THE DOMICILIARY MIDWIVES NEWSLETTER.

OCTOBER 1989

Domiciliary Midwives Society of New Zealand.

DOMICILIARY MIDWIVES WEEKEND 1989

November 24 / 25 / 26

at **Riverside Community**

in sunny Nelson.

We never get enough time to talk

when we get together at the annual

Home Birth Conference

so

come and talk,

socialise,

share experiences,

share knowledge,

and generally have a good time!

Hostel accommodation - bring your own bedding - all meals provided

Cost: $25

Further details and booking contact:

Bronwen Pelvin
Riverside Community
R.D. 2
Upper Moutere
ph: (0524) 77 807

OPEN TO ALL DOMICILIARY MIDWIVES

Domiciliary Midwives Society of New Zealand.

Secretary: Bronwen Pelvin

Riverside Community
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Upper Moutere

ph: (0524) 77 807

October 1989

SECRETARY'S LETTER

Well, here I am on Labour Day, at the beginning of Home Birth Week, writing this. Highly appropriate even if well overdue!! You may all be wondering what is going on in the world of domiciliary midwifery - despite my silence, all is ticking over nicely.

.....Since my rather public stand in 1988, when I attended the home birth of a women who did not have a "medical practitioner taking responsibility for the care of the patient", my practice has gone ahead and 1989 will be my busiest year ever. I have since attended about three other births without a supervising doctor and I have been paid for them as well! The situation in Nelson is now that when I have a woman who cannot get medical support for her home birth, I notify my PPHN and they attempt to find someone to cover. In reality, this has meant the woman writing to the PPHN and describing her attempts to obtain a doctor and to state her intention of staying at home to give birth. I then make it clear that if that woman calls me when she is in labour, I am obligated, both professionally and ethically, to attend her. The reason that this series of events occurs is that I have never been lucky enough to have a MOH prepared to cover me when women insist on staying at home. Now, after eleven years of practice, I have lost the last G.P. in Motueka who has been covering homebirth. It seems that Nelson district G.P.s are particularly susceptible to peer and O&G pressure and the number of G.P.s willing to attend home births has gradually dwindled over the years. Roll on autonomcus practice, that's all I can say.

.....Both Joan Donley and myself have represented DMs on the Department of Health working party for Safe Options for Low-risk childbirth. First thing the group I'm in did was change the title! So its now Policy Recommendations for Care for Pregnancy and Childbirth. Much better! A number of you will have seen the Sixth draft of the document and have commented. I didn't send it to absolutely everyone because of the time pressure we're under to have comments back to Wellington. Hopefully, the rest of you will have at least heard, if not seen, the document through the College. Anyone who hasn't and would particularly like a copy, could get in touch with me. The final meeting is in Wellington on November 15th after which it will be presented to the Minister for her approval.

.....I hope all of you are getting involved with the College of Midwives at your local region. I know that domiciliary midwives have a lot to show the others about midwifery perspective and practice. There seems to be real thirst for knowledge amongst midwives, especially for knowledge not based on the prevailing medical model of childbirth. Even amongst DMs there is a real hunger for information and I was really aware of a need for time to share and discuss cases and experiences at this year's annual meeting in New Plymouth. So to provide us with an opportunity to get together, I have booked the hostel here at Riverside for anyone who would like to come and socialise and share. It will be a weekend just for us - I will need to know who is coming by November 20th so I can organise food etc. The weekend will start about 6pm Friday evening and go until Sunday or Monday - whenever evryone has left!! So think about joining in and let me know if you want to come. If there is enough interest I will organise discounts through Air New Zealand for those who are flying but if you book soon, you will be able to get cheap air fares. So, ring me (0524) 77807 and I'll book you in.

.....Changes to the Nurses Act: The Nurses Act Amendment Bill has been drafted although it has yet to be presented to Parliament. It amends Section 54 to read ".....where a medical practitioner <u>or registered midwife</u> has not undertaken responsibility for the care of the patient. I'm waiting for it to go to

Select Committee and then I'll present a submission supporting it. Individuals need to present submissions too so get your Home Birth Association members and sister midwives to write in as well just to counteract all the negative stuff from the medical and nursing professions. And if you're worried about being independent, autonomous and accountable - come to our weekend in November and let's talk about it!

