SAVE THE MIDWIVES

18 AUTUMN 89

CONTENTS

WOMEN NEED MIDWIVES & MIDWIVES NEED WOMEN

The Inaugural AGM and official opening of the NZ College of Midwives on April 2nd in Christchurch marked an exciting and significant development for the midwifery profession; and for the childbearing women who rely on the advocay role of midwives to ensure a natural birth without intervention unless absolutely necessary.

For those of us able to attend this momentous occassion there was a feeling of strength and solidarity, a little unease and uncertainty amongst some; and a very moving moment as Joan Donley was awarded the College's first honorary membership in recognition of her enormous contribution to midwifery - in particular to the establishment of the College.

The future of the midwifery profession now looks brighter - following a sordid history of the undermining of the status, training and scope of practice of the midwife. This is of crucial importance to women and their families, as midwives have such an important influence in childbearing - in their supporting role of empowering women to feel confident as mothers at the commencement of the momentous journey into parenthood.

The existance of the College will now ensure that midwives control their own professional matters and define their scope of practice as other professions do. This is of particular importance for issues like midwifery training programmes and autonomy of practice.

In tune with its visionary inception, the College recognises the importance of the partnership between the profession and the recipients of the service the profession provides. Consequently, in a move that has to be a world first, the constitution ensures that "consumers" can operate jointly at the executive and policy development level.

Such an innovative and appropriate move to recognise the active involvement of consumers as the measure of any professional services success, has to present a strong challenge to other professions who now visibly lack this essential presence.

* * *

Dr Wendy Savage is now a possible candidate to replace Professor Bonham at National Women's Hospital as she has officially applied for the job. At this stage we understand there are 4 applications and all are women. Wendy is particularly well known amongst midwives and women for her strong public stand on the need for women to feel in control of the birth process and their own fertility. She feels that women need to be able to talk as equals with doctors to enable them to make their own informed decisions, and has proved by her actions that she is a strong advocate for womens health. Judi

FROM THE NZ COLLEGE OF MIDWIVES:

PHILOSOPHY:

Midwifery is a profession concerned with the promotion of women's health. It is centered upon sexuality and reproduction and an understanding of women as healthy individuals progressing through the life cycle.

Midwifery is dynamic in its approach based upon an integration of knowledge that is derived from the arts and the sciences; tempered by experience and research; collaborative with other health professionals.

Midwifery care is delivered in a manner that is flexible, creative, empowering and supportive. Midwifery care takes place in the context of mutual support. Clients play a role in shaping midwifery. (Midwifery Policy Statement NZNA 1988)

FOR SALE: SWEATERS in black, white, maroon, bright red, dark red, royal blue, navy blue, light blue, bottle green, emerald green, gray, pink and teal.

Words - WOMEN NEED MIDWIVES (on front)
MIDWIVES NEED WOMEN (on back) or
- Save a mother Educate a midwife or
- Picture of mw & 4 babies & MIDWIVES FOREVER

Send size and $32 with order + $2.50 postage & packing to-
Auckland Branch of NZ College of Midwives,
c/-Denise Knapman,28 Rotoiti Ave,Pakuranga,Auckland (09)567757

Self-adhesive bumper stickers **MIDWIVES MAKE IT A LABOUR OF LOVE** are available at $1.50 plus 40 cents postage from the College PO Box 21 106, Christchurch.

Midwives and Student Midwives are entitled to full membership to the College, non-midwives associate membership and groups affiliated membership. * HAVE YOU JOINED YET? *

NEW ZEALAND COLLEGE OF MIDWIVES - Membership Application
PO Box 21-106, Christchurch

NAME:.....

ADDRESS:.....

PHONE.....
HOME WORK
IF AFFILIATE MEMBERSHIP-SPECIFY GROUP.....

Annual Subscription - Midwives/Full Membership - $52
- Student Midwives/Full - $26
- Non-midwives/Associate - $52
- Affiliated Membership - $26

Midwives step out on their own

Growing demand from women for less medical intervention and more control over the birth experience has led Northland midwives to raise their profile.

They are joining a national move to break away from the Nurses' Association and establish a new professional group, the New Zealand College of Midwives, to be launched this weekend in Christchurch.

Northland co-ordinator for the college, Ms Lynley McFarland, said historically midwifery and nursing were separate professions, but with increasing medicalisation of birth the two had become merged.

"When pregnant women were hospitalised and anaesthetics became a common part of the birth process midwives lost their traditional role of birth attendant.

"The medical profession needed nurses rather than midwives to support their approach to birth," she said.

Role confusion had been exacerbated by the requirement for midwives to complete a nursing course before qualifying. However the college would be pushing hard for a direct entry training course for midwives, Ms McFarland said.

Experience overseas was that a greater role for midwives could bring about less medical intervention in birth — and they were also cheaper.

College president Mrs Karen Guilliland said the establishment of the college was one response to women's calls for more control of their births and a return of the traditional midwife.

It would provide a focus which hopefully would stop the erosion of the midwife's role and women's choice, she said.

Non-midwives, or "customers", would be included as active members of the college to help achieve a service which reflects their needs.

"The objectives of the college reflect our commitment to sharing knowledge," Mrs Guilliland said.

Northern Advocate April'89

Midwives go it alone

MIDWIVES have set up their own professional organisation to break away from what they see as elitism in the medical profession.

After several years planning, the New Zealand College of Midwives was formally launched in Christchurch.

The national president, Mrs Karen Guilliland, said the Cartwright report had made a lot of midwives accept that a separate body was needed.

"The report highlighted how elitist the medical profession has become," she said. "We do not want to exclude women from what is going on."

Mrs Guilliland said the women the college worked for were included as active members.

"We rely on the involvement of other women in order to achieve a profession and health service which reflects their needs. The objectives of the college reflect this commitment to sharing knowledge."

In the past midwives have been represented by the Nurses' Association.

NZ News UK - 17.4.89

Midwives' new baby

An open letter to NZNA members

April 2 marked the official opening of the New Zealand College of Midwives. It also signalled the end of the National Midwives Section.

Midwives and nurses have had a professional "bonding" that dates back to 1969 with the formation of the midwives and obstetric nurses special interest section. At times it was a stormy relationship, but in recent years we believe many nurses have come to acknowledge (if not understand) the differences in our roles.

In 1986 we were delighted at the NZNA acceptance of the World Health Organisation's definition of a midwife and also, two years later, with the support we received from the association for the Midwifery Policy Statement. Collaboration of nurses and midwives also enabled the separate midwifery education courses to eventuate. All of these were milestones for midwifery.

However midwives have also undergone much political and personal development in this time and have come to believe it is essential for us to have our own voice and take on the responsibility for our profession.

