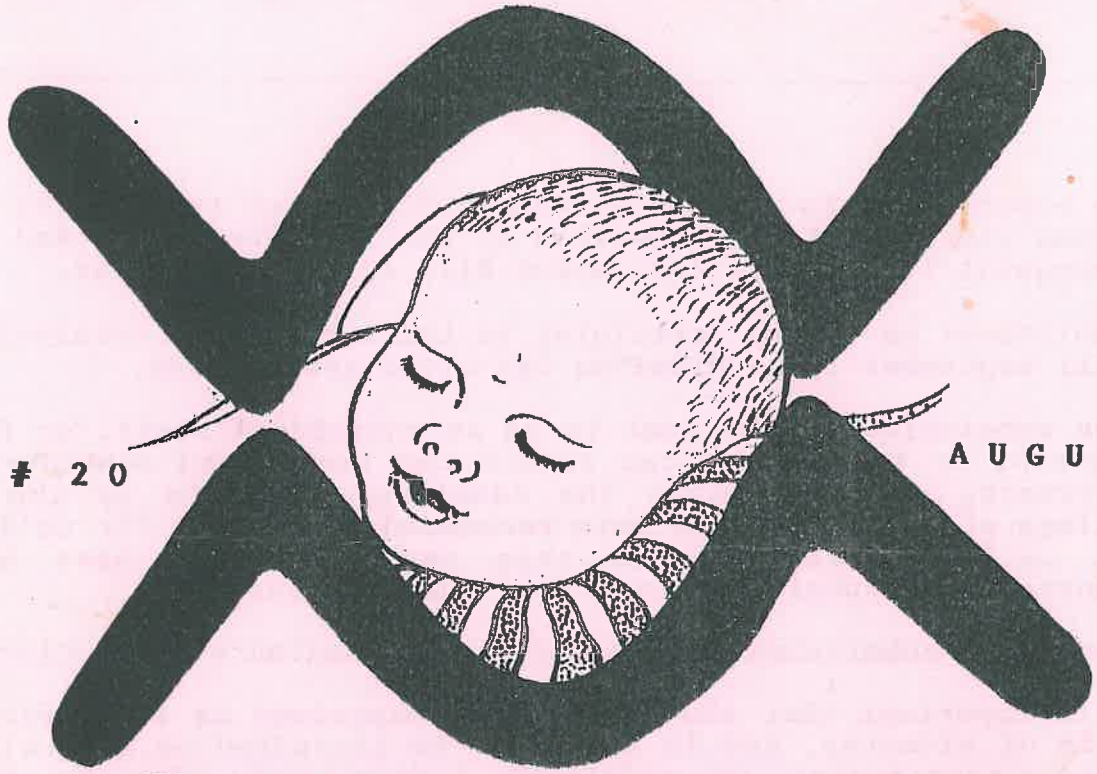
SAVE THE MIDWIVES



20 AUGUST 89

CONTENTS

LET'S GET IT RIGHT

The opportunity to restore autonomy of practice to midwives has arisen with the planned revision of the 1977 Nurses Act and the subsequent 1983 Nurses Ammendment Bill later in the year.

Submissions on issues pertaining to the Act will be received up until september 1st - Midwives Day....so get writing.

Your submission can be sent in on an individual basis, or from a group, or both. You can select the issues you consider of relevance, and/or endorse the submission sent in by the NZ College of Midwives. The main recommendations from the College are outlined elsewhere in this newsletter and have been endorsed by a submission from Save The Midwives.

Send your submission to the Minister of Health - Helen Clark.

It is important that the College be recognised as the official voice of midwives, and in this role be consulted on all policy matters pertaining to midwifery issues. It is therefore appropriate that the Ministry of Health obtain the services of midwife advisors from the College.

The separate midwifery register must be retained, and it is logical that this be administered by the College of Midwives.

NZ's present legislation is unique in that it prohibits midwives practising without another profession providing medical cover and ultimately taking legal responsibility for the midwives "performance". This is irrational and insulting to the midwifery profession who should be accountable to their own profession, and to the women who use their services. This requirement is also a very costly one to the health services, as it involves the payment of 2 health professionals for the task undertaken by the midwife.....quite ridiculous!

The Act must be changed to allow midwives autonomy of practice as professionals in their own right. The term MIDWIFE must be legally recognised and defined as a health practitioner also in her own right - a midwife must not be defined as a nurse. There must be a clear distinction between the role of the midwife and the obstetric nurse as they are NOT one and the same. The term obstetric nursing should be replaced with maternity care, and maternity care services.

The Act should reflect pregnancy and childbirth as a normal physiological event, and the appropriateness of women being involved in the planning, direction, and discussion of changes to areas involving women's health. The Midwifery Profession offers a profound advocacy role to women's health which must be protected and restored to its former status.

Judi Strid

FROM THE NZ COLLEGE OF MIDWIVES SUBMISSION ON THE REVISION OF THE 1977 NURSES ACT & 1983 NURSES AMMENDMENT ACT

Recommendations

* The title MIDWIFE be legally recognised. This would require that the revised Act be known as **THE NURSES AND MIDWIVES ACT.**

* The Midwife be legally defined as an autonomous practitioner in accord with the World Health Organisation & International Confederation of Midwives definition of a midwife.

* The New Zealand College of Midwives be recognised as the midwives professional regulatory body.

* Legal provision be made for midwife advisors to the Ministry of Health, nominated by the NZ College of Midwives.

* The Register of Midwives be retained.

Other Issues pertaining to the Act

- Comment is also required on the role of the Nursing Council - Should it be left in its present form.....and is it even appropriate for midwives?

The Nursing Council by its history has exposed itself as a council that is exempt from the Official Information Act, the Ombudsman and consumer input. If it is to continue as a council, it must have lay representation and most certainly midwifery representation if it is dealing with the midwifery profession.

Alternatively, the disciplinary role of the Nursing Council could be undertaken by the Health Commissioner in conjunction with the standards and quality control roles of the College of Midwives, Domiciliary Midwifery Peer Review Committees and employing hospitals.

- Section 54 3a & b must be revised to permit direct entry midwives to register with the Minister of Health as domiciliary midwives.

- That under the principles of the Treaty of Waitangi and the principle of partnership, that changes to the Act be made in consultation and with regard to the needs of Maori women.

- Direct Entry Midwifery training must become an option of the future to meet the needs of those women drawn to the profession who have no interest in nursing & to increase birthing options.

New Zealand

College of Midwives

* The first College JOURNAL is due out within the next month and will be obtainable from each Region of the College of Midwives. Cost of the first issue $4.00.

* 1990 NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE - Dunedin
Aug 17,18,19 Knox Theological College
WANTED - abstracts, ideas & fundraising suggestions
Contact: Conference Cmttee,Otago Region of College, PO Box 6243
Dunedin North

NZ College of Midwives **Ball Point Pens** are available through regional committees for $1.00.

