compulsory unionism at a stroke (because freedom of association is meaningless without the freedom not to associate).

FEATURES

Doctors' exclusive right to deliver babies ended last week when the Nurses Amendment Bill became law. JOHN CROWLEY argues that it is in the mother's best interests to be cared for by both a doctor and a midwife.

# Midwives merit equality

THE Nurses Amendment Bill, passed by Parliament last week, means midwives can deliver babies independent of a doctor.

The equality, in many ways, is justified, because it is the midwife who normally spends the long hours of labour with the mother. The doctor, who does the occasional visit in labour, comes in at the crowning moment, gets the credit and is paid more.

Certainly the midwives should get paid as much as the doctor, but it is to the advantage of the mother to have both doctor and midwife throughout pregnancy, labour, birth and the postpartum.

A doctor cannot do without a midwife. But can a midwife do without a doctor?

New Zealand's maternity services are unique. A woman having a baby in New Zealand is cared for by doctor and midwife.

In the United States, where most of the medicalisation of birth comes from, it is doctor-only care and in Holland and Sweden, it is midwife only care.

How good is the maternity care in New Zealand? Results are measured by the number of babies surviving. In the past it was the number of mothers dying. That is now rare, though mothers still die in childbirth in New Zealand.

The most accurate cross-country comparison is of deaths during the first week of life (see chart).

New Zealand is among the best places in the world to give birth to a baby.

It is among the worst to rear a child in the first year of life, with a cot death mortality three times that of Sweden. We are, at age one year, 21st after Puerto Rico and Hong Kong. But there is no evidence that changing birth practices affects cot death numbers.

Quality assurance has been a strong feature of the care of mothers and babies for many years. If a mother dies in childbirth, an assessor — a senior obstetrician — goes to the place of the birth and prepares a detailed report setting out the quality of care, or lack of it.

In New Zealand every new baby is reported and regular comparisons are made between districts. Hospitals have regular meetings to discuss perinatal mortality meetings.

Every baby death is reported on with the people involved present and it is sometimes a humbling experience.

Midwives, by law, must be part of this quality control. A home birth can easily slip through this checking net. To leave it to area health boards is not good enough.

A general practitioner cannot carry out certain deliveries — a breech baby or a diabetic mother — without seeking specialist help.

In Holland midwives have to refer complicated cases for approval. This needs to happen in New Zealand if mother and babies are to be safe, and the list must be regularly updated.

Could a midwife take a severely toxemic mother out of hospital and lose the baby and perhaps the mother as well? There appears to be nothing in this new law to prevent that.

A mandatory referral list should be prepared and updated by the College of Obstetricians and College of Midwives each year. But it must be more than a wish list, it must be mandatory. There are rogues in every profession.

New Zealand has had excellent midwives, but with the closure of the St Helen's Hospital, midwife training takes place in the largely theoretical polytechnic. I have encountered a fully licensed midwife who has never seen a breech birth or twins delivered.

New Zealand's present live birth status among the first three or four in the world, is not the result of good luck but the result of constant awareness and hard work. In under-developed countries where the measure is maternal death, millions of women still die in childbirth, and this underlines the fact that childbirth cannot be relied on to be normal.

A women needs two professionals present at a birth because:

☐ There are two patients — mother and baby. With a mother who is bleeding and a baby that won't breathe, even a midwife and a doctor may not be enough.

☐ If complications arise there is not enough time to call a doctor and get the patient to hospital. If the midwife has done all the antenatal care, the doctor may know nothing about the patient.

☐ Doctors may not get to the birth at home in time, but midwives don't always either. The patient at least has one or the other who should make it.

☐ With the equality of midwife and doctor, the patient gets a balance of care.

☐ Complications can arise very rapidly. Ergometrine which is given to control postpartum hemorrhage, can cause severe hypertension, convulsions or coronary artery spasm.

☐ Eclamptic fits come out of the blue and a sudden eclamptic convulsion is a major complication.

On the one extreme, the doctor may induce unnecessarily, give pain relief before it is needed, use forceps before needed or do an unnecessary episiotomy.

On the other hand, the midwife may delay pain relief or let labour go on too long before rupturing membranes. He or she may leave the head on the perineum for too long and let a tear occur rather than do an episiotomy, or may not induce labour in the belief that all labours eventually start without stillbirth, which is not true.

But if both are equal the patient gets care balanced between the midwives' "normal" and the doctors' "enough is enough".

In the maternity department in which I work, we introduce five new doctors every nine months to obstetric training as general practitioners. We tell them that our midwives are their basic teachers and it has proved to be an excellent system.

These young doctors are most enthusiastic about the direct obstetric teaching, and about a midwife's ability to stay with mothers in labour and to be all things to all people, in different cultures, races and the multitude of approaches to birth.

Having midwives teach doctors has been highly successful and lays the background for general practitioners and midwives working together to care for mother and baby.

Under the old system when a baby was delivered at home the midwife and doctor were both paid. From now on they will be paid equally.

Only 1.7 per cent of births occur at home. The numbers choosing midwife-only care in hospital are likely to be small if a study in Victoria applies here.

It is to be hoped that a women will be not forced to choose between her midwife and her doctor by a rule that says only one of them will be paid, as occurs in Holland. The continuation of the present home delivery principle, where both are paid, is essential if the mother's free choice is to operate.

If parliamentarians want to help the women of New Zealand they must allow for a midwife to every woman in labour.

Where a midwife has the time to be with the mother throughout labour and delivery — and that does require a person whose instinct is to be a genuine midwife — the percentage of mothers achieving normal birth is greatly increased, there is a reduction in pain relief and in instrument birth.

A mother and baby need both doctor and midwife to care for them in childbirth.

Midwives are fully entitled to equality with the doctor by virtue of their contribution. We must not go backward by placing the midwives in isolation.

New Zealand has the best of both worlds with midwife and doctor at birth. Do not let us separate them. If competition, professional distrust and dislike separate doctor and midwife, who will pay the price?

☐ *John Crowley is chairman of the Department of Obstetrics at Palmerston North Hospital.*

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**Baby death during first week of life (Rate per 1000 live births)**

1. Norway (1986) 3.2
2. Sweden (1986) 3.3
3. Denmark (1985) 3.5
4. New Zealand (1986) 3.9 (1987) 3.3
5. England and Wales (1985) 4.3
6. Australia (1985) 5

LETTERS