We have many major health and welfare issues ahead of us in today's political and economic climate. We need to give our time, energy and commitment to midwifery to ensure New Zealand women have the midwifery service they require. We need a distinctive, obvious place of contact to focus our energies from and towards. We believe the college will provide this.

We also rely on the involvement of other women in order to achieve a profession which reflects their needs. The New Zealand College of Midwives is different from most professional bodies in that we have consumer members represented on regional and national committees. Midwifery is intertwined with women and we are unable to separate ourselves from them — neither do we wish to! It is the women who define our practice and who give us our direction.

We see professionalism equated with expertise and expertise as something to work for and to share. It is therefore appropriate that our constitution allows non-midwives to be active members. We are a professional organisation, consequently the majority of our members will remain individual members of NZNA for their industrial representation. We will continue to encourage midwives to be actively involved at the workplace and many are already doing so.

The decision to have our own professional body was not taken lightly and is the result of many years' discussion among midwives. We believe it is a decision that has not only been shaped by professional growth but also the social context in which we practise.

We hope you will celebrate with us.

New Zealand College of Midwives
PO Box 21-106
Christchurch

NZNA blessing

NZNA offers best wishes to the NZ College of Midwives and will continue to liaise with the new organisation on matters of mutual interest to midwifery and nursing.

As outlined in the above letter NZNA continues to represent all midwives industrially ie in award negotiations, and NZNA members in personal grievance situations, staff-surplus situations and in many professional areas affecting nurses and midwives.

Gay Williams
NZNA Executive Director

NZ Nursing Journal, April 1989

Single Registration - For the Sake of Change?

Karen Guilliland, Midwife and Tutor, Christchurch Polytechnic.
Sally Pairman, Co-ordinator, Southern Region Midwifery Course,
Otago Polytechnic.
Julie Hasson, Midwife, Christchurch Womens Hospital.

Any change made to nursing registration must have sound rationale clearly understood by all who are affected.
Having studied the three articles on single registration in the Nursing Journal October-January 1988-1989, and the single registration paper presented by the Nursing Council in 1985, we are not convinced that a sound basis for change exists.
In amongst a very circular debate presented by the Nursing Council, New Zealand Nurses Association and the Department of Health and Education, few concrete arguments emerge. One is that single registration creates ease of administration for the Nursing Council.
Most of the arguments presented have at least two differing perspectives and it depends on your point of view whether you see these as supportive of single registration or not. The following are examples of this.

Single registration may lead to:

Either	Or
1.Fewer legal restrictions for employers.	1.Dependence of the nursing profession on employers to uphold their professional responsibilities.
2.Potentially wider career pathways for nurses.	2.Nurses being forced by employers into career pathways they do not choose; the public put more at risk of being cared for by nurses not educationally prepared (especially if employers do not support nurses to short courses etc.).
3.Provision of a 'focus' for nursing and a blurring of the medical model of nursing.	3.A redefinition of nursing by people other than nurses.eg.Non nurse managers.

Whilst we accept that the move to single registration is, in essence, a move to 'focus' nursing, and we have no argument with that need, we do question the timing of this debate.
Our main concern is the introduction of single registration in the present economic and political climate.
The recent sweeping and often indiscriminate changes in the health system have placed many nurses, and ultimately their profession, in jeopardy. Now we want to introduce another change which relies on the employers being aware of their professional responsibilities. This would seem to be naive in todays climate. Employers are demonstating throughout New Zealand that their main concerns are budgetary.
The time for thinking that employers care about the nursing profession is past, and nurses alone are responsible for the nursing profession.

The rate of change is always critical to the success of change, and it is obvious that the natural attrition of nurses and the recent cessation of all specialist first level nursing courses, will lead inevitably to single registration. Perhaps this slower process would be most successful.

As midwives we are concerned that any changes made to the registration of nurses may indirectly or directly threaten the maintenance of the midwifery register.
We believe it is essential to protect the midwifery register.
Midwifery has its own philosophy and body of knowledge which is different from nursing. Historically midwifery and nursing developed along parallel lines - nurses cared for the sick, midwives worked with women having babies. There are common elements but midwifery does **not stem** from nursing.
There has only been a short period in the history of the western world where the midwifery role has been confused with the nursing role, and only a few countries which have seen midwifery as advanced nursing practice. These countries include New Zealand, Canada and the U.S.A.
This confusion arose as a direct result of the medicalisation of birth and the take over by the medical profession who needed nurses to support this medical approach to birth.
The majority of maternity units in NewZealand today are staffed predominately by Registered nurses and Enrolled nurses, with midwives in the minority. These nurses are unable to fulfill the essential role of the midwife, and medicalisation abounds.
In countries such as the USA, which have lost their midwifery registration, progressive medicalisation of birth has meant that 1:4 women is delivered by Caesarian Section.
This erosion of women's control over their birth experience has brought with it an outcry from women for the re-instatement of the midwifery register and the traditional role of the midwife.

The concept of nurse/ midwifery has inherent problems, and the struggle for professional identity should not be at the expense of women and babies.
The move into primary health care for nursing in New Zealand should not be at the expense of the midwifery profession.
It is possible for the two professions to exist side by side.

We hope that nurses will support midwives in our efforts to maintain the midwifery register.
Women in New Zealand want midwives to help them have the birth experiences they desire, and increasingly are demanding a return to the traditional role of the midwife.
These women are prepared to actively campaign for the midwife as an autonomous practitioner, as is evidenced by remits passed by Parentcentre, the Home Birth Association, La Leche League and the Playcentre Association in 1988.
Women have also seen the need to set up specific groups such as "Save the Midwife" and "Maternity Action Alliance" to arrest the threatened demise of the midwife.

The existence of the midwifery register protects these women. It protects them because it enables qualified midwives to exist. The very real support that women give to midwives should tell us something about the importance of midwifery. Retention of a separate midwifery register and acknowledgement of women's specific midwifery needs goes some way towards protecting women's choices.

If changes in the Nurses Act allowing single registration are made, without also making changes to the Act which give autonomy to midwives and protects their register, then we would oppose any move to single registration. Registration, after all, is about protecting the public's health interests.

References.
Articles in the New Zealand Nursing Journal, October, November, December/January, 1988-89.
Nursing Council of NewZealand, "Towards a Single Registration", 1985.

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?

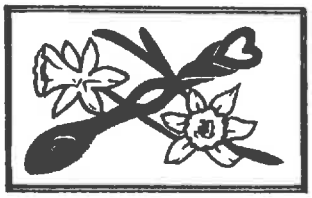
Will this midwife feel that she does not want her position weakened and her autonomy diluted by accepting a course of action that, in her considered opinion, carries a greater risk?

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



Reproduced with permission from Association of Radical Midwives Newsletter, no 36, Spring 1988, pp 9-10.

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.