* SWEATERS in black, white, maroon, bright red, dark red, royal blue, navy blue, light blue, bottle green, emerald green, gray, pink & teal with WOMEN NEED MIDWIVES MIDWIVES NEED WOMEN or
SAVE A MOTHER EDUCATE A MIDWIFE or
MIDWIVES FOREVER with picture of mw & babies
send size, colour $32 with order + $2.50 p+p to Auckland Region of College c/-Denise Knapman,28 Rotoiti Ave,Pakuranga,Auckland

* 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? *

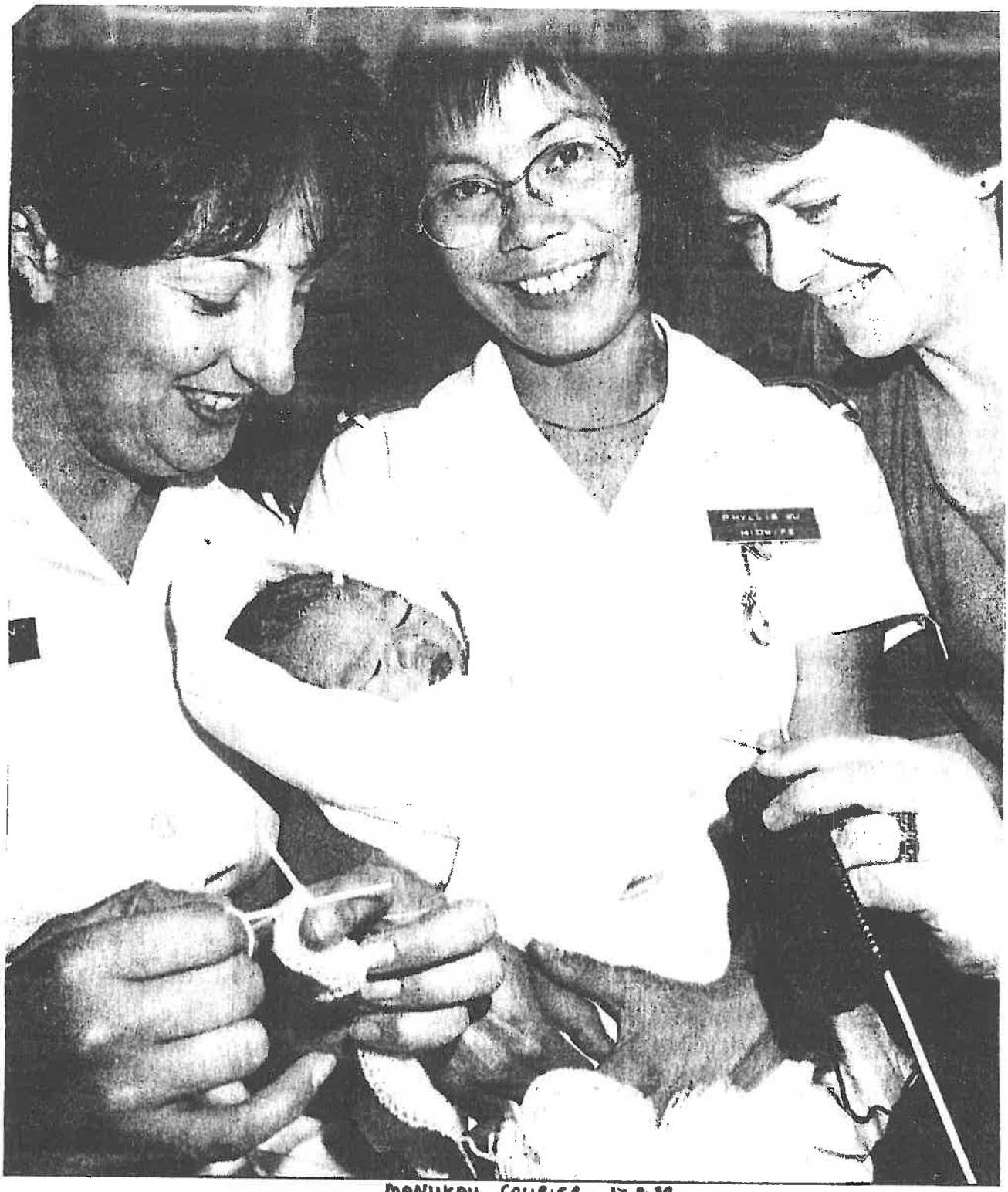
NEW ZEALAND COLLEGE OF MIDWIVES - Membership Application
PO Box 21-106, Christchurch

NAME:.....

ADDRESS:.....

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

Annual Subscription - Midwives/Full Membership - $52
- Student Midwives/Full - $26
- Non-midwives/Associate(waged) - $52
- Non-midwives/Associate(unwaged)- $26
- Affiliated Membership - $26



MANUKAU COURIER 17-8-89

The wool is out and the knitting needles are clicking as Middlemore Hospital midwives (from left) Ann Hanson, Phyllis Wu and Lesley Hinson prepare for Midwives Day. With them is baby Tahapehi whom they delivered just an hour before this photograph was taken.

Click go midwives' needles...

Middlemore Hospital's midwives are working frantically knitting, sewing and crocheting.

Their aim is to produce as many items of babyware as they can to mark Midwives Day which falls on September 1.

"We want to be able to give every child born at Middlemore on that day, a gift to mark the occasion," says Sarah Hodgetts, one of the local co-ordinators.

September 1 has been set aside by the New Zealand College of Midwives to celebrate and promote the importance of the work done by midwives.

"The work of midwives is becoming more acceptable in South Auckland and nearly 60% of babies born at Middlemore Hospital are delivered by midwives,' says Mrs Hodgetts.

"Mothers in South Auckland are becoming more receptive to midwives whose work involves neo and post-natal care for mother and child. There is a general misconception about our profession. Many people believe we just deliver babies."

Celebrations will be low-key with the emphasis on trying to attract more young nurses to the profession.

There are now nearly 60 midwives working at Middlemore Hospital.

DIRECT ENTRY MIDWIFERY UPDATE:

The recent focus of the DE Midwifery Task Force has been predominantly on the anticipated changes to the revision of the Nurses Act. It is essential to define a MIDWIFE as a practitioner in her own right and NOT a nurse for direct entry to be adopted as a feasible midwifery training option in this country.

However, since the Task Force undertook its committment to establishing direct entry midwifery training in this country, there has been a significant shift generally in how such training is viewed. In only 3 years DE has moved from being a subversive overseas concept to a viable and much needed training option.

We defined our tasks as -

* Dealing with the Community Attitude
  - increasing awareness of midwifery issues
  - mobilise support amongst women's groups
  - promote the positive aspects of midwifery care

* Conduct a Feasibility Study
  - to show community support for the project
  - to assess level of interest from prospective participants

* Organise funding to employ an appropriate person to formulate & construct a Direct Entry curriculum draft proposal

* Inform Maori women of our objective & to welcome their active involvement at all stages if this is their wish

* Explore existing resources such as Technical Institutes for the purpose of conducting Direct Entry Midwifery courses

* Change the legislation to extend the scope & areas of midwifery practice, and redefine what a midwife is

Aside from changes to the legislation which is pending, action has been taken on all other tasks. Gill Eyres White has compiled a proposal package for Technical Institutes with an interest in midwifery education and to date, 6 of these have been issued to Technical Institutes who we hope will consider a 3 year DE training module as a pilot scheme. Further packs are available to other Techs. if the interest is there.

Now that the NZ College of Midwives is operating at such a strong level and raising the profile of midwives in such a positive and uplifting way, the Task Force will be able to focus on more specific areas pertaining to direct entry.

DE training in NZ is no longer a case of IF, but WHEN. JS

WORDS FROM THE PAST:

I had experienced and heard of widespread mistreatment of women by doctors. So regular were the tales of abuse from the first gynecological examination to the last delivery that it began to resemble something more systematic in character than an occasional lapse we have all been encouraged to dismiss as phenomenal. It seemed rather like a rite-de-passage, which, typically of female initiations, is conducted in isolation, without fanfare, and with brutality.

—Antoinette Groesser, "Is Gynecology for Women?" 1972

Lynda Williams

Patients given advocate

HERALD 11-8-89

By JULIET ASHTON

A longtime campaigner on women's health issues, Lynda Williams, has been appointed patient advocate for National Women's and Green Lane hospitals.

The appointment of patient advocates in all hospitals to look after the rights of patients was a major recommendation of the Cartwright report.

Lynda Williams, who will be responsible for obstetrics and gynaecological patients at the two hospitals, is the first advocate to be appointed.

She was selected from 47 applicants by an independent panel of representatives from the Human Rights Commission, the Mental Health Foundation, the Maori Women's Welfare League and the Department of Health.

She will work independently of the Auckland Area Health Board and will be responsible to the Director-General of Health, Dr George Salmond, until the appointment of a Health Commissioner this year, who will oversee all advocates.

