20073-220-003

Auckland Home Birth Association Inc.
P.O. Box 7093 ▲ Wellesley St. ▲ Auckland

HOME BIRTH WHANAUTANGA

A SAFE ALTERNATIVE

Dear Midwife,

We are currently lobbying the Minister of Health regarding two recent demands by the College of Obstetricians and Gynecologists and the Medical Association.

1. That national protocols regarding care during the childbearing cycle be adopted.

2. That the Nurses Amendment Act be repealed so that the legal requirement for medical practitioner to have overall responsibility for each women's care is reinstated.

To assist us in presenting our opposition to these demands we need you to:

1. Read through the attached "Guidelines" from National Women's Hospital and send us brief profiles of women you've cared for recently who had successful home births who would have been obliged to be under the care of a specialist had these guidelines been protocols.

2. Names, address and phone numbers of women who have had midwife only care who you think would be happy to write a brief note about why they chose this option and how satisfied they were with the care received.

Please send us this by the 6th of December.

Thank you.

Regards
Home Birth Assn. committee.

Te Puuri Oranga O Tamaki Makau Rau

Green Lane/National Women's Hospital

Green Lane West, Auckland 3, N.Z.

TELEPHONE
Green Lane 0-9-689 909
National Womens 0-9-689 919
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YOUR REFERENCE - GL 91

IN YOUR REPLY PLEASE QUOTE

Address reply to officer whose official title appears below signature.

D R A F T D I S C U S S I O N D O C U M E N T

25.07.91

GUIDELINES FOR OBSTETRIC CARE

AUCKLAND AREA HEALTH BOARD

GENERAL

1. The individual responsible for a patient's care must be clearly recorded in the notes at all times.
2. An antenatal record should be held by the patient, carried by her to all visits to care givers, and brought with her at the onset of labour.
3. Identification of non-obstetric risk factors requires that all pregnant women should have at least one formal history and examination by a medical practitioner with obstetric training and a Board contract.
4. Once referred, the specialist will
    1. discuss with the primary care provider when necessary,
    2. decide on the appropriate level of subsequent care,
    3. provide a clear management plan,
    4. clearly indicate the need for additional specialist consultation for those patients referred to the primary care provider; and
    5. document the above in writing.
5. Referral in all situations should be as early as possible to encourage early risk identification and allow formal planning of subsequent care.
6. Antenatal inpatients should be under the care of a public hospital specialist.
7. The below list comprises those situations where a consultation by an obstetric specialist is required.

A. Consultation in Early Pregnancy (Booking)

Age >39 or <18 years
Weight < 50 kg
Obesity (when fetal assessment is difficult)
Short stature <148 cm
Medical disease
- hypertension
- previous pulmonary emboli or thrombosis
- autoimmune disease
- thyroid disease
- heart disease
- renal disease
- diabetes
- epilepsy (on treatment)
- unstable or severe asthma
- neoplasia
- major psychiatric disorder
- haemorrhagic disorder
- multiple sclerosis
- significant respiratory impairment

Substance abuse
Previous
- caesarean section
- uterine, major cervical or vaginal surgery
- perinatal or intermediate fetal death
- growth retarded babe (<10th percentile)
- difficult labour or delivery, eg shoulder dystocia
- severe proteinuric pre-eclampsia
- premature delivery (<35 weeks)
- PPH requiring transfusion
- baby requiring active resuscitation or child with brain damage
- puerperal psychiatric disorder

Recurrent miscarriage (3 or more)
2 or more terminations of pregnancy
No antenatal care prior to 34 weeks

B. Consultation during Pregnancy

Recurrent bleeding prior to 28 weeks (2 or more episodes)
Fetal abnormality
Gestation 42 weeks and beyond
Hypertension (>95mmHg diastolic) without proteinuria at any time
Hypertension with proteinuria
Antepartum haemorrhage
Polyhydramnios
Oligohydramnios
Anaemia (< 80g/l)
Unstable lie or malpresentation after 36 weeks
Multiple pregnancy
Intrauterine growth retardation (or suspected)
Suspected disproportion/large baby
Abnormal glucose tolerance test
Rhesus antibodies
Assessment for induction
Preterm labour <36 weeks
Fetal death

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C. Consultation in Labour

Non cephalic presentation
Fetal heart rate abnormalities
Thick meconium liquor
Prolonged rupture of membranes >24 hours
Failure to progress (>4 hours at any dilatation, >1 hour in second stage)

D. Consultation in Postnatal Period

Placenta undelivered after 30 minutes
Third degree tear
Primary PPH not responding to initial therapy
Secondary PPH
Puerperal psychosis
Neonatal death

E. Paediatric Consultation

All newborn infants should be examined within 12 hours of birth by a medical officer.

Immaturity (<36 weeks gestation)
Low birthweight (<2500g birthweight)
Birth asphyxia (severe depression, eg 5 min Apgars <6, sustained hypotonia
Apnoea or respiratory distress, persistent or recurrent cyanosis, grunting or tachypnoea
Meconium exposure
Jaundice - early onset jaundice (first 36 hours)(>120)
- bilirubin >280 anytime (term baby)
- prolonged jaundice (>3 weeks)
Bile-stained or persistent vomiting
Abdominal mass or distension
Persistent fresh blood in stools
Suspicion of oesophageal atresia or tracheoesophageal fistula
No passage of meconium by 36 hours
Definite feeding problems
Convulsions
Irritability
Lethargy

Prepared by mixed professional group 25 July 1991

Midwife Bronwyn Cox

General Practitioners Lee Nixon
Tony Hay

Obstetricians Lesley McCowan
Neil Buddicom
Neil Pattison