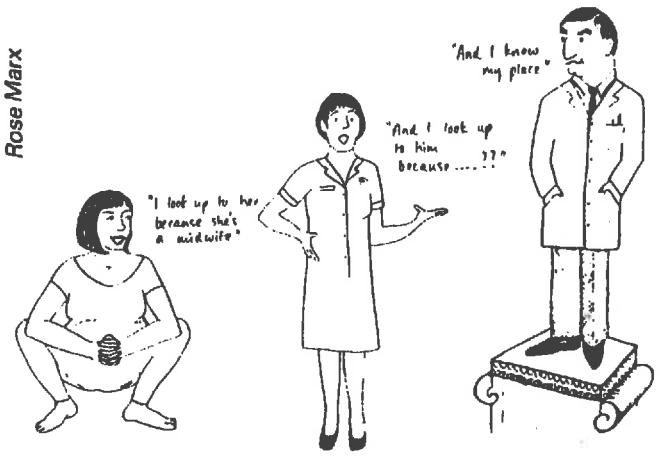
If pregnancy is illness, then there is no place for choice or alternatives. The midwife in charge of this pathological state must dictate the rules. There is no provision for individual variations or wishes.

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.

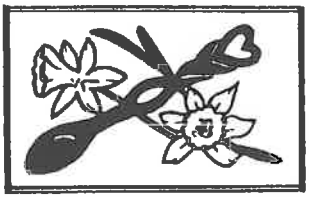
I believe that choice in childbirth, far from threatening the professional status of the midwife, enhances and improves her role to womens' ultimate benefit. Choice in childbirth need not lead to a deterioration in care, it may well improve it. Midwives who are really autonomous are those who have escaped 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

References

1. Freidson, E. (1970) Professional Dominance: the social structure of medical care. *New York, Athenson Press*
2. Walker, J. (1978) "Practitioners in their Own Right" *M.Sc. Dissertation, University of Wales*
3. The Nurses, Midwives and Health Visitors Act 1979. H.M.S.O.
4. Goodman, P. (1978) in P. Ward "Goodmans Gift". *New Society, June pp* 670-671.
5. United Kingdom Central Council (1986). A Midwives' Code of Practice for midwives practicing in the UK.
6. Stanway, A. and Stanway, P. (1984). Choices in childbirth. *Pan Books, London.*
7. Weber, M. (1985). Dictionary of Sociology. *Penguin Books.*



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BITS AND PIECES:

FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES:

8-10th Nov. 1990
Massey Univ. Palmerston North

Theme: **Women as Health Providers within a context of culture, society & health policy.**

Wanted: Abstracts of completed or ongoing research for presentation to the congress.

Enquiries: Dept. Of Nursing Studies, Massey University Palmerston North, N.Z.

The NZ and Australian Governments will consider supporting a sub-regional seminar in the Pacific on the UN convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) following a UN request that the seminar be organised in conjunction with Pacific Island countries.

WORLD FEDERATION FOR MENTAL HEALTH

1989 WORLD CONGRESS

21-25 AUGUST 1989
AUCKLAND, NEW ZEALAND

The Mental Health Foundation of New Zealand is hosting the 1989 World Congress. The general theme is "Mental Health — Everyone's Concern", reflecting the view that mental health issues and problems touch the lives of all the world's citizens and that solutions must involve the active participation of many groups.

Co-sponsors: World Health Organisation, UNESCO, International Academy of Law and Mental Health, International Social Science Council, International Council of Psychologists.

Congress '89 will create a forum for examination and discussion of national and international issues in mental health for all those involved — professionals, users of services, researchers, volunteers and administrators. Over 1,000 people from more than 60 countries will meet in Auckland to share experiences and debate approaches to illness and health, treatment, legislation, rights, rehabilitation and prevention. There will also be opportunities for skill development through workshop participation.

THEMES

The Congress programme will be organised around eight major themes. Each theme will be expressed in three to four days of keynote addresses, papers, poster sessions and workshops.

Global Issues — the nuclear threat, conflict resolution and peace; environmental change and hazards; population growth; demographic and rapid social change; poverty and unemployment.

New Public Health — prevention, health/mental health education, health promotion and health psychology.

Mental Health Services and Alternatives — deinstitutionalisation, comprehrensive community-based services, special populations, service planning and monitoring, self help groups.

Drug Dependence and Disorders of Impulse Control — alcohol, minor tranquillisers, cannabis, tobacco, compulsive gambling.

Cross Cultural and Minority Issues — transcultural psychiatry/psychology, indigenous peoples, migrants, refugees, lesbian and gay issues.

Victimology and Trauma Studies — child abuse, elder abuse, victims of crime, terrorism, torture, survivors of natural and man-made disasters.

Legal and Consumer Issues — mental health law, advocacy, patients' rights, user (consumer) organisations, ethics

The Cutting Edge of Research — developments in epidemiology, biomedicine, the behavioural and social sciences and other fields relevant to practitioners.

CALL FOR PAPERS AND REGISTRATION — NOW

World Congress '89 will be a high point on the international mental health calendar. Now is the time to submit paper and workshop proposals.

Further information from:

Convention Management Services
P.O. Box 12-442 Auckland, New Zealand.

A New Ministry of Women's Affairs Publication

WOMEN'S HEALTH: WHAT NEEDS TO CHANGE

Copies available from the Ministry of Women's Affairs Private Bag, Wellington.

Women's Health: What Needs to Change answers many of the questions raised by women and is a practical guide to action for officials in health services, particularly those employed by Area Health Boards.

The booklet summarises the essential features of adequate health care practice, bringing together the recommendations made by Judge Sylvia Cartwright and additional, more detailed information, drawn largely from submissions to the Inquiry.

It also describes what needs to change in order to ensure that the events at National Women's Hospital are not repeated elsewhere. It covers not only cervical cancer screening and treatment but particularly the protection of patients' rights at all medical institutions.

Women's Health gives clear guidelines on what decision makers in the health service and women as consumers can do to bring about change at both the national and local levels.

Working for patients?

Wendy Savage and David Widgery—a hospital doctor and GP—argue that Kenneth Clarke's proposals for the NHS get both the diagnosis and the treatment dangerously wrong

Reading the glossily produced white paper and observing the media blitz designed to promote it, our reactions have ranged from disbelief to anger. Mrs Thatcher is not a stupid woman; can she really not understand that the end result of the "business-like" approach to the provision of health care is the sale of human organs which she describes as "utterly repugnant"? The media report this soundbite endlessly without questioning her sincerity or her motives, and meekly report the high-sounding rhetoric of this white paper without examining the underlying premises or philosophy.