.....Domiciliary Standards Review Committees: How are you all going with establishing one in your area? Committees are now up and running in Auckland, Whangarei, Rotorua - anywhere else? Let me know. I have copies of the document describing the terms of reference of DMSRCs plus domiciliary standards additional to Standards of Midwifery Practice and I will send these to anyone who wants them - just write and ask and I will try to be prompt!

.....Allison Livingstone and Kelly Grovehills are still working on our behalf to complete negotiations on our contract. It seems to me that contracted DMs are going to be in a very good position once the law changes and I imagine we'll be looking at extending our practices to incorporate DOMINO clients once we can negotiate with Area Health Boards for the use of their facilities. Great, eh?

.....Subscriptions. As you will read in the minutes of our meeting in May, subs have gone up to $50/year. The main reason for this is so that we can continue to employ Allison and Kelly to represent us for negotiations on our pay rates. Some of you have sent in subs at the old rate of $40 - you can send another $40 whenever. Heaps of you haven't sent anything at all - you know who you are!! All 1989/90 subs are due now - please fill out enclosed form and mail to me.

.....So that's all from me. Happy reading - hope you enjoy and please think about coming to our weekend here in November.

Happy home birthing!

Bronwen.

Autonomy, accountability and choice...

Sheila defines professionalism and its implications for midwifery and how choices in childbirth can enhance rather than threaten our professional role.

As a professional I believe my practice as a midwife is based on research, knowledge and experience. In the unit where I work I exercise probably more than an unusual degree of professional autonomy. I can control my own practice and make my own decisions. I am certainly accountable for the decisions I make, and the actions I take in my practice, and I wholeheartedly believe in the woman's right to choose how her care should be managed.

Does this last statement raise a dilemma for midwives? Can we as professionals allow the consumers to choose and does this participation dilute our professional status?

I would like to develop this argument further by considering Autonomy, Accountability, and Choice in turn. Autonomy is irrelevant without discussion of professionalism. Today we have professional footballers, professional plumbing, professional house painters. The word professional equates with the feeling of an expert.

Friedson (1970) says "a profession is an occupation which has assumed a dominant position in a division of labour so that it **gains control** over the determination of the substance of its own work". Additionally Walker (1978) states "A profession is an occupational group which has had more success than other occupations in controlling its own work".

A profession controls its members, regulates recruitment, selects for training, determines and evaluates the way its work is performed. A profession is based on a body of knowledge and conforms to agreed ethical standards.

In section 17(1) of the Nurses, Midwives and Health Visitors Act it states "A person other than a registered midwife or a registered medical practitioner shall not attend a woman in childbirth".

Thus professionalisation is the process by which an occupation obtains exclusive rights to perform a particular kind of work. Members of a profession, if it is a true profession, are answerable and accountable for their actions and decisions. In midwifery, the profession is controlled and regulated by the UKCC. The control exists to safeguard the standards of care and to protect the midwife.

Goodman (1978) describes autonomy as "the ability to initiate a task and do it one's own way" and the Oxford Dictionary defines it as "The right of self government and personal freedom".

I believe that conflict can arise when an individual striving for autonomy, i.e. "initiating and doing it my way", is working within the broader constraints of a profession.

It could be argued that if midwifery is a truly autonomous profession, then all the rights and freedoms associated with childbirth are the midwives' and not the womens'. If this is the case then women should be given no choice and no opportunity to select from the options available. When there is more than one option the professional may see it as appropriate for her to take it upon herself to select the method or course of action she favours or considers more appropriate. The woman would then be presented with a *fait accompli*; her opinion would be neither sought nor considered. By retaining this full control, the midwife as a professional can be confident. She has made a decision based on research, knowledge, experience and previous success. Her autonomy and professionalism is not threatened.

However, today's consumers are becoming increasingly experienced and well-informed. They are frequently articulate and more assertive than ever before. Now more and more women from all social classes and from more occupational groups are asking for their views to be considered and their preferences to be taken into account.

But where does this leave the midwife?

If she as a professional, autonomous and accountable, has

taken a professional decision based on research, knowledge and experience, is she putting herself at risk to **allow** choice?