Both she and Dr Salmond made it clear that she would not be subject to the board's ban on speaking out publicly on issues. Dr Salmond said she would exercise her own discretion but could consult him or others if necessary.

Lynda Williams, who is aged 39, with four children, has worked in private practice as a childbirth educator for the past 10 years. She is a member of the Auckland Women's Health Council and is involved in many community groups.

In 1984 she helped set up the Auckland caesarean support groups, and this year has worked part-time for the Fertility Action group.

She said yesterday that one of her strengths was that she knew what it was like to be a victim of the health-care system, as a result of experiences in Green Lane Hospital and having two of her children.

"I know what it is like to feel helpless and powerless and not to have the support you need to make choices."

She said she already had a good relationship with some of the senior staff at National Women's.

"I do not see any problems with being able to work effectively with doctors at the hospital."

She said some things had changed at National Women's since the Cartwright report.

There was much more emphasis on patients' access to information and to medical records, and a lot of focus on the patient code of rights.

However she said not enough had changed or there would be no need for patient advocates.

She begins her work on September 13.

Health care move to 'wellness'

22-7-89

A $4 million health studies building, opened at Carrington Polytechnic yesterday, will cater for 360 nursing and midwifery students.

The building was opened by the Minister of Health, Helen Clark.

The minister said the mismatch between the supply of nursing graduates and the immediate demand for them would not be a long-term problem.

"Labour-market planning projections show that we will need today's nursing graduates."

Helen Clark said the health sector was moving from institution-based services to the "wellness end of the health spectrum."

"A re-emphasis on wellness involves encouraging clients to understand that, for most of us, the key to good health is largely in our own hands."

She said the public needed teaching about good diet, regular exercise, the hazards of smoking and alcohol and stress management.

The health studies building contains three laboratories, lecture theatres and a clinical practice suite.

Helen Clark

Group to examine births

Star 18-7-89

Options for giving birth are being studied as professionals and women join forces in a new working party.

The group, set up by the Health Department, met for the first time this month to talk about the voice, choice and safety of New Zealand mothers.

Department principal medical officer (women's health policy) Gill Durham said the party would report to the Government within one year and would be concentrating on the options of low-risk or "normal" women.

THE WORLD RENOWNED
SHEILA KITZINGER MBE
COMES TO NEW ZEALAND

24th - 26th September 1989

public lecture on "Birth, Breasts & The Passage to Motherhood"

25 September 7.30 pm AUCKLAND UNIVERSITY

Lecture Theatre underneath the library(B28) Fee $10

Sheila Kitzinger is widely respected internationally as the foremost authority on women's experience of pregnancy, childbirth and motherhood. Sheila is also acclaimed for her outstanding work in women's health issues. For decades she has helped women understand their bodies and fully experience the joys of childbirth.

Sheila Kitzinger has written over 20 books including the new fully revised and expanded edition of her classic book, **Pregnancy and Childbirth.**

She is an advocate of women's rights in health care and has helped thousands of women in many different countries towards self-awareness and self-confidence.

Sheila has two main fields of activity and interest. She is Britain's foremost childbirth educator and a social anthropologist studying the comparative aspects of birth, breastfeeding and motherhood in different cultures. She is known in many countries as a writer, lecturer and teacher on the social and psychological dimensions of birth, parenthood and female sexuality. She lectures widely and publishes in medical and women's magazines in Britain, Scandinavia, Australia, South Africa, South America, Germany, Italy and the USA.

ISSUES IN WOMEN'S HEALTH

A new, investigative and informative series especially commissioned and introduced by Sheila Kitzinger.

THE MIDWIFE CHALLENGE
Edited by Sheila Kitzinger

Midwives from all over the world compare their roles in different medical systems, in industrialised and developing countries, the problems they face and their hopes for the future.

MOTHERHOOD — WHAT IT DOES TO YOUR MIND
Jane Price

Jane Price, psychiatrist and psychotherapist, draws on women's accounts of their feelings at every stage of pregnancy and early motherhood, for a better understanding of the intense emotions which cannot simply be explained away as post-natal depression.

THE POLITICS OF BREASTFEEDING
Gabrielle Palmer

This powerful and provocative book looks at breastfeeding issues around the world. Women are still pressurised into feeding their babies artificially; Gabrielle Palmer challenges our complacency about breastfeeding and radically reappraises this important subject.

THE TENTATIVE PREGNANCY
Prenatal Diagnosis and the Future of Motherhood
Barbara Katz Rothman

In this groundbreaking book, Barbara Rothman draws on the experiences of over 120 women and a wealth of expert testimony to show how one simple procedure — amniocentesis and, more recently, chorion villus sampling — can radically alter the way we think about childbirth and becoming a parent.

Taking the positive approach to childbirth

Learning how to cope with labour isn't enough, says **Sheila Kitzinger:**

expectant women also need to learn how to cope with doctors

IT IS difficult to say what you want lying flat on your back, pants off, exposed from the waist down, with a strange man in a white coat towering over you.

All you can see is the top of his head as he prods with gloved hands inside your vagina. Many women find it impossible to be assertive in the hospital antenatal clinic and come out feeling depressed and anxious, and sometimes as if they have been violated. Learning about what happens in labour and how to breathe and relax is not enough. A pregnant woman also needs assertiveness skills so that she can say what she wants and not be side-tracked, patronised, cowed or emotionally blackmailed into submitting passively to whatever kind of care is routine and whatever the obstetrician decides to do to her.

Yes, of course there are pleasant, humane, friendly obstetricians, but even they are part of a power structure in which women are objects over which authority is exercised and rights asserted. It is the system which is at fault. In antenatal classes women often learn techniques for labour and receive doses of warm reassurance and hints on how to wheedle concessions from hospital staff by employing feminine wiles (most obstetricians are men).

This is not what many women are looking for from classes. They would like to know how to avoid being sucked into the medical system and turned into patients who are unable to make informed decisions about their own bodies. They want to be treated as intelligent adults.

Many doctors confuse assertion with aggression, do not know how to react to assertive women and turn hostile. An article in the

Even midwives can side with the system

Journal of the American Medical Association describes how doctors haven't the faintest idea what to do when a patient refuses an investigation or treatment. The trouble is that there is usually very little in their training which prepares them to cope. A sociologist, Diana Scully, asked doctors in obstetric training schools in Boston what they thought of as "a good patient".

One doctor put it in a nutshell: "She understands what I say, listens to what I say, does what I say, believes what I say."

Even midwives, who might be expected to understand what other women want and protect them against unnecessary intervention, sometimes side with the system against those who ask for something different from what is routinely provided. Margaret Miles, author of the major midwifery text-book, writes: "To the expectant mother labour is a very personal experience which engenders the presumption that she ought to participate in professional decisions and dictate regarding her obstetric care."

She warns: "If she knew more she would realise the wisdom of having faith in professional experts and allowing them to make decisions regarding her own and her baby's wellbeing and safety." Many midwives would dissent from that authoritarian point of view, but there are still some around who wish that women having babies would behave like obedient little girls and do what they are told.

Though we may think there have been great strides towards freedom and choice in childbirth, women are often prisoners of a system which pays mere lip-service to choice.

A World Health Organisation report about maternity care in Europe published a few months back disclosed that women can sometimes choose who can be with them at the birth in only 10 out of 23 countries, may have choice about pain relief in 10, can sometimes choose whether or not to be shaved in five, may be allowed to decline electronic foetal monitoring in five, can sometimes choose the position they are in at delivery in only three and may have some choice about episiotomy — the cut to enlarge the vagina at birth — in just one (which must be Britain). When a woman is assertive there is at least a chance of building a relationship in which she can work in equal partnership with those giving her care rather than being at the receiving end of treatment about which she is not consulted.