These can be summarised as: the NHS is inefficient, poorly managed, and requires an ever-increasing proportion of the country's GNP. Doctors are responsible for the majority of this expenditure and are unaccountable to anyone for their actions. Consultants abuse their power by not fulfilling their contracts in the hospital service. The drug budget is excessively high, so GPs' expenditure must be curbed. The manual workers in the NHS are a greedy undisciplined body. The district health authorities are unworkable because of the anarchic tendencies of the local authority members. Proper financial management and a "market strategy" will make the service more efficient, and we can have a better service for less public money by cooperating with the private sector.

The underlying philosophy is that those who have money should pay for their health care, so that "scarce" resources can be used for those who cannot, and that private care is more efficient than NHS care. The "crisis" in the NHS is sold as being a result of its underlying structure and aims of the service, and not as a result of prolonged underfunding.

Having got the diagnosis wrong—the NHS is, in fact, a low-cost system, British doctors have relatively low prescribing rates, private care is inefficient, expensive and not interested in a large proportion of the population anyway—the proposed treatment is impractical and undesirable. The central proposals would extinguish what little democracy remains within the system, returning the big hospitals to their pre-NHS state and lumbering GPs with an immensely time-consuming variant of the Health Maintenance Organisations, a North American solution to a North American problem which is failing even in North America. This ad man's dream of the medical future would take us back 40 years, tearing up the present pattern of services with no guarantee of improvement.

Of course, the details are still lacking and there is a plum or two. A hundred new consultants sounds marvellous, yet a mere 0.00005 per cent budget increase is earmarked for it and it represents only half a consultant per health district. And we agree that audit is useful and efficiency is desirable.

But the proposal to let large hospitals opt out is akin to the oft-quoted action of Nye Bevan's in "stuffing their mouths with gold", a cynical bribe to buy off the powerful elite who dictate policy and training in the Royal Colleges. It flies in the face of government policy to give more cash to the less prestigious specialities such as mental handicap, psychiatry and geriatrics.

There is a serious risk that the teaching hospitals will pull up the ladder on the local services they now provide, since they will be under powerful pressure to direct their activities towards more "profitable" lines of clinical work. If the "internal market" encourages the big hospitals to deal directly with budget holding mega-practices in the home counties, whose patients will come bearing gifts, what happens to the bread-and-butter clinical work on their inner-city doorsteps?

The probability is that the geriatrics will be shipped out to the nursing homes offering the lowest rates and that the hernias, hip replacements and terminations would be sent off to the private sector. Instead of district general hospitals offering a full range of services to their locality, we shall see a return of super-specialist hospitals, in competition with each other and with a catchment area covering the entire country.

As for services for women, they are not mentioned in the "core services" which these opting-out hospitals will have to provide for their districts. So is maternity care seen as a likely plum for the private sector? Abortion is not referred to in the page about the number of private operations performed, although it is the most commonly performed operation for which either sex pays.

If the big hospitals go solo, it will destroy the network of services which the NHS provides — a network which has enabled hospitals to discharge people earlier into the hands of increasingly hard-pressed GPs, district nurses, community midwives, health visitors, and community physiotherapists. The integration of primary and secondary health care which is the real way to make the system more efficient and responsive would, in the name of patient choice, be dealt a terrible blow.

The proposals for general practice are even more curious. They blatantly contradict the ideas in the white paper on primary care which the General Medical Services Committee thought it was currently negotiating. The idea

that GPs themselves become budget-holders would inevitably exercise a powerful pressure on them to avoid registering patients likely to be high users of medical services and drugs.

There is no guarantee that a self-held budget would be spent on expanding the staff and range of services available in primary care. It is equally likely to encourage a GP to tell a patient to grin and bear it so that the practice pockets the money "saved". Anyway, an increasing number of GPs and health centres are already expanding their range of services within the present set-up. The few GPs who have a fixation on holding their own budget will rapidly lose enthusiasm when they realise how much of their time will have to be spent cross checking prices and availabilities of treatments once they have made their diagnoses. After all, most of us studied medicine to practice as doctors not accountants . . . or travel agents!

The "fine print" proposals on capitation fees, basic practice allowance and drug budgeting are still more alarming. The capitation fee is the payment the GP gets per head of registered patients. The proportion it contributes to the doctor's total income is probably the most significent factor affecting that doctor's total list size. In the bad old days, a GP had to take on more patients than could be comfortably handled simply to make a living. Over the past few years there has been a steady and welcome fall in the average list size of GPs, allowing them to spend more time with individual patients. The white paper proposes to yank up this capitation element in GPs' income from 49 per cent now to 60 per cent, presumably under the misapprehension that a doctor with a lot of patients on the list must be a good one. Kenneth Clarke is also talking about the removal of the Basic Practice Allowance, an element in pay which many GPs, especially in inner cities, depend upon.

Further curbs on drug spending which are to apply to all GPs, not just the budget-holders, will create more problems and ill-will. At present, hospital clinicians are forced into making (nominal) savings on their budgets by sending their outpatients and newly discharged in-patients back to the GP to get their prescriptions. Apart from being inconvenient, this maneouvre is cost-ineffective (because the drugs will probably cost more from a high street chemist than a hospital pharmacy) and ethically dubious (because the doctor who signs the prescription has the clinical responsibility if there are problems). But it will be ten times worse for the patient if the GP bounces them back because their budget allocation is spent too: patients with chronic illness, and that predominantly means the old, will be shunned by GPs. Tax relief on private care might help the affluent pensioner (a rarity) but opens the door to tax relief on private medicine at all ages, a further fillip for commercial medicine and the well-off.

Overall, the policy will put the same fiscal clamps on the GPs that have the hospitals in such public pain. This despite the fact that GPs are internationally recognised as being exceedingly cost-effective in view of the vast number of patients they see and screen. Yet there is hardly a word about prevention in the white paper. Instead, the GP is invited to become the agent of unpopular cuts rather than the politicians, an offer which they would be wise to decline.

There is no need for this radical revision of the NHS structure. It's already been reorganised three times in ten years, 1974, 1982 and 1984. The effects of the last two upheavals are still being felt. Managers who suffered from two rounds of "musical jobs", are only now getting to grips with the complexities of managing their units. What the NHS needs is a period of stability during which time the systems to show exactly how money is spent are installed. Clinicians could then, with the information provided by management, see rationally how to reduce their expenditure without harming patient care. Further, the proposal to reduce all consumer or local input on the new boards of management bodes ill for patients. It concentrates power in the hands of a few non-elected people and managers who will be rewarded for not spending money, not for the quality of service provided (since the shake-up provides no real patient or local pressure).

The NHS is a complex organisation which has provided a comprehensive service with certain drawbacks: old buildings, long waiting lists, often a lack of patient choice, and little consumer representation on decision-making bodies. Most of these things could be dealt with by increasing the proportion of our GNP spent on health from 5.9 per cent (the lowest in the Common Market) to 7 or 8 per cent; and secondly, by changing the composition of local health authorities and consultant and senior management appointment committees by adding directly elected representatives of the community. But this white paper is not about patient care. It is an exercise of authoritarian control over a service provided with our money through taxation. As such, it is an abuse of power, packaged as a rational economic reform, and sold with £1,000,000 of our money – a technique criticised by the government when used by local authorities facing loss of local autonomy (or even their demise) against the will of the majority of local people. Some of the proposals, cross-boundary charging, flexibility about salaries and wages – could be implemented without this drastic change which has neither electoral mandate nor professional support.