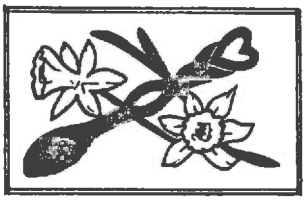
Will this midwife feel that she does not want her position weakened and her autonomy diluted by accepting a course of action that, in her considered opinion, carries a greater risk?

There is no doubt that today's midwives are accountable for their actions. The independence of the midwife in her practice is stressed in the Midwives' Code of Practice of the UKCC.

> "Each midwife as a practitioner of midwifery is accountable for her own practice in whatever environment she practises" page 1.

and

> "Present day maternity care is essentially the work of a



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team. Within the team the midwife has a defined sphere of practice and is accountable for her actions, her professional judgement and the care she gives to mothers and babies".
page 3.

Is this whole debate really about power? The feminist movement has urged women in today's society to change from their traditional role and become more assertive in controlling their own bodies, their health and their future. Is not this an attempt to redistribute power?

Weber (1985) says that power is "the probability that a person in a social relationship will be able to carry out his or her own will in the pursuit of goals of action, regardless of resistance".

I would suggest that, in most instances, the midwife is the person in the relationship holding the power. That power is upheld in hospital policies, rules, procedures and fear of litigation. The midwife may choose to impose her will on the women in her care and justify that imposition with veiled threats of "it's what doctor wants".

I would suggest that consumer choice arouses fear and conflict not because it brings into question the midwife's professionalism, but because it undermines her power in the situation. It must be seen as threatening to think that someone else (the consumer) knows as much as you!

Do we not as midwives, in league with medical men, begin to assert this power when a woman undergoing a normal physiological event is admitted into hospital and redefined as a patient. Once a woman is admitted to hospital, the responsibility for the pregnancy is taken out of her hands and placed firmly in the hands of the midwife and the obstetrician. The woman becomes a patient, becomes passive, and does what she is told. The midwives become warders rather than guests in her home.

If pregnancy is illness, then there is no place for choice or alternatives. The midwife in charge of this pathological state must dictate the rules. There is no provision for individual variations or wishes.

Hence the conflict is intertwined with the medicalization of childbirth. By making pregnancy an illness, the midwife and medical men assume control. The case is out of the womens' hands. By accepting a provision for choice and encouraging alternatives and the woman's involvement in her own pregnancy, some will argue that the midwife's control is diminished, her autonomy diluted, and inevitably her power weakened.

Perhaps you are now mumbling to yourself that you **allow** choice, you do not feel a loss of power in consumer choice, but why are many women who arrive with a birth plan labelled "eccentric, troublemakers, or NCT freaks"? Why do books such as Stanway and Stanway's "Choices in Childbirth" have to be written? It has a chapter called "Making the best of the system" and another "Drawing up a plan of action". It gives a step by step guide to being pregnant and assertive.

I feel this is a sad reflection on my profession, my image of the midwife as being 'with women' does not include fighting to beat the system.

Professionalism, autonomy, accountability and choice in childbirth are complex and vital issues that the profession must consider.

At the end of the day the midwife is responsible and answerable to the UKCC for her standards of care.

She must ensure that the advice she offers is based, not only on her experience, but on research-based evidence. She must also be sure that parents, women and partners are fully aware of the consequences of their choice. The midwife must never abdicate her professional responsibility to give advice in favour of freedom of choice. This is not the time to opt out and let the consumer decide.

I believe that choice in childbirth, far from threatening the professional status of the midwife, enhances and improves her role to womens' ultimate benefit. Choice in childbirth need not lead to a deterioration in care, it may well improve it. Midwives who are really autonomous are those who have escaped the medical model of childbirth, and who treat the medical staff as friends and equals with different roles: friends (male and female) who can be called upon when childbearing deviates from normal and becomes an illness.

A midwife who acts within her sphere of competence and follows 'the rules' has no need to fear being accountable. She is in a unique position to be 'with women' at a most precious time.

