20073-13-049

MEETING ON THE NURSES AMENDMENT BILL, HELD AT 4 ST.STEPHENS RD, PARNELL
17 November 1989, at 8 pm.

PRESENT: Sally Liggins, John Hilton, Phil Railton, Carolyn Young, Maggie Crocker, Jenny Macdonald, Joan Skinner, Rhonda Jackson, Sian Burgess, Veronika Muller, Sarah Hodgetts, Mary Hammonds, Graham Gulbransen, Monica Usac, Brenda Hinton, Kate Jaunay, Sarah Macleod, Marjet Pot, & Janet Thomas.
APOLOGIES: Di Nash, Sean McGarry, Linda McKay.

INTRODUCTIONS and individual statements of intent and concern.
Sally Liggins explained her role as facilitator, the ground rules, and we set a finishing time of 9:30.

Sian: It would be great if this meeting could produce a submission.

Carolyn: The most important piece of the submission would be to say that "the woman has the right to choose a midwife and /or doctor" the 'and/or' is the thing.

Sian: If two midwives attend a birth they should both get paid, without having to justify the reason. There should not be a list of criteria of risk.

Joan: In the past a midwife was paid a pound if she attended a birth with a doctor and 2 pounds on her own. There should not be any disencentive to calling in help.

Sarah: I'm surprised that the WHO definition of a midwife as an autonomous practitioner was not known by the g.p.s at the previous meeting.

John: I see the rlationship of drs and midwives as a partnership. It should not be adversarial.

There was a digression then into discussion of the disparity of rates of pay between drs and midwives, and how it was accepted (as something for midwives to complain about, etc.)

Phil Railton: I feel that it is important for gps to continue the antenatal care, so that they can screen out unsafe or risky births from the homebirth option.

Carolyn: But it is important for women to be allowed a trial of labour, as sometimes the ones who might have been considered unsafe risks are quite able to give birth successfully and naturally at home.

Mary: I agree with the idea of screening, but I feel that midwives can be just as capable of doing this as gps. Perhaps if the woman were to see the gp early in pregnancy and again once or twice later on, the rest of the antenatal checks could be done by midwives. There are women I would not accept for a homebirth booking after my first antenatal visit, because of attitude, or lack of support, etc.

Joan: If there was an upgrading in the skills of midwives, they could be more able to do things they now have to call in gps for, e.g. use of IV drips, suturing of tears, etc.

Janet: It would be best if the majority of care in labour is provided by the antenatal caregiver, whoever it may be. But gps would be unable to spend so much time with labouring women, so it would be more likely the midwife.

Mary: The woman should have the choice of having the gp for the antenatal care and a midwife for labour as now, or whatever combination she needs.

John: There are two separate areas of concern here: 1) the hospital midwives, who have had a bad deal so far, the handmaidens of the doctors, at the mercy of the registrars, obstetricians, etc, who will rejoice at the coming of autonomy; and 2) the domiciliary midwives, who have led the way, with the HBA to the changes of the rules. I feel there is a hidden agenda of the midwives to push the gps out of the homebirth area. I think the ideal would be to make the gps the hub of family-centred health care, with the partnership continuing with midwives providing their

unique attributes, their acumen and sensitivity, etc. and the doctors providing hospital knowledge and skills.

Graham: speaking for Sean McGarry: He favours autonomy but feels every birth should be attended by two professionals. The gps could see the mother 3 times antenatally, at an early stage, for the general physical checkup, and at 28 and 36 weeks, and the midwives could do the other visits.

Graham: After reading Joan Donley's book and Michel Odent I sometimes question the appropriateness of men in birthing. I am doing homebirths partly for political reasons (to ensure there is choice for women) and partly to apply my skills (at resuscitation, suturing etc.), to be a second opinion, and to be a liaison between the hospital and mother when necessary. I prefer more than one practitioner at a birth, would not be comfortable doing births on my own, but would not like to be called upon only during an emergency; that would not be fulfilling.

Phil: In the options for low-risk pregnancies the gp takes the middle ground between midwives and specialists. With autonomy, won't the gps just be squeezed out?

Sarah: In the midwifery unit I worked in in the U.K., we only brought in the gps for things we couldn't handle ourselves. And the specialists were only called for the most seriously abnormal births.

Sian: Marsden Wagner of the WHO says that places where there is a healthy O & G society, you find the morbidity and C-section rate is very high. I think we'll find the strongest opposition to this amendment from the O & Gs. Perhaps if we increase all our skills we can put the O & Gs out to grass. ...sometimes a doctor at a homebirth is a liability, if they are not keen on what is happening or want to interfere.

Carolyn: The problem with having only a single practitioner at a homebirth is that there can be a time-lag in getting the extra skilled help: in hospital you can call someone from the ward upstairs or down the hall, but in a home it will be different.

Sarah: In order for this to work, there must be a sharp increase in the number of midwives trained. Now there are about 300 new doctors each year, and only about 100 new midwives. In a while, with attrition, there just won't be the midwives to go round. And without midwives to be at labours, gps won't be able to do homebirths.

BRAINSTORMING SESSION resulted in the enclosed list of requirements.

Following the brainstorming, a committee was set up, consisting of John, Sian, Mary, Sarah, Carolyn and Joan. They will meet to begin work on the submission from gps and midwives, and report to the next doctors and midwives meeting.

There was then discussion of why the AHBA will not be part of this submission: because they have always done independent submissions in the past, though are quite prepared to endorse other submissions. Also in the interest of influencing a select committee of parliamentarians, the more submissions containing similar recommendations the better, to give the impression of a groundswell of public opinion.

Meeting closed at 9:45 pm.

IDEAS FROM THE BRAINSTORMING SESSION

Train more midwives

Extend the role of g.p.s, reduce the role of obstetricians

Secondary careggiver to be called at the discretion of primary caregiver

Woman can choose doctor & midwife, doctor only, midwife only for antenatal and labour care

Midwife can choose to involve a doctor

No financial disincentive for the above

Midwives taking on more antenatal care

Midwives having direct referral to base hospital, access to ambulance, direct referral to obstetrician, paediatrician or other specialist

Upgrade midwives and doctors education and skills

Pay equity for midwives and doctors

Provision of equipment for homebirth practitioners

Provision of home-help for mothers post-partum

Access to medical laboratories for midwives

Number of antenatal visits at the discretion of mothers and caregivers

Payment for 2 people attending birth

Option for woman to have 2 birth attendants as of right

Referral to hospital under midwife's care

Recognition of uniqueness of Home birth

Improved pay for doctors and midwives

Continued role for g.p.s in birth

Free transport to hospital with transfers

No bar to solo practise

Domino scheme

Better access to drugs & other facilities for midwives

Contracts with Area Health Boards

Requirement of doctors to respond to call-outs (e.g. Coromandel homebirths)