We remain convinced that the majority of the population, including many people who voted Conservative in the last election, want an NHS which is humanitarian, efficient and compassionate, not price-tagged and dependent on market forces. We urge clear-cut and united rejection of the white paper's proposals and philosophy by the medical and nursing professions, the unions and the general public. Managers who want their large hospitals to opt out of the districts, GPs who want to opt into budgeting and the commercial medicine tyros should be made aware of the grave reservations the rest of us have about the whole exercise. ●

Wendy Savage is a Fellow of the Royal College of Obstetricians and Gynaecologists and senior lecturer in obstetrics and gynaecology at the London Hospital Medical College, Whitechapel. David Widgery is a general practitioner in a health centre in Linehouse.

D A T E S T O R E M E M B E R

NATIONAL HOMEBIRTH ASSOCIATION CONFERENCE, New Plymouth
12-14 May 1989 Theme: CONCEPTIONS & CREATIONS
Papers & workshops on - bi-cultural sensitivity, immunisation, acupuncture/acupressure in childbirth, maori medicine, taditional childbirth.....and others.
Enquiries: Jasmin Hales, 33 Wrantage Street, New Plymouth

10TH NATIONAL AUSTRALIAN HOMEBIRTH CONFERENCE, Sydney
12-14 May 1989 Theme: CELEBRATING A REVOLUTION IN BIRTH
Enquiries: 521/197 Pittwater Road, Manly, NSW 2095, Australia

AIDS CONFERENCE: Facing The Next Five Years - 15-16 May
To discuss the National Strategy on Aids. Fee: $50
Enquiries: Postgraduate Medical Society,School of Medicine, Wellington Hospital, Private Bag, Wellington

9th INTERNATIONAL CONGRESS OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY, Amsterdam, The Netherlands 28-31 May 1989
The main theme of the congress will be "Psychological, emotional and emancipatory aspects of women's health care."
Enquiries: Congress Secretariat, c/- QLT Convention Services, Keizersgracht 792, 1017 EC Amsterdam, The Netherlands.

ETHICAL ISSUES IN THE RATIONING OF HEALTH CARE RESOURCES May 29
7.30-9.30pm Fee:$5.50 Basement Library Bldg, Auck.University

ETHICAL ISSUES IN THE TRAINING OF HEALTH PROFESSIONALS June 20
7.30-9.30pm Fee:$5.50 Basement Library Bldg. Auck.University

SIXTH BIENNIAL CONFERENCE OF THE AUSTRALIAN COLLEGE OF MIDWIVES
Darwin, Northern Territory 21-23 June 1989
Theme: Midwifery - Back To The Future Key Speaker- Ruth Lubic
Enquiries: Teresa Raines, Conference Convenor, ACMI NT. Branch, PO Box 41781, Casuarina, NT 0811, Australia.

1989 INTERNATIONAL ICEA CONVENTION, Minneapolis USA June 23-25
For all those who work with women in any childbirth related field, consumers, childbirth & parent educators, nurses, midwives, physicians and other health professionals.
Enquiries: ICEA Minneapolis Convention,PO Box 20048, Minneapolis, Minnesota 55420-0048, USA.

WORLD FEDERATION FOR MENTAL HEALTH 1989 WORLD CONGRESS-Auckland
21-25 August " Mental Health - Everyone's Concern "
Enquiries: Convention Management Services, PO Box 12-442, Auck.

NATIONAL FEDERATION OF PARENTS CENTRE CONFERENCE - 26-27 Aug'89
New Plymouth High School. Enquiries: PO Box 11310, Wellington.

PROMINENT BRITISH FEMINIST, SOCIOLOGIST & WRITER *ANN OAKLEY* WILL TOUR NZ - Sept'89. She is well known for her work in the area of women's health & childbirth issues, and for her books "The Captured Womb" and The Sociology of Housework & Housewife
Enquiries: Centre For Continuing Education, Auckland University

CHILDBIRTH EDUCATORS ASSOCIATION X111 BIENNIAL CONFERENCE-
Sydney 6-10 Sept'89 "Birthing - Toward 2000"
Contact: Conference Committee, Suite 11, 127 Forest Rd., Hurstvale, NSW 2223, Australia

INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS: October 8-12 1990 Kobe, Japan
Enquiries: ICM International Congress, Nursing Association International Relations, 8-2, 5-Chrome Jingumae,Shibuya, Tokyo.

FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES:
8-10 November 1990 - Massey University, Palmerston North

Wouldn't it be wonderful if the birth experience could be joyful for every woman on the planet?

Judy Chicago

A SURVEY OF THE INDUCTION AND CAESAREAN SECTION RATES FOR MAORI AND PAKEHA WOMEN OVER A SIX MONTH PERIOD:

Conducted by Lynley McFarland - Midwife
(Obstetric Unit, Northland Base Hospital, PO Box 742, Whangarei)

(This was conducted initially for a Massey University paper on Women's Health; looking at the political implications of the patriarchal structure on women's health.)

The findings of this research have been before the Northland Area Health Boards Ethics Committee prior to publication; and the comment of the Obstetric and Gynaecological Consultant Graham Parry is that -

" This survey has raised some interesting questions to which a prospective research project may provide some answers. It would need to look at the infant outcome in some detail, including premature birth rates and infant apgar scores. "

All births at Northland Base Hospital/Whangarei for the first six months of 1988 were included in the survey.

The total Caesarean Section and Prostin Induction details were taken out of the sample. The births for women from the collecting areas of other hospitals have been taken out of the sample, so that the remainder reflect the outcome for Northland Base Hospital area.
i.e. the distortion of high risk obstetric transfers in from other hospitals, has been removed.

Total number of births at NBH in 6 mth period January-June 1988	- 594
Total number of caesarean sections	- 103(17%)
Number of out of area births	- 57
Number of births in NBH area	- 537
Number of C/S in NBH area	- 14.7%
Number of Maori Women giving birth in NBH area	- 163
Number of C/S on Maori Women in NBH area	- 11(6.7%)
Prostin Inductions total	- 113
Out of area inductions	- 12
Inductions for NBH area	- 101(18.8%)
Inductions on Maori Women in the NBH area	- 29(17.8%)

Induction rates for individual doctors, GP's, private consultant and unit consultant were surveyed. The variation was from 7% to 52% - the extremes belonging to independent GP practitioners.