Yet many pregnant women find it especially hard to be assertive because they have been programmed since they were little girls to behave in an acceptably "feminine" way — being polite and charming, smiling when the doctor smiles, and avoiding at all cost being thought demanding.

It is true that more and more doctors are willing to discuss and explain the care and treatment they are proposing. They sometimes complain that women just don't want to know. Obstetricians and gynaecologists are the self-appointed guardians of women's bodies. They do not — usually — live in them but study them from the outside. Women may not have medical information but have other, equally or more important, knowledge about their bodies.

"I don't want to make them angry in case it goes down in my notes that I'm a difficult patient. They might have it in for me when I am in labour — or take it out on the baby." The more women speak out in a commonsense way about what they want, the more hospital staff will learn how to offer the right kinds of care. If a woman acts as if she expects to be bossed about the more likely it is that she *will* be.

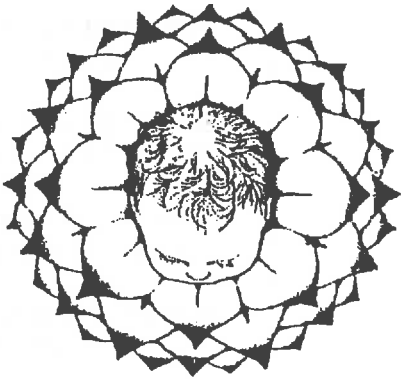
Always a price to pay for being submissive

"I don't know all the arguments so I couldn't explain why I didn't want to be induced." Though it helps to have as much information as possible beforehand, if an intervention is proposed that a woman does not want she can simply say: "No thank you."

There is always a price to pay for being submissive in childbirth. A woman avoids conflict but afterwards feels that birth was done *to* her, not something she did herself. I get hundreds of letters from women who have suffered a sense of complete powerlessness in birth, and who go on feeling this long after the baby is born. It often leads to them feeling incompetent with the baby too.

Being assertive can change conditions for other women, not just for you. Improvements in human care given to women in childbirth, do not, for the most part, come from inside the medical system. They come from outside, from pressure by parents who band together to take action and those women who have the courage to jump off the conveyer belt and say what they want.

National Childbirth Trust,
9 Queensborough Terrace,
Bayswater,
London W2 3TB
Tel: 01-221 3833
Association for Improvement in Maternity Services,
163 Liverpool Road,
London N1 ORF
Tel: 01-278 5628



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

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

* **NATIONAL FEDERATION OF PARENTS CENTRE CONFERENCE**
  26-27 Aug'89 New Plymouth High School.

* **MIDWIVES DAY** - September 1st **Tell us what you did**

* **PLAY FOR LIFE CONF.**-Sept.1-3 Spencer Park Camp,Christchurch

* **FRAMEWORK FOR HEALTH CARE IN AUCKLAND** - evening of Sept'5th
  Harold Titter,John McLeod,David King. Contact Auck.University
  Eugenia McCullagh, Dept.of Community Health

* **SUFFRAGE DAY** - September 19th

* PROMINENT BRITISH FEMINIST, SOCIOLOGIST & WRITER ***ANN OAKLEY***
  TOURING 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 & The Sociology of Housework & Housewife
  Itinerary arranged by Dr Sally Casswell,Community Health Dept Auckland Medical School Ph.795780 (Forum details as follows)

  Effects of Social Intervention in Pregnancy - 19th Sept. 12.30pm- 1st Floor Lecture Theatre, Nt.Women's Hosp.Auckland

  Feminism & Motherhood - 19th Sept. 7pm Lecture Theatre 1.401 Engineering Dept. Auckland University

  Perinatal Mortality: A Social Problem? - 20th Sept. 1-2pm Cole Lecture Theatre, Auck.Medical School

  Some problems of the Scientific Method & Feminist Research Practice - 21st Sept. 9-5pm Auck.University Conference Centre

  Public & Private Lives - Women's Book Festival Public Meeting 22nd Sept. 1pm Ellen Melville Pioneer Women's Hall, Auckland

  Women, Technology & Reproduction - 23rd Sept 1-5pm Conference Room, 208 Ponsonby Road, Auckland

  Consequences of Obstetric Technologies: Social, Psychological and Medical - 26th Sept 12.30pm Nt. Women's Hosp. 1st Floor

  Who Cares For Women? Science versus Love in Midwifery Today 30th Sept. 10.30-5pm Colquhoun Lecture Theatre, Dunedin Hosp.

  Topic to be arranged 2nd Oct. 2pm Memorial Theatre,Wellington

  Sexism - Does It Effect Health Care? 3rd Oct. 1pm Flat Lecture Theatre, Auckland Medical School

26th - p.m.
24th - Sunday p.m.

Sociology of Housework Revisited - 4th Oct 11am-1pm
Sociology Dept. Room 919, Auckland University

Promoting The Health of Childbearing Women/Women & Midwives An Empowering Partnership 4th Oct 7pm
Marion Davis Library, Auckland Hospital

Consumerism & The Future of the Perinatal Health Services
5th Oct. 10-11am Auckland Public Hospital

Birth as a Normal Process: The Sociological Perspective
5th Oct. 12.45pm 1st Floor Lecture Theatre,Nt. Women's Hosp.

* **BIRTH, BREASTS & THE PASSAGE TO MOTHERHOOD - Shelia Kitzinger**
Sept.25th 7.30pm Lecture Theatre B28, Auck.University $10
If there is enough interest a workshop will be organised max. 30 -approx.cost $60 on Childbirth & Culture, Birth & Violence Towards Women & Waterbirth on the 26th Contact Lynda Williams 16 McEntee Rd., Waitakere, West Auckland Ph.(09)8109442

* **CHILDBIRTH EDUCATORS ASSOCIATION X111 BIENNIAL CONFERENCE-**
Sydney 6-10 Sept'89 "Birthing - Toward 2000"
Contact: Conference Committee, Suite 11, 127 Forest Rd., Hurstville, NSW 2223, Australia (ph. 574927)

* **FREEDOM FROM HARASSMENT CONFERENCE** - Auckland 9-10 Nov'89 To address issues of equal opportunity and sexual harassment. Enquiries: PO Box 6751, Wellesley St., Auckland

* **1990 NATIONAL HOMEBIRTH CONFERENCE** - Whangarei
Calling for ideas & input, suggestions, fundraising etc.
Contact: Agnes Hermans 24 Pah Rd, Onerahi, Whangarei

* **NZ COLLEGE OF MIDWIVES BIENNIAL CONFERENCE** - Aug 17-19 1990
Enquiries:Conference Cmttee. NZ College of Mws, Otago Region PO Box 6243, Dunedin North. (Calling for abstracts/ideas)

* **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

* **EARTH FIRST EXPO** - an enviromental awareness event planned for October 1990. If interested in participating/exibiting or performing write to : P O Box 8371, Symonds St. Auckland

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

* **2ND INTERNATIONAL HOMEBIRTH CONFERENCE** - 1992 Sydney
Calling for ideas & input, suggestions re.areas of concern, specific people to be invited & fundraising. Open meeting 21.10.89 - 77 Albert Drive, Killara, NSW 2071,Australia
Enquiries & Input: Jane Thompson,12 Thornton St.Fairlight,NSW

Free advertising of events available

Book Review

Hauora - Maori Standards of Health a study of the years 1970 - 1984

by Eru Pomare, Professor of Medicine, Wellington School of Medicine and Gail de Boer, Assistant Director, National Health Statistics Centre.

National Health Statistics Centre. $15

"Hauorau" presents a formidable amount of statistical information, covering a fourteen year time span, in a lively and easy to read format.

It updates statistics from Professor Pomare's 1980 publication "Maori Standards of Health" and extends it to include information relating to socio-economic, self esteem and cultural factors.