Sheila Hunt MSc *Econ*, SRN, SCM, RNT, PECE, ADM
Caerphilly

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FROM VERONIKA MULLER, AUCKLAND

SETTING UP OUR MIDWIFERY COLLECTIVE

Setting up our collective has been interesting, challenging and fun. Initially it took a fair amoung of organising, meetings, discussions and mulling over ideas. Now after six months it is working smoothly and running even better than expected. In setting this up our aims (of equal precedence) were:

- Having regular time off that is not difficult to arrange. Time when your family knew you would be with them (and not racing off to a birth), when arrangements could be followed through without interruption and when the night was ours for sleep.
- To lessen the dependence of the woman on her midwife so that they would be happy with any one of us at their birth. To encourage women to have a good support network organised and to encourage the realisation that it is her and not the midwife who makes the difference.
- To have more antenatal input, not necessarily on a one-to-one basis, i.e. run classes. These have been successful and very enjoyable - we have learned a lot from them. There is a strong emotional bias to the classes in which women feel free to discuss things and in which we can stimulate a philosophy of independence and courage for birthing women. These also fulfull the need for the women to meet and get to know all three of us.
- More peer contact, sharing and support. We meet weekly for 1½ - 2½ hours before each class. In this time we sort out jobs, organisation and next classes. We allow plenty of time to discuss problems, worries, successes and share things we have learned along the way. Our various areas of strength/knowledge have been very complimentary and we make sure we discuss any hiccups. This time is invaluable. The knowledge that there is another midwife to help should any one need it has made the job a lot less stressful. Our collective arrangement has brought about a much greater feeling of caring for, and sharing with, each other and has enabled us to call upon each other more easily.

We started working on our idea about six months before we started our roster. From that point on we told all women booking of our arrangement, the roster, classes, etc. First we all stated our ideas and needs of this arrangement - these boiled down to mutual support, more antenatal input and quality time off. We agreed upon two days off a fortnight. In retrospect we should have taken three x two days per month or even two days per week. We set up the roster taking time off where appropriate (birthdays, holidays, etc.) excluding Mondays as these were class days. (We forgot that quite a few holidays fall on Mondays!) We made a calendar for the classes. We worked on specific points we wanted to cover in our information leaflet: (We have kept it as concise as possible.)

THE LEAFLET

Cover page (coloured) headed "This is an information leaflet about Sian, Rhonda and Veronika" with a central logo and on the bottom "Please read thoroughly" and "Check the roster when you are in labour".

How we work: A brief note on why we set up this co-operative with a passport sized photo of each of us. (First page)

Support people: We have increased our emphasis on the woman setting up a good support system for herself and family, during the labour and afterwards. We have been specific about what we think support people need to do (have a good relationship, help with food, cleaning up, etc.) We also discuss this at the third class (including visitors, help with children, postnatal support, etc).

Accompanying midwife: If there are no support people and one is needed, if the labour is long and we are exhausted and/or feel another midwife may improve the outcome we want to be able to freely call another midwife. We point out that only one midwife is paid by the Government.

Children: We have five between us. That we aim not to bring them to births but that they may come on occasional postnatal visits.

Phone calls: (takes almost a whole page)
DAYTIME - contact your midwife as soon as you know you are in labour.
NIGHTTIME - ring when you need your midwife to come.
Let your midwife know of any plan, changes, emphasised urgent calling instructions, best times for non-urgent calls, feel free to ring anytime, beep if phone is engaged too long, call one of the others if you cannot contact your midwife.

Roster key: and clear explanation of off call times.

Classes: (also takes a whole page)
Objectives: to meet all the midwives, meet other pregnant women, focus more deeply on the emotional side of giving birth and working on physical preparation. Format, venues, times, cost and a table listing dates (i.e. if you are due in July your classes will be May 6, 13, 20 and 27 - they start attending at about 32 weeks.

We also suggest that women go to exercise-for-pregnancy classes if they desire as we do not have enough time for this. We do a little stretching and a breathing and relaxation time. It is tempting to do more classes rather than just the four and include more exercise. Most of the time is spent in discussion. The two daytime classes are for women only and the rapport built up over these two classes runs into the larger classes with partners and support people. The women often say how much they enjoy this format. Even though we are steering the class and making sure various aspects are covered we are also very much part of the group and it takes us off our pedestal. The women are sharing more than they do on the one to one client/midwife basis.

At the second class we show videos (Active Birth, Channel for a New Life and Midwife) and discuss them. We repeat these in the hour before the third class so that partners are able to see them (we are having a meeting nearby). Also at the third class one of us collects a list of women for the next series of classes and sends them an invitation letter reminding them of time, venue, dates, etc. The $10 per class cost covers room hire, postage and printing costs and very little else.