Validity - This survey has been taken entirely from the information contained in the birth register. It is possible that some instances of Prostin Induction may not have been recorded and only a search of the in-hospital notes would correct that.

The Pakeha group of women included five women of non-European ethnic origin; Chinese, Indian and Filipino.

The Maori group included a few women from other Pacific Islands, Rarotonga, Fiji and Niue.

WHY THE DOMICILIARY MIDWIVES REVIEW COMMITTEE

Joan Donley

The present upsurge in home births began in 1974/5 in response to the increasing regionalisation of childbirth. Although the domiciliary midwife (DMW) was governed by the comprehensive Obstetric Regulations monitored by the medical officers of health (MOH) she operated outside the bureaucratic hierarchy of hospital boards where the obstetric monopoly of childbirth is maintained. Therefore, the obstetricians had no control over either the GPs or the DMW's who supported home births.

In 1979 the Medical Council moved to control this movement. It established the Obstetric Standards Review Committee (OSRC) " to present precise proposals for the establishment and monitoring of obstetric standards in NZ (because) a lot of antenatal care and an increasing number of births are taking place outside Hospital Board institutions ".

To some extent this 'controlled' GPs who had contracts with hospital boards as these contracts could be granted/renewed or rejected/cancelled on the basis of the doctor's adherence to the 'precise monitoring proposals', plus a little judicious 'peer pressure'.

However, since DMW's were under the direct control of the Department of Health (DOH) through their contract with the Minister, the OSRC were unable to 'control' them. Like all midwives, DMWs were registered with the Nursing Council which issued their annual practising certificates. Therefore, the obvious way to 'control' DMWs would be through the Nursing Council or the NZ Nurses Association which, at that time, spoke in the ? interests of midwives.

It was surely not mere coincidence that in Feb 1980 the Midwives & Obstetric Nurses' Section, NZNA submitted to the Maternity Services Committee (MSC) a **Policy Statement On Home Confinements** which recommended four criteria for DMWs. One of these was that 'her/his practice (be) evaluated yearly by a midwife and an obstetrician'.

This was followed up by the **NZNA Policy Statement on Maternal & Infant Nursing**, April 1981, prepared by an ad hoc committee. It included the above policy statement as an appendix. It mentioned ' the relatively independent nature of domiciliary practice ' and recommended ' that the NZNA take active steps to ensure that the recommended criteria governing the preparation and employment of DMW's are accepted by the DOH and implemented '
Of 7 criteria, 2 involved assessment by obstetricians, first as a pre-requisite to application which should include 'a written assessment of the applicant's suitability, efficiency and competence in midwifery practice.....

...This assessment to be made by the Principal Nurse and the Obstetrician in Charge, in consultation with appropriate other professionals '. Subsequently, ' formal evaluation of the midwife's clinical practice is undertaken annually by a competent practising midwife and an obstetrician. Her client records are available for inspection also '.

This Policy Statement which dealt with numerous other aspects of ' maternal & infant nursing ' was presented for endorsement at the NZNA Conference the following month. To make sure that the strictures on DMWs was reinforced the NZNA National Executive put a remit 'urging' the Minister of Health to formulate policy for DMWs. One of these was that the practice of DMWs be evaluated by an approved midwife and obstetrician each year.

At conference this portion of the remit was amended to delete the words 'and obstetrician'...and carried. Since this remit was passed subsequent to the blanket approval of the Policy Statement , it takes precedence over the former.....

In November 1982 the MSC published its Report, **Mother and Baby at Home: The Early Days** which ' affirm(ed) its position that it cannot recommend the practice of domiciliary confinement ' and recommended that the contracts of DMWs be transfered to hospital boards and monitored by OSRCs with addition of a midwife to these committees. (Recommendations 11, 23, 25)

Reviewing this MSC Report, the Auckland Branch of the Midwives Section recorded in their minutes (17.2.83) "...no other group of nurses have their practice proscribed and evaluated by medical practitioners. Moreover, no other group of nurses, other than those attached to private practice, require approval by medical practitioners in order to gain employment. The control of nurses and midwives is properly carried out by senior members of their profession. These recommendations are clearly discriminatory and could be interpreted as an insult to the nursing profession. "

Being a politically aware lot the DMWs had formed the Domiciliary Midwives Society Inc. in 1981 in response to the first NZNA document on Home Confinement, for the purpose of speaking for themselves. With the backing of that 'vociferous minority' the NZ Homebirth Association (NZHBA) the DMWs successfully resisted the O&G and NZNA takeover bids.

In September 1985 the DOH presented Auckland DMWs with Draft Guidelines for Domiciliary Midwives. Prepared by Trix Bradley, Nurse Advisor to DOH (ex UK DMW) it was a mix of the aforementioned documents and proposed to ensure that DMWs provide a high standard of care and are aware of their responsibilities under legislation and that evaluation of their practice is carried out periodically with help from ' obstetric unit staff '.

This document was rejected by DMWs as 'archaic' and 'retrograde'. Not only was it ' unrealistic ' in that it ignored the world trend towards primary health care (phc) eg. **Health For All By The Year 2000** and the recommendations of the Women's Health Committee of the Board of Health. It was also based on midwifery as a post graduate course of nursing although the 1985 NZNA Conference had endorsed the WHO definition of a midwife - as a practitioner in her own right.

DMW opposition resulted in the Study Proposal, a 14-month research into home births/DMWs etc. including the ' contentious political issues '. One of the most revealing political statements in this Proposal was that " ...the Nurses Association, those who work within level 2 & 3 maternity services have maintained the status quo on domiciliary midwifery at a policy level. They see change in the condition of practice of domiciliary midwives as a threat to the scope of their practice " !

The research done by Jennie Nicol resulted in **A Choice Of Birthing** November 1987 which found that in general midwives feel they should not be accountable to the medical profession. " Instead most midwives maintain they are responsible to themselves, their peers and their clients ".

The responses of some obstetricians were something else again! Some felt it was " too easy to get approval to practice as a domiciliary midwife and that once registered there is no accountability ". Also that the present system " leaves the question of competence and standards of practice entirely in the hands of the licensee and hence offers no assurance to the public that minimum standards of safety in midwifery practice can and will be met ". One felt threatened by midwives considering themselves practitioners in their own right " with no obligation to consult with a doctor "; while some were reluctant to acknowledge the skills and training of the midwife.

Hardly had the ink dried on the DMWs new contract with the Minister of Health (30.7.87) and before publication of **A Choice of Birthing** than the NZNA National Executive were asking the Nursing Council and the Minister of Health to consider " the matter of the monitoring of domiciliary midwives ". Maureen Lawton reported (NZNJ Oct'87) that the Maternal & Child Health Committee was looking at domiciliary midwifery practice as part of its policy. This, despite the fact that the contract recognised the DMW Society as the negotiating body for DMWs!