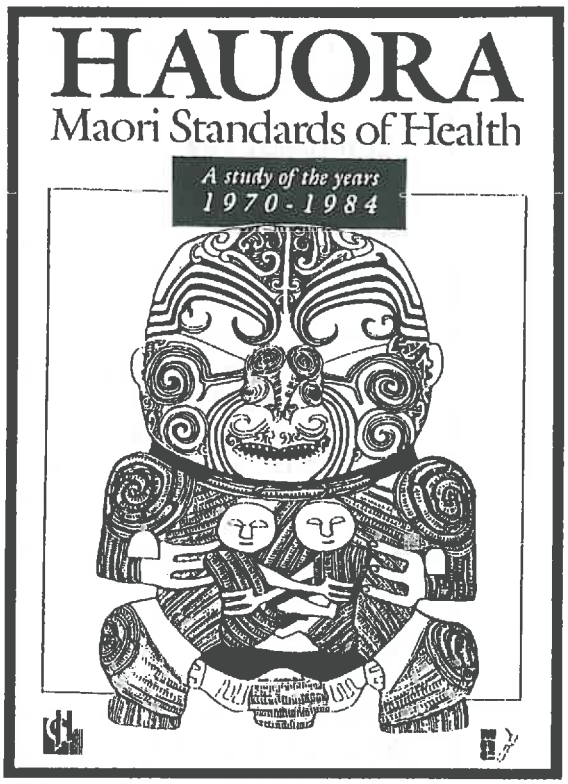
The clear, attractive layout, the boxing of information and use of colour to edge pages aids the absorption of the statistical information contained in 64 tables and 40 graphs. There are boxed summary highlights from each section in English and Maori and an excellent discussion at the end of each section. Preliminary lists of figures and tables with page numbers make easy reference.

In the introduction, which deals with the Treaty of Waitangi and the Maori concept of health, the authors note that implicit within the Treaty "were the concepts of equity, partnership and economic and cultural security, all of which contributed to Hauora (spirit of life/health)."

They summarise recent moves in which health authorities are being challenged to re-think basic attitudes to health and health care along cultural and ethnic lines.

"Tribal authorities have been advocated as custodians of Maori health and more emphasis on culture as a component of health has been recommended for the training of health professionals."

They point out that involvement of Maori people in health planning is a critical factor if the health needs of many Maori people are to be adequately met, while also acknowledging that "health cannot be imposed on a community but must develop from within, in response to problems perceived at a local level."



Health needs and related factors are dealt with in detail in sections that deal with Maori population, fertility, socio-economic factors, mortality, public and private hospital discharge, psychiatric hospital admissions, cancer incidence and health risks.

Recommendations range widely: from the adequate resourcing of Maori health initiatives at Marae, Hapu and Iwi level and the development of appropriate programmes for major health risks, to the establishment of a Maori health resource unit with advisory, monitoring and reasearch functions which should have a Maori director and research officer and be supported by the Medical Research Council and/or the Department of Health.

Another major report on Maori health issues and health trends up until 1990 is also suggested.

An extensive reference section is a potentially valuable resource for other people working in this area.

National Health Statistics Centre, Private Bag 2, Upper Willis Street Post Office, Wellington.

Celine Kearney MENTAL HEALTH NEWS

Reshaping hospital management

NZPA HERALD 13·7·89 Wellington

A revamp of area health and hospital boards completed its passage through the House yesterday.

The Area Health and Hospital Boards Amendment Bill alters boards' make-up, financial management, purchase of land and annual reporting procedures.

Moving the bill's third reading in Parliament, the Minister of Health, Helen Clark, said it had returned from the social services committee unamended, though there was discussion on measures dealing with appointments and enabling the closure of Picton Hospital.

Helen Clark rejected the need for an amendment requiring the minister to consult boards when appointing members.

"I think that consultation may well occur but I don't think it is necessary to have that written into the statute books," she said.

The Government had taxed heavily for the provision of health services but had had very little control on decision-making at that level.

It must be confident, in the taxpayer's interest, that boards comprise a broad range of people with the skills necessary to hold their management to account.

Under the reform, the number of government appointees increases from three to five and elected representatives drop from 14 to 12.

From the NZNA Winter Series on Bi-culturalism
Irihapeti Ramsden - Dept. of Education Nurse Advisor

In her role of Educ. Nurse Advisor Irihapeti looks at how nurses are prepared in Technical Institutes, and then sets about changing it. Her task includes the entire country and she holds the position on her own.

She describes maori people as all being anthropologists as they have spent their whole lives observing the other culture.

She has observed that Techs. have cultures of their own and that some are more difficult to penetrate than others.

The seeking of partnership, negotiation & recognition of their culture by tribal people is worldwide and undergoing a global process at present. Maoris are in many ways diametrically opposed to pakehas but they are good chameleons in the way they fit into pakeha culture. Although maoris have very clear differences the education system does not recognise or teach this. It offers instead an amalgamated and assimilated view.

We all need to know the deeds of the past so we can have a balanced perspective, as no education system is neutral. We need to know about events such as the 1835 Declaration of Independence which pre-dated the Treaty of Waitangi and was written by maori about maori sovereignty. We need to understand that the pakeha accountability of form filling is like not being trusted and undermines mana.

We also need to look at the warlike jargon used in nursing that came from a warlike time, but is no longer appropriate. For example - combating disease, targeting groups of people, having a blitz on head lice and body defenses.

In maori culture, the disease aspect of the body is very small as their health model is totally different. If the land is OK and doing well and is safe, then they are well. Maori will not be well until their mana and rangatiratanga is restored. When the earth is polluted & the eco-system disturbed then maori health is also disturbed.

Partnership of the future must involve mutual auditing and if pakeha use of maori aspects is wrong it must be removed. Education must change to affirm maori and change the history so maori children no longer need to feel like scrubbing or cutting off their skin.

There must be maori control over maori things - maori health, maori educational facilities, maori old peoples homes and maori birthing centres etc.

Pakehas can help this to be achieved and once maori are set up as a healthy people then we can work in partnership.

Cultural Awakening - with Frazer McDonald Social Anthropologist

was an enlightening workshop (July 20th) with the emphasis on the need to understand the uniqueness of each culture. The issue of bi-culturalism has to be sorted out first before we take the then short step to multi-culturalism. This is an issue that should have been dealt with long ago so requires urgent attention.

He described each culture as having its own continuum
Traditional----------Modern
and that we all fit somewhere along this spectrum in the way we view others and our enviroment - within our own cultures.

Communication affects our perception profoundly and is characterised in the following ways

Verbals 18%
Vocals 27%
Visuals 55%

Cross-cultural communication can present numerous problems such as the use of abstracts at the modern end of the spectrum when at the traditional end there is no such conception. Body language such as raising eyebrows, maintaining eye contact, nodding, and touching the head all have very different meanings between cultures. Cultural differences in social behaviour & abbreviations of the lanuage add to confusion and intimidation. Some examples.....

Polynesians -convey meaning by body language & listen by watching.
Pakehas -convey meaning by voice & word & listen by attending to words.

Specific Cues	Polynesian	Pakeha
head tilt/eyebrow raise	agreement	question/surprise
hunched shoulders	I don't know	I don't care
sniff	apology	disdain
standing to greet	superior status	sign of respect
sitting to greet	sign of respect	superior status
looking away	politeness	boredom/guilt
steady gaze	opposition	full attention
pauses/silence	companionable	awkwardness
"you don't want it do you"	No (I do want it)	Yes(I do want it)
quick frowns	please help	disapproval
"Do this" statement	is acceptable	an order

Different senses of humour can affect the level of communication, as can ending sentences on a high note which gives the wrong impression of asking a question. 30% of the worlds population approve of direct eye contact whereas the other 70% view it as the first sign of aggression. It is important to be aware of these everyday occurrences and to be aware of the pain of those caught between 2 cultures

5 Key Questions

The Ministry will shortly be publishing **Women's health: a checklist for Area Health Board members.** The Checklist has been designed to assist board members decide whether their board has the necessary policies, plans and procedures in place to ensure that women's health needs are met.