We have standardised our work in various ways. When women ring to book we explain the co-operative to them and invite them to the classes (we have thought of having an early pregnancy class). We send them an envelope with four items: our information leaflet, the Homebirth booklet, a Homebirth Association registration form and our own one sheet obstetric record for them to start filling out. At the first visit we leave all the necessary papers (records, birth notifications, etc). We complete and take with us our own obstetric record which we copy (with permission) for each other so that we have a record of all the women. This sounds complicated but runs smoothly.

At 36 weeks we do a final home visit to make sure the woman, her partner and support people are completely comfortable with arrangements, all questions are answered and worries discussed. We check that they are conversant with the roster and midwife calling procedures.

When actually covering for each other we call with brief details of who is due, overdue and who needs postnatal visits. (We generally only let the midwife know if births or important events have occured when she comes back "on".)

We fill out a claim (H555) form when the work is done and leave it in the woman's notes. The primary midwife sends this in when she does the woman's claim. Little cheques arrive every now and then. We book our own women and we only care for each other's women while covering. We include any births we do in our own registers and do HBA and DMSRC statistics.

Now that Veronika is pregnant Sian and Rhonda are working together. In 1990 they are going to continue a similar pattern but will take off two days each per week.

from Terryll Muir in Lumsden:

Ihad a birth recently I'd like to share and would appreciate some feedback from you or other midwives.

Christine was having her 2nd baby and opted for a home birth. Her 1st child was born 10 years ago and she had been infertile since.

Her 1st pregnancy went to 43 weeks when she was induced, followed by epidural, forceps etc. This 2nd pregnancy had been conceived while on fertility drugs and under obstetrical care. You can imagine the obstetrician didn't think she was being very "sensible" when she refused a scan and told him she wanted to have this baby at home.

Anyway, I'm pleased to say she stood up well to all this pressure even the old "I'd hate to see anything happen to this precious baby after you've waited for so long" from GP, obstetrician and some so-called 'friends'.

The pregnancy proceeded really well and we were all very confident.

As 42 weeks approached, we were all getting a little on edge as the doctor concerned was adament that that was all he'd allow her to go.

The baby felt quite large but everything seemed OK. 42 weeks came and fell on a Thursday. She managed to persuade him to wait the weekend. We had tried most things we knew of: nipple stimulation, sex, avoiding fish, eating oysters, castor oil, homeopathics but no luck. We were getting niggles but that was about all.

Christine was sick of trying and resolved that it was in God's hands and what would be would be. She was to go into hospital 9am Monday.

On the sunday, I happened to be reading something Joan had written about inserting Evening Primrose

Oil vaginally which works as a natural prostaglandin. I rang Christine who happened to have a jar at home.

How many do we use? How to insert it? Rae Abraham suggested soaking a tampon. Christine found only one in the house! She cut open 4 (capsules) into an egg cup and soaked the end of the tampon. It was about 10pm on Sunday night when she inserted it. By 1am she was in labour and 5am fully dilated, 6.15am she delivered a beautiful healthy 10lb 13oz girl with a head circumference of 38.5cm! The delay in 2nd stage was aided greatly with a positional change from kneeling to standing and in the last stages, squatting.

Neither the placenta nor the baby looked overdue and Christine was really pleased with the outcome as we all felt, had she been in hospital, things would have run along similar lines to her first pregnancy.

The Evening Primrose Oil seemed to do the trick and I'd be interested to know of anyone else having used it.

(So would I - Bronwen.)

World's most fertile mum!

AMAZING MUM . . . Leontina Albina with just a few of the 59 children she has given birth to.

LEONTINA Albina is the world's most prolific mother — she's given birth to a mind-boggling 59 children, all of them twins or triplets!

And incredibly, four of her children — two sets of twins — were born to the 62-year-old woman in the past three years.

Most of the children are grown up but 13 still live with their mum and dad in a squalid two-room shack in Colina, Chile.

The home has no running water, no bathroom and dirt floors . . . but Leontina says she's happy because there's plenty of love inside.

The amazing mum, whose claim is backed up by the Guinness Book of World Records and a Chilean vital statistics official, told new Truth:

"It seems as if I've been pregnant more times than not in my life — and I'm ready to have more children if God sends them to me!"

Leontina's husband Gerardo is the proud father of all 59 children.