Obviously pressure was increasing for the practice of the 'relatively independent' DMW to be 'monitored' before their heretical midwifery values and assertiveness could spread to all midwives and a demand for midwifery autonomy. A committee set up by NZNA/O&Gs would be primarily to maintain the status quo ie. the power base for the medical model of childbirth.

The time had come for DMWs to outflank the NZNA moves and set up our own monitoring committee. A proposal for a Domiciliary Midwives Standards Review Committee was put at the NZHBA Conference, Wellington, 1988 and approved. Auckland was asked to establish a pilot committee and this was done.

The top medical brass are bitterly, but passively, resisting the Cartwright Report

ADVANCE #52 March 1989

The Cartwright Inquiry was set up to look 'into certain matters concerning the treatment of cervical cancer'. It became an inquiry into the monopoly power of New Zealand's obstetricians and gynaecologists -- and their arrogant use of that power in the name of 'clinical freedom'.

As the six-month public inquiry unfolded, people were horrified to learn of the callous disregard of ethical standards and patients' rights in carrying out research and teaching. It exposed the contempt for women held by this 'very strong macho clique' operating from its power base, the Auckland University's Medical School and its clinical fiefdom, the National Women's Hospital.

On the other side, it exposed the powerless position of women — the 'raw material' that kept this medical machine running profitably. Profitably, that is, for its very highly paid operators.

Judge Silvia Cartwright concluded: 'The medical profession failed in its basic duties to its patients'. It was not just a matter of 'little or no formal training on ethics at the Auckland School of Medicine'. It was far more that the O & G department at NWH was a law unto itself. The hospital's Ethical Committee had 'no established procedure for independent assessment; nor for obtaining the opinion of referees; nor for reviewing the hypothesis to see if it can be tested'. In the interests of 'clinical freedom', there had been a total disregard to the rights, welfare and feelings of the women involved in research projects.

Clinical freedom is a jealously guarded concept that wha doctors do with their individual patients should not be monitored or interfered with. In her book, *The Unfortunate Experiment,* Sandra Coney scathingly writes 'it is a shibboleth erected by doctors to protect their own interests. It says no more than that their interests are beyond question'. But, in this case, women — working class women, Maori and Pacific Island women, who couldn't afford to see a private consultant — were sacrificed 'on the altar of clinical freedom'.

But, once hospital patients were referred to Dr. Green's research project, under the doctrine of clinical freedom they became forbidden territory. Even Dr. Graeme Duncan, president of the Royal College of Obstetricians and Gynaecologists, was reluctant of change Green's treatment of a patient transferred to him. He went on with Green's treatment even though he disagreed with it. And Dr. Fred Moody, one-time Medical Superintendent-in-Chief of the Auckland Hospital Board, maintained to the inquiry that clinicians, being people of integrity, are monitored by 'individual conscience'.

The Judge would have none of all this. She found that 'clinical freedom has been proved worthless at National Women's Hospital when patients' safety or the rigorous testing of a new treatment protocol was at stake'.

She was not impressed either by the vaunted 'peer review'. This is a system whereby doctors allegedly monitor each other's practice and standards. But, in practice, it has almost invariably confused ethics with medical etiquette, the system of internal self-government that exerts powerful control over its memers to be 'loyal' to each other and to the profession.

In fact, one GP saw the Judge behind closed doors. He knew there would be repercussions if he spoke out in the public hearings. He explained that he practised obstetrics under contract to the Hospital Board. But that contract depended on the nod of the top obstetricians organised into the Obstetrics Standards Review Committee. A public statement would jeopardise it.

'Peer review' assumes that all doctors are reasonable, open to criticism, willing to change and to admit it if they are ever wrong. But it would be unthinkable for the peers to suggest base motives — or even such human ones as self-interest, ambition, pride. Their conscience is pure and clear. Their acts in 'good faith' require no admission of guilt. Not even, it will be noted from the results of Inquiry, an apology.

'When it came to evaluating or reviewing the 1966 trial', said Judge Cartwright, 'Dr. Green's peers failed him. Twenty-one years after the first oral and written challenge to the proposal, an article in a non-medical magazine *('Metro')* achieved in a few days what his colleagues could not.....an Inquiry into medical practice is one form of peer review, albeit enforced. It is also the most disastrous, for the profession, for the patients and for the public purse.....(but) unless the profession can establish adequate peer review and adequate systems to cope with the inevitable mistakes or problems caused by incompetence, then there will be a continuing succession of inquiries of this nature.'

Finally, there is the Medical Practititoners' Disciplinary Committee. A complainant would have to pay her own lawyer to put her case before a panel of doctors — and to oppose the doctor's lawyer paid for out of his medical insurance, the cheapest in the world. But this MPDC has no power to award compensation. If it agrees there is evidence of 'medical misadventure', the Accident Compensation Corporation picks up the tab. Thus the ACC gives the doctor immunity against negligence and incompetence. Doctors' pocket books are protected, along with their consciences.

However, following the Inquiry, nine women did issue claims amounting to $11.41 million against Dr Green, Prof. Bonham, Dr Warren, the Auckland Hospital Board and the Auckland University. They are claiming assault, breach of good faith and negligence, all occurring before 1974, before the ACC abolished liability for 'accidents'.

There was other 'protection' for patients. In 1964, the 10th World Medical Assembly produced the Declaration of Helsinki, a code of ethics for medical experimentation on humans. This was endorsed by the NZ Medical Research Council — a doctor-dominated statutory body which distributes government funds for research of approved scientific standards. Since 1969, this MRC has had a Committee on Ethics of Research,but its work has always been left to the local ethical committees. These latter were initiated by the Department of Health in 1972, but no national standards were set for them and no central register has been maintained.

When Drs McIndoe and McLean challenged Green's trial, the NWH's Hospital Medical Committee, which was used to do the work of an ethical committee, set up the Macfarlane Committee to investigate. Dr. McLean drew this committee's attention to Principle 7 of the Helsinki Declaration. It read: 'Physicians should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Physicians should cease any investigation if the hazards are found to outweigh the potential benefits.'

To no avail. The Macfarlane Committee whitewashed Green's trial. Neither Prof. Bonham nor Dr Warren, the NWH Medical Superintendent, chose to intervene. Only in 1976, when the clinical staff was finally utterly fed up with 'the overbearing attitude of the university staff', was there any change. A NWH Ethical Committee was set up in 1977 — chaired by Bonham! No existing research projects were reviewed and publication of results was 'not encouraged or enforced'.

Judge Cartwright saw these inadequacies as posing a serious risk to patients' rights. She recommended that this latest committee be disbanded and declared: 'The doctor is no longer autonomous.....the focus of attention must shift from the doctor to the patient.'