It lists five basic questions which should be asked each time a policy decision is made:

- What direct involvement have different groups of women (providers and consumers) had in the development of this proposal?
- What impact will the policy have on the well-being of women in our area?
- What impact will the policy have on Maori women?
- What implications does this policy have for equal employment opportunities, as required under the Area Health Boards Amendment Act 1988?
- What involvement will there be by different groups of women in the further development of this policy proposal?

If you would like a copy of the Checklist contact the Information and Liaison Officer at the Ministry.

Ministry of Women's Affairs,
PO Box 10-049, Wellington

If a doctor picks up a scalpel and cuts open a woman for an abdominal delivery primarily or even in part because of fear of litigation, he is clearly putting his interests before those of the woman as well as the baby.

Marsden Wagner

Are Drug Abuse and Suicide Linked to Traumatic Birth Events?

Ob.Gyn News (Vol. 23, No. 7, April 114, 1988) reports that researchers at the Karolinska Institute in Stockholm, Sweden are turning up strong evidence that drug addiction and suicide sometimes have their origins in traumatic birth experiences caused by obstetrics procedures.

The birth records of 412 adults who were born in Sweden after 1940 and died there between 1978 and 1984 were reviewed by Dr. Bertil Jacobson and his associates at the Karolinska Institute; 263 of the 412 adults had committed suicide, 96 were drug addicts and 53 were alcoholics.

A sample of 2,901 births provided a control group.

Remarkably, administration of opiates or barbiturates to mothers during labor was associated with adult drug addiction. Asphyxia during birth was associated with later suicide involving asphyxiation. Mechanical birth trauma, including breech presentation, forceps delivery, and nuchal entanglement, was associated with violent suicide. Dr. Jacobson and his associates have published their results in **Acta. Psychiatr. Scand.** 76:364-71, 1987.

Calling the results "astounding and alarming," Dr. Jacobsen and his associates hypothesize that self-destructive behavior may result from an imprinting process at birth that creates an unconscious need to repeat a traumatic birth experience.

They point out that their study is not the first to link infant and maternal risk factors with suicide. In 1985 a group of New York investigators reported an association between adolescent suicide and a respiratory distress at birth that lasted more than one hour, no prenatal care before 20 weeks' gestation and chronic illness of the mother during pregnancy.

Teen Suicide

The popular science magazine, **Omni**, published an article, "Born under a Bad Sign," in its November issue. Written by Sherry Baker, the article recounts the research that links suicidal tendencies with traumatic birth experiences.

Such investigations seem relevant and necessary, given that the overall suicide rate in the U. S. has tripled in the last 30 years, increasing most dramatically among young men between the ages of fifteen and twenty-four, according to Jim Mercy, a sociologist at the Centers for Disease Control (CDC) in Atlanta. According to the National Center for Health Statistics, one American teenager attempts suicide every 78 seconds, and one completes a successful suicide every 90 minutes. About 5,840 American teenagers die by suicide each year.

Psychologist Lee Salk of Cornell University Medical School documented a link between birth trauma and later suicide in a 1985 article published in **Lancet.** His groundbreaking study was designed after he began to wonder if birth (and post-birth) stress were not related to the tripling of suicides among teenagers in the last three decades. "The idea of attributing the tripling of suicides among teenagers to the stress of modern life just didn't sit well with me," he recalls.

The article recounts the work of Dr. Bertil Jacobson, head of the medical engineering department at Stockholm's Karolinska Institute. Jacobson's study found a correlation between the kind of birth trauma and the method of suicide. As he compiled his statistics, he postulated that clusters of babies born at certain hospitals at particular times later became drug addicts.

He confirmed that the future addicts were born in hospitals where doctors most frequently chose to administer opiates, barbiturates or chloroform to women in labor.

Dr. Jacobson notes that he has been unable to get his controversial studies published in an American scientific journal. "I understand that the subject is alarming," he says. "It suggests that everything about our obstetrics procedures needs to be carefully investigated and possibly modified. But it doesn't help to ignore the way what happens during birth may pave the way for tragedy in later life.

Write to: **Omni** *Publication International, 1965 Broadway, New York, NY 10023-5565.*

THE ADVISORY COMMITTEE ON WOMEN'S HEALTH:

This committee was established Nov'88 by the then Minister of Health David Caygill and the Minister of Women's Affairs Margaret Shields to act as a focal point for women's concerns on health, and to report directly to the Minister of Health.

The Terms of Reference -

In carrying out its functions the committee shall enter into consultation with women & health providers to identify current and future needs in the area of women's health and in establishing priorities. It will support the Dept. of Health in the promotion of policies with regards to women's health.

The committee will, in all its work, be responsive to the principles of the Treaty of Waitangi.

1. To report to the Minister of Health & make recommendations -
   a. on the health concerns & health aspirations of women
   b. on the development in area health boards.of health services for women
2. To encourage women to identify their own health needs & to participate in health services at all levels.
3. To act as a focal point and channel of communication for matters relating to women's health in NZ.
4. To encoursge the development of national, regional and local policy which meets women's health needs.
5. To promote the recognition and understanding by health providers of women's perspectives on health.
6. To encourage the provision of information & education which will facilitate women making informed choices and decisions about their own health care and treatment.
7. To advise on any related matters as may from time to time be referred to the committee by the Minister.

Committee members were chosen for their personal qualities and experience and were not appointed as representatives of any groups or organisations.

Chair: Dr Diana Edwards/Christchurch (former director of FPA)
Honey Betham/Christchurch (Drug & Alcohol Centre)
Dr Barbara Brookes/Dunedin (History Lecturer)
Marion Miller/Winton (Community Health Worker)
Colleen Urlich/Dargaville JP (Dargaville High School)
Dr Hilary Liddell/Auckland (O&G National Women's Hosp.)
Mary Lythe/Auckland (Health Educator)
Lynn Potter/Auck. (ex Patients Rights & Area Health Bd member)
Colleen Manihera/Tauranga (Maori Health Co-ordinator/T.Hosp.Bd)
Rovina Maniapoto-Anderson/Te Awamutu(Tokanui Hosp.Maori Health)
Sally Wilkinson/Whakatane (Public Health Nurse)
Bibby Plummer/Dannevirke (Dannevirke Women's Health Centre)
Anne Phillips/Wellington (lawyer)
Mary Robinson/Wgtn. (Wgtn.Hosp.Bd.personnel & training Dept.)
Ann Warner/Wellington (Ex Officio representing the Health Dept)