"The first children were triplets, all boys, born when I was still 12.

"My labour was long and difficult, but when I held them in my arms I forgot all about the pain.

"Neither they nor any of my other children were born in a hospital. Some were born at home and some on the family cart.

"Other times I'd go out in a field, raise my arms and hold on to a tree limb when I felt contractions to make it easier for the children to come into the world.

"I've always been too busy for doctors.

"I really don't remember all of my children's birthdays and where they all live. It's simply too much information to keep in my head.

"And several of them have the same names! I just couldn't think of anything original at the time of their birth.

"For example, I have three Susanas, three Miriams, two Estrellas and two Soledads."

Forty-eight of her children are still living. The other 11 died at birth or in an earthquake, she said.

DIFFICULT

The tiny home she now shares with her husband and 13 children, ages 21 months to 18 years, has only six beds.

At night the family spread four mattresses on the dirt floor.

"Our table seats only six, so we take turns eating."

Making ends meet is difficult, she admits. Her husband, a retired municipal worker, receives a pension of only $196 per month.

They also get a government subsidy for each child under 18, but it amounts to only $3.50 per child per month.

To earn extra money, she and her husband buy wool from a factory and sell it from their cart — but that brings in only $6.50 to $13 a day, all of which goes for food and school supplies.

Domiciliary Midwives Society of New Zealand.

MINUTES OF MEETING HELD 12TH MAY, 1989.

34 midwives present(!)

Sian Burgess facilitated.

Bronwen Pelvin secretaried.

Secretary's report read and accepted.

Matters arising: Letter to NZ College of Midwives authorising use of word 'Midwives' in their title.

Agreed that the Domiciliary Midwives Society affiliate to the New Zealand College of Midwives.

Midwives' reports:

Sian Burgess, Auckland: Good year, has organised a collective practice with 2 other midwives.

Veronika Muller, Auckland: Has had 6 months off. Good to be part off collective and have time off and not worry; running antenatal classes with other midwives in collective, charge $10/person/class. Midwives meet weekly before classes, do claim forms then.

Jenny Johnston, Wellington: Good year; has lost woman GP who's been doing homebirths for 10 years. Acknowledges "my need to be with people"; finds it hard to give up cases and have time out/off.

Jan Klausen, Rotorua: Started last October but doctor pulled out at last minute from supporting first case in Taupo; Has had 2 primips since; Support from Anne Sharplin at Papamoa; lack of confidence re blood loss and managing breastfeeding. Has organised for hospital aids to do home help for 2hours/day for home birth mums and a nappy service as well! Paid for by Area Health Board.

Kali Judd, Rawene: Lay midwife practising for 6 years in response to women in area staying at home either not acceptable for home birth or not wanting established midwives. DMs in area restricted to 10km radius around hosptal. MOH mounted witch hunt this year; threatened to prosecute; now not going to. Would do direct entry training if available.

Feliz Barnett, Whangarei: "10 months of being somewhere between centre channel and shore on a swift outgoing tide." Withstood complaint to Nursing Council; felt most violated as person and midwife with Nursing Council procedure - complainant not known; statutory bodies are now subject to Official Information Act but weren't at the time. So grateful for all support - can't express. Nursing Council hears complaint only - does not resolve. Chief Nurse accepted no reponsibility for her staff member; Principal Nurse facilitated meeting between Feliz and complainant - Feliz was "not careful for a few minutes" asked for and received written apology. Otherwise okay; 28 births and 8 transfers.

Lynley MacFarland, Whangarei: Part-time covering for Feliz. Feliz gained tremendous respect in the system through her ordeal.

Ruth Pouly, Rawene: 3 homebirths inarea; only attended one. No work at Rawene hospital - no on call, no domino option.

Jenny Woodley, Auckland: 25 deliveries; 4 supportive GPs; student midwives following through cases.

Jane Sykes, Masterton: Parent Centre is support group; bookings have increased 250% on last year ! 6 supportive GPs; no problems with transfers; now working part-time at hospital; mums get nappy service; is paid for transfers. Marion Griffiths now contracted for back-up; telepager a big plus. One cot death; extending area.

Chrissie Sygrove, Kaitaia: Lots of negative comments from staff at Kaitaia.

Elizabeth Carlaw, Hamilton: Now set up for practice.