She ordered that medical disciplinary procedures MUST be put in place, in consultation with COMMUNITY HEALTH GROUPS, while the Director-General of Health should ensure that HALF THE ETHICAL COMMITTEES ARE LAY MEMBERS.

The Government endorsed these recommendations, But, when it came to their implementation, the old boy network has so far prevailed. The Auckland Women's Health Council met the Minister of Health on October 19 on issues of concern. But he failed to tell them that a committee of Health Department and Area Health Board representatives had already been set up — with no consumers on it!

A month later, the DOH proclaimed a standard for medical ethics committees. The NWH set up ad hoc committees to monitor the implementation of the recommendations. And their concept of consumer input was to include the National Council of Women. The Council is by no stretch of the imagination a 'community health group' In fact, it is a highly conservative organisation, unlikely to be any threat to the status quo.

The AWHC felt, as a genuine grass roots health consumers group, it should be represented, as should Maori and Pacific Island women. The Hospital Board said no. However, after presentation of a petition and representations by Board member Lyn Potter — not to mention a sizeable watching delegation at a Board meeting — AWHC inclusion was granted.

The Board set up six committees to deal with various recommendations. Some AWHC members have been satisfied with progress made by these committees. But others have found the doctors and nurses resist telling patients what is happening to them. They claim the patients would get upset. Yet the Judge's ruling was that the patient not only had the right to all relevant information, but needed to exercise her right to be involved in decisions on the management of her treatment and her right to decide on a freely given, informed, written consent.

Failure to let the patient decide if she wants to be fully informed is the subtle way to subvert and undermine the recommendations, while the medical profession continues to play God.

Nurses, said the Judge, should most appropriately be the advocates for the patients. But, they are still so intimidated by the medical staff that they shy away from openly confronting the issues raised by the Inquiry into the 1966 'unfortunate experiment'.

Their reluctance stems from the fact that others who have power over them show great resistance to change. Judge Cartwright found during evidence given at the Inquiry by not a few doctors and administrators 'a prevailing atmosphere of defensiveness and even arrogance, which, while understandable at a human level, does not bode well for the future care of patients at National Women's Hospital'.

Those who work at NWH can have some pressure applied to them by the Department of Health. Their Board is dependent on the Ministry of Health for its funding. But the University is quite free from this pressure. This is a serious matter, as the University is not only responsible for teaching and administration. On top of that, as the Postgraduate School of O & G, it greatly affects attitudes to obstetrics and gynaecology throughout the whole of New Zealand. In fact, the British professor who assisted its founding in 1946 said at that time: 'Whoever is appointed to this Chair has a unique opportunity to mould obstetric and gynaecology practice and thought in New Zealand'.

No doubt. But Judge Cartwright was not impressed by how it had worked out. She commented sharply on the 'intellectual impoverishment' displayed. 'The views of some members of the academic unit at NWH,' she said, 'have demonstrated unwillingness to accept up-to-date information and to incorporate it in teaching both students and General Practitioners.'

In line with her terms of reference, the Judge expressed reservations about the teaching and treatment of cancer precursors. She felt that the Royal College of

Obstetrics and Gynaecology review of ALL teaching should be brought forward in order to 'reassure the public and the medical profession that any mediocrity in the teaching programme is confronted, and that written, clinical and other teaching in this area is rigorously reviewed to ensure it is up to world standard.'

In fact, she recommended that Prof. Bonham's replacement should be a 'person of world class' so as to 'invigorate the Department's image and morale'.

Many in New Zealand would like a woman in the Chair — not just any woman, and certainly not a male clone, but one who has demonstrated her concern for women and her ability to stand up for them against her male colleagues.

In view of the Judge's well-founded criticisms, what IS the University doing about her recommendations. The Auckland University Council has set up the Ryburn Committee to 'report' on the issues raised by the Inquiry Report. But the Ryburn Committee is to be strictly limited to the Terms of Reference in so far as any of them applied to the Medical School. And, despite the Judge's order for consultation with community health groups, this is an in-house committee.

This lack of consumer representation was one of the issues raised by the AWHC when they met with the Minister of Health — alas, to no avail from that quarter. However, their efforts have resulted in the committe being enlarged to include a member of the Women's Academic Group, a member of the general staff and a medical student. The committee even condescended to meet with the AWHC.

The Director-General of Health, the Chief Health Officer and the Chief Medical Officer have all discussed the implications of the Cartwright Report with the Dean and members of the University's Medical Faculty. But the Minister and his Ministry have no power to enforce compliance. What the Judge witheringly labelled the 'old habits and attitudes (which) provided a sense of security for many who have been buffeted by the cold winds of this Inquiry' still prevail.

Pay grudging lip service to the Inquiry recommendations while whittling away the level of compliance, watering them down, remoulding them to retain medical and academic domination — such is the name of the power game.

All the doctors under fire in the Inquiry are still practising. Dr. Green still has access to patients' files and specimens. Prof. Colin Mantell, who was contradicted in the Report for his statement that vaginal swabs of newborn girl babies was not a trial but part of day-to-day care, has been appointed Administrative Head of the Department of O & G — without the position being advertised.

There is medical pressure to appoint a Medical Ombudsman instead of the independent Health Commissioner advocated by the Judge. Professor North, who has re-replaced his brother-in-law Professor Cole as Dean of the Auckland Medical School, has publicly expressed concern that 'informed consent guidelines are in danger of becoming too restrictive' and may 'impair the future training of medical students'. ('Auckland Star', 20.11.88)

As for Professor Bonham, the University Senate is considering making him a Professor Emeritus since no disciplinary procedures have been taken against him. (Under the present structure, who could or would bring such action?)

Is it any wonder that the Judge concluded, with regret, that she could 'not leave the encouragement of new habits and practices to the medical profession alone'? And, in passing, it must be said that, if there is this level of resistance to losing this level of power and income, how much more does it apply to capitalism faced with losing it all to socialism? It makes 'peaceful transition' on pretty poor odds at the TAB!

Obviously, this is just another field where the consumers, the victims if you like, are the ones who have to demand disciplinary action to ensure against recurrence of this type of 'unfortunate experiment'. And, as far as possible to prevent others. For there have been others — like the death of new-born Polynesian babies (1970-72) from routine iron injections; like the unrevealed (1971-72) administration of intravenous ethynol (1000 mls twice weekly) to women in the antenatal ward whose babies were 'small for dates'. At that time, the effects of alcohol on the foetus (foetal alcohol syndrome) were not officially known. So there should be a follow-up on these children.

Since the publication of the Cartwright Report, it is consumer health groups that have forced the National Women's Hospital and the Auckland Hospital Board in any way to face up to the recommendations in it and to take any positive action.

Sandra Coney is calling on consumers to campaign for the Commission of Inquiry to be reconvened in a year to ensure that the suggested changes and developments are under way.

It's a call that needs everyone's support.

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