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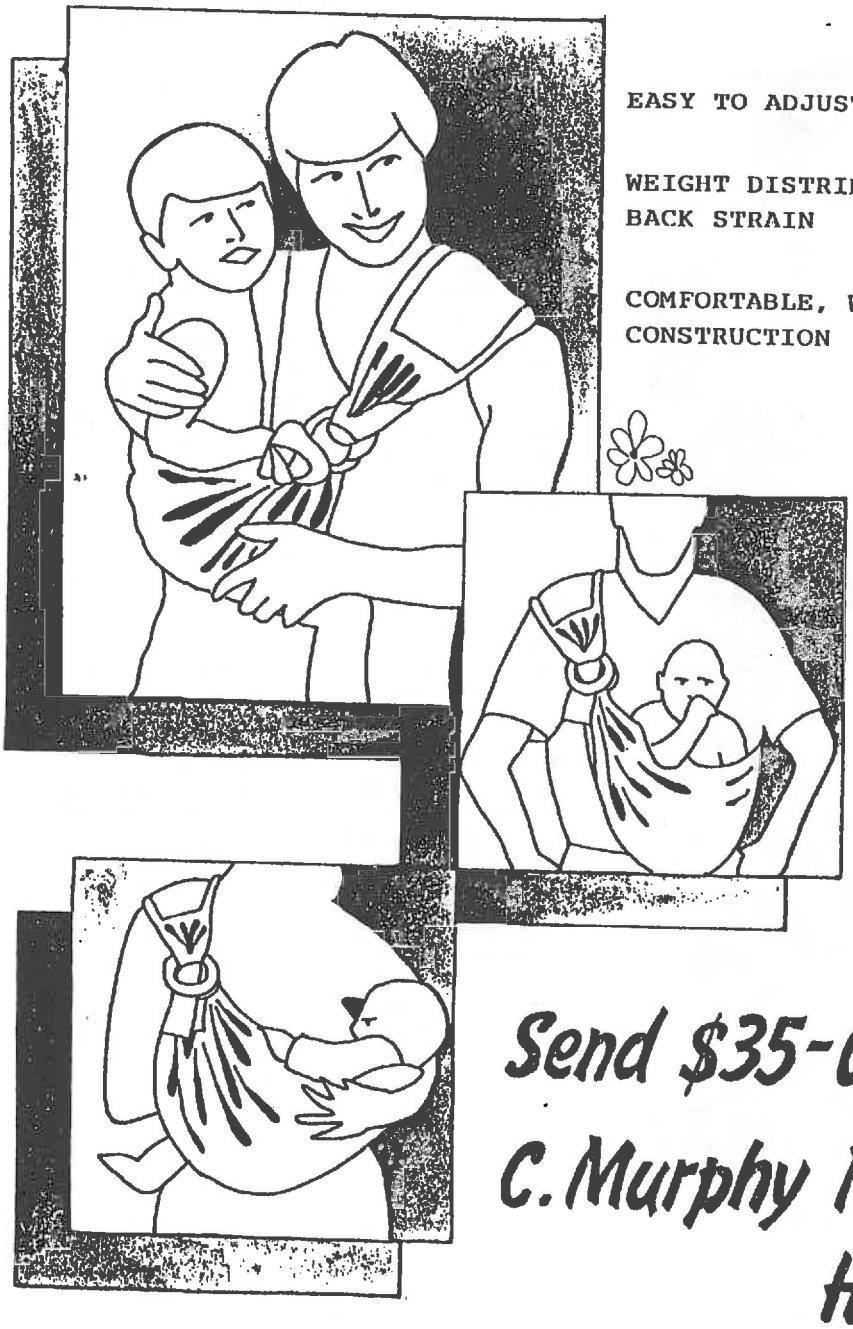

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HUNTLY & DISTRICTS COMMUNITY HOSPITAL

The Huntly and Districts Community Hospital is set in pleasant, tranquil surroundings giving a peaceful home-like atmosphere and is staffed 24 hours a day with experienced Registered Nurses and midwives. We are proud of the service we offer the Huntly community and would like to extend that service to the neighbouring region. We have a total of 16 beds

Antenatal: Antenatal classes are held weekly and a specialist from Waikato Womens Hospital visits the hospital each fortnight for antenatal clinics.

Birthing: With a well equipped birthing room as well as the theatres, patients/clients are given the option of a home-like birth in the security and safety of the hospital environment.

Mothercrafting: This is another service we offer 24 hours a day, 7 days a week to mothers who for one reason or another, need further support or guidance. Babies up to nine months can be catered for.

Cabbage keeps abreast of pain

HUNTLY maternity hospital acting charge nurse Colleen Yorwarth

WAIKATO TIMES 27·5·89

By RACHEL BUCHANAN

Cabbages are not used only in coleslaw at Huntly Maternity Hospital.

Hospital staff have discovered a new use for the leafy vegetable — helping new mothers recover from child birth.

For the past three weeks nurses have been putting chilled cabbage leaves on women's breasts to help relieve the pain and swelling which occurs when a woman starts producing milk.

The leaves are also used on the vagina to help ease bruising after an episiotomy (a cut in the vagina).

Acting charge nurse Colleen Yorwarth said the hospital started using cabbage leaves after charge nurse Jan Trass read an article about the soothing properties of cabbage leaves in a magazine.

"For a long time we have used ice and that does help but now we have discovered cabbage," Mrs Yorwarth said yesterday. "We are prepared to try anything as long as it doesn't harm the patient."

Mrs Yorwarth said the hospital has had to increase its cabbage supply so there are enough cabbages to be used for food and for healing. Two women have been treated with cabbage leaves so far. The leaves are applied to the breasts under a bra and are replaced after every feed or when they become too warm.

"We told the girls about the cabbages and they went along with it," she said.

Both women had said the cabbages had been soothing and now two new mothers in the hospital are thinking about using leaves once their milk "comes in".

Mrs Yorwarth admits that using cabbage leaves might seem a bit odd.

"Everyone giggles and laughs — it has caused a lot of hilarity. We used a whole cabbage in two days."

In spite of this the idea seems to be catching on.

Waikato Women's Hospital nursing supervisor Pat Oettli said a women had brought her own cabbage with her when she was admitted to hospital to give birth.

Two other women had also tried the cabbage method after they had seen it in action.

Mrs Yorwarth said she was not quite sure why cabbage leaves worked so well. There could be some sort of enzyme in the cabbage or it could just be that the leaves were cool and moulded well to the women's body.But she could remember her father using dock leaves to relieve swelling.

One cup of sliced, raw cabbage contains about 20 different vitamins and minerals including large amounts of Vitamin B.

Hamilton nauturopath Paul Hume said it also contained a little-known substance called Vitamin U. This helped in the healing action and was used to cure stomach ulcers.

The vitamin also had a drawing action which could help breasts swollen with milk, he said.

Government agrees to home birth payments

15-6-89

SYDNEY: Women are to be given a Federal Government handout to have their babies at home, despite warnings that more babies will die as a result.

The Government yesterday decided to support an Australian Democrats amendment to health legislation to provide financial support to women who give birth at home.

The Minister for Health, Dr Blewett, is examining ways of covering the cost, but he has ruled out extending Medicare to pay for midwife services.

Only one in every 200 women chooses home birth, with the average cost $1000.

But the Royal Australian College of Obstetricians and Gynaecologists said yesterday any measure which encouraged women to give birth at home was potentially dangerous.

The president of the college, Dr John O'Loughlin, said the Government had been badly advised.

He said there was ample evidence to show the mortality rate for babies born at home was "significantly higher" than for babies born in hospital.

"More babies will die — it's as simple as that," he said.

And he said that of even greater concern was the untold number of babies born with brain damage and other abnormalities as a result of the home birth process.

The national co-ordinator of Home Birth Australia, Mrs Hilda Bastian, angrily denied suggestions of a higher mortality rate for home births.

"The National Health and Medical Research Council published a report in 1987 saying there was no scientific evidence to justify the concern about the safety of home births," she said.

"It is wrong for the college to suggest home birth mothers place the lives of their babies at risk.

"The standard of midwifery in Australia is extremely high. There is simply no evidence that home births are more dangerous."

Mrs Bastian said the community would save an average $2000 if women chose home rather than hospital births.

Home birth prediction stirs docs

Sunday Star 23.7.89

By JOANNA WANE

MONT LIGGINS

National Women's Hospital researcher Professor Mont Liggins has caused a stir in international obstetric circles with a prediction that home births will soon be accepted as a fact of life.

He told the British Congress of Obstetricians and Gynaecologists in London that support services must be made available to make births outside hospital as safe as possible.

Liggins, one of three keynote speakers, also predicted that within the next 10 years most births will take place in a more "homely" environment with care provided mainly by non-medical staff.

His comments have been welcomed as a significant change of direction by home birth advocates who say they have battled for years against prejudice and opposition from the medical profession.

One British specialist who attended Liggins' address says his vision of the future caused quite a stir.

"Some consider him a bit of a prophet, but others thought he was indulging in fantasy," she says.

"Home births have hardly been accepted by the medical profession, particularly in New Zealand, but people will listen to what Mont Liggins says."

The four-day congress drew more than 1000 people from 52 countries.