Jan Stojanovic, Otaki: Working part-time in Levin. One booking; 6 supportive GPs Home birth group.

Mary Garner, Wellington: Prof Hutton declared "no home births on the Kapiti Coast" ! Intense politics this year; now 6 supportive GPs.

Anne Sharplin, Tauranga: 100% increase. Had to transfer very flat baby with meconium inhalation and mother with retained placenta. Has done 130 early discharges/PN care. Te Puke has closed. 3 supportive GPs. One used prostin pessaries at home. Has O_2 and flow meter. Back-up and cover from elen Parsons. Home birth group strong; paid home help; free linen pack.

Mary Hammond, Auckland: Clear about leave and cover - learning to "let go". "Standing tall" in hospital. Dealing with all problems not just 'failure to progress'. Surveyed doctors, held meeting - GPs indicated support. Colin Mantell said no need to educate re homebirths for Dip Obs. Talked to him about it and Jenny Woodley asked to speak.

Anne Brown, New Plymouth: had a year off, otherwise 12 births. Doctors a problem; small hospitals closing. No legal cover for one birth - covered by Social Security Regulations.

Jane Marshall, Hastings: Stable interest, growing in Napier. Mucking around with contract. Vit K being pushed.

Elizabeth Walker, Dannevirke: Contract through, has attended one birth.

Ruth Martis, Palmerston North: Wanganui now has Home Birth Association and 1 GP. One birth in Pahiatua. Palmerston North carries on as usual.

Jan Gargen, New Plymouth: 4 Home births; one domino.

Maria Ware, Christchurch: Independent Midwives Service doing early discharge service. Closing Burwood - want a chair of Anaesthesiology at ChCh Women's.

Joan Donley, Auckland: 14 midwives attended 308 births in 1988 - 45% of homebirths for year. New DMs registering; increased case-loads from early discharge work; Pilot DMSRC up and running - three DMs already reviewed. Growing requests for water births; taking midwifery students out; new midwifery course is home birth oriented. 2 Quarterly meeting with home birth doctors.

Bronwen Pelvin, Nelson: 29 homebirths, 6 transfers, all except one delivered by DM in hospital. 9 Rh negatives ! 2 births without Drs prepared to cover - one had a doctor who wouldn't be involved; the other no doctor at all. Celebrated 10 years as DM.

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Agenda:

Lay Midwifery: Lay midwives able to be open about what they're doing with DMs. We're only group that support. Being outside law gives them some freedoms that DMs don't have.

Negotiations: Agreed to raise subscription to $50 to cover costs of employing Kelly Grovehills and Allison Livingstone as our negotiators with Department of Health. Offer them 60 hours work at $37.50/hour; will increase if our rate goes up. Concern not to price PN care out of market at $37.50/hour. DMs contract should specify homebirths. Will we be contracted to Area Health Boards? Kelly to shepherd us through changes in system - protect interest already gained. DOMINO contracts.

DMs: Domiciliary midwives = home birth midwives. Need to promote DMS and ensure all DMs belong.

DMSRC: Pilot scheme up and running in Auckland; important to get set up elsewhere especially larger centres; will have some weight negotiating contracts with AHBs and prevent us from being under OBstetric Standards Review Committees.

Legalities: Doctors responsibilities not spelled out anywhere - they make them mean whatever they want. If woman attending doctor and he has accepted for AN care then he is responsible according to Social Security regulations - can't just sidle out of it. Women without Doctors at all - just attend them, what can anyone do about it.

Statistics: Would like to be more detailed to include information on ecbolics, Vit K, Hep B, discharge weight, transfer outcomes, labour starts, labour established.

Ultrasound: Overdiagnosis of IUGR discussed.

Marijuana: Concern over pregnant women smoking. Depletes body of manganese, affects testosterone levels in male foetus; self-regulating dose.

Bleeding: Piece of placenta in mouth. Vit E effective anti-coagulent, people should stop taking it before due date.
Placenta stops post-natal depression - put it in fridge and the thought of eating it stops you getting depressed !!
(courtesy Jenny Woodley!)

Next years conference in Whangarei. Contact: Andrea Wilburn
15 Lovatt Crescent
Whangarei ph:71511

STILL NOT ENOUGH TIME FOR TALKING !! MID-YEAR MEETING SOMEWHERE SUGGESTED.