Liggins told the *Sunday Star* obstetricians should feel obliged to back up the home birthing service as far as possible, but greater emphasis must be placed on reliably assessing risk.

"I can see the merit of home birth in terms of satisfaction to the family group, but we are also aware of the fact that out-of-the-blue things can go wrong."

He forsees a division between high-risk patients who will receive sophisticated, hi-tech obstetric care and low-risk patients who may opt for shorter stays in hospital with less medical involvement.

A working party set up by the Health Department is expected to report to the government this year on the options of low-risk women.

The group will concentrate on women's choice including where they give birth, the position they use, who they have with them and ante-natal work.

A discussion paper is also due to be released next month by the Auckland Area Health Board reviewing the provision of maternity services.

Auckland midwife Joan Donley says opposition from doctors to home births remains widespread.

The New Zealand College of Midwives is preparing a submission to Health Minister Helen Clark seeking the restoration of autonomy to midwives in a review of the Nurses Act.

Home births are allowed by law only "if a medical practitioner agrees to take responsibility for the woman.

Staff terms

PROFESSOR Liggens predicts (*Star*, July 23) that maternity care within the next 10 years will be "provided mainly by non-medical staff".

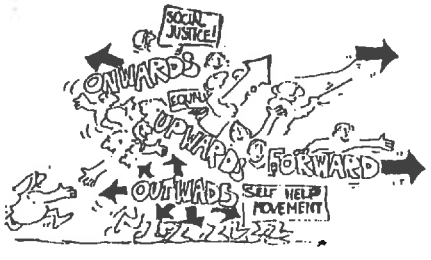
To whom does he refer? Ward cleaners, hostesses, orderlies, dieticians, lab technicians? Or could he possibly mean midwives? If so, I wonder why he appears so reluctant to say so.

JOAN DONLEY
Mt Albert

Auck. STAR 7.8.89

INFORMED CONSENT - DEFINITION
(Auckland Area Health Board)
March 1989

Informed consent may be defined as the process whereby some one who has the capacity to consent is given sufficient information about the nature, effects, risks, benefits and (where applicable) the alternatives to a projected therapy or procedure to enable that person to arrive at a reasoned and unpressured decision as to whether or not to consent to that therapy or procedure.



AUCKLAND WOMEN'S HEALTH COUNCIL

presents

"A DAY OF RECKONING"
THE CARTWRIGHT REPORT — ONE YEAR ON

The conference (5.8.89) was attended by 400 women including the Minister of Health Helen Clark who spoke briefly at the conclusion of the day and presented a press statement on the progress in implementing the Cartwright Report. $14 million has been allocated for a national screening programme.

Dame Cath Tizard opened the conference and Clare Matheson (Ruth of the Metro article) told her very moving story of the trauma in being one of the women involved in the unfortunate experiment - unbeknown to her at the time. Her experience along with those of the many other women involved has highlighted the lack of accountability that Drs have and how even when a case of medical malpractice is under investigation, the patient who has been wronged is put through an intimidating and ruthless process which ultimately serves to protect the profession.

To date, 18 women have taken their cases to the High Court but it doesn't look hopeful. Lawyers for the defense are trying to change the charge to medical mis-adventure which means accidental. Obviously the 28 deaths of women involved in this planned and deliberate experiment were not accidental, and if legally it is described and accepted as such....then anything goes. We can't let this be fobbed off as medical misadventure.

A special presentation was made to Judge Sylvia Cartwright who got a standing ovation as a great sign of respect for her contribution to women. She seemed quite overwhelmed by the response and described her experience with the Enquiry as a moving and searing experience she will never forget.

Phillida Bunkle emphasised the importance of the Judge being a woman and how contrary to the usual situation where the professionals define the terms, the Cartwright Report had turned it all around so consumers define the terms. This shift is necessary for the medical profession to be accountable. The Report exposed the medical profession as being above the law and self serving, breeching their monopoly and opening it all up for scrutiny.

She described the Report as providing a recipe for hope...and hope worth fighting for.

The medical profession have responded with an expensive swept up consent form and kit complete with little stickers claiming

"My Dr Cares" (for what?)...but it still leaves consumers dependent on their goodwill.

Women have achieved alot this year with the unprecedented support for change amongst women's groups all over the country. Patients are now more assertive and there is a powerful willingness to act for change.

However, the arrogance continues and Drs have actually stated that women are mentally unstable if they are unable to tolerate vaginal examinations, and that men are better able to understand the scientific technology. Apparantly, when men complain, they become honorary feminists, and when they become patients, they become honorary women!

Drs are further expressing their concern that all these moves and assertion of patients rights will stifle medical research, poison the relationship between patient and doctor, and cause a shortage of clinical teaching material. Their conclusion is that patients rights just aren't good for you, and that patients are even manufacturing complaints out of thin air!

Consumers are whats wrong with consumer demands...and there is the belief that if consumer activists are discredited then the grievances will go away! However, Phillida assured us, the public is aroused and wants to see positive action, not just PR Drs are even undertaking community consultation themselves to avoid contact with consumer appointed representatives.

She accused the Health Dept. of showing a lack of will in responding to women's needs and the Cartwright recommendations. The report recognised the importance of co-ordinated leadership to ensure the shift in power to make the system more accountable - but to date there is no procedure for carrying out the recommended protocol. 7½mths after the national workshop, there is still no report and the Dept. still haven't decided whether smears should be free, or how to deal with at risk groups. She raised the question of how long will they go on consulting until they get the "right" answers....it could go on forever.

However, behind all this is a determined and noisy majority....
Things will never be the same again.

Sandra Coney stated that for 30yrs women were subjected to a reign of medical abuse that shocked the world, and we are not safe until we can guarantee it won't happen again.

She outlined how an eminent O&G commenced a project that continued risking women's lives even when women were dying. The project was only formally stopped a year ago even though Drs knew but did nothing. Experiments included babies even though the research was useless, and for 20yrs vaginal examinations and IUD insertions were conducted on women undergoing

anaesthesia without their knowledge or consent. Sometimes the Drs even approved their own research.

She described the aftermath of the enquiry as being a demonstration of the medical professions power...the twists & turns, the manoeuvering, the attacks on those who complain and the determination to retain their power. One strategy is to keep writing reports which delays any action and bogs down the whole system. When you don't want to change, form a committee ask for submissions and write a report. As a consequence we now have the Ryburn Report on the Cartwright Report....and the North Report on the Ryburn Report and subsequent reports on all these reports.....but NO action, even though all the reports have similar conclusions to the Cartwright Report!

Sandra described a dim perception of consumer involvement that lacks any committment and is applied to anyone who doesn't have an MD.

However, she also described the positive achievements that have resulted since the Cartwright Report. Lives have been saved as women get access to their files and proper treatment. More women are asking for smear tests due to the publicity, and Drs are also more aware and reminding women to have smears. The cervical smear issue is now seen as an important one and many obstacles have been abolished as a result of the enquiry.

Women's Health is now news and has a high profile. Reporters are interested, the medical disciplinary process has been exposed and the mood is now for the need for change. New ideas are being explored in areas that were formerly the territory of the medical profession, and people are skeptical of the medical profession now so things are no longer going unchallenged.

Drs are being forced to think about topics and confront issues they can no longer ignore. Some Drs have responded positively, others feel threatened and are resisting change.

Vaginal examination without consent has now stopped. The prohibition on this meant their "teaching material" (we call women) has dried up over night. An approach was made to the Auckland Women's Health Council about the need for vaginas, and for the first time women could select their representatives. On committees they demand CV's and make the selection themselves, whereas for vaginal examinations - any old woman would do.
The Auckland Women's Health Council has drafted a teaching module for vaginal examination that places the teaching programme into the hands of women and has been sent to the O&G's for consideration.

Sandra concluded by stating the Cartwright Report legitimated women's reality showing that no woman was alone and that this was a pattern of behaviour from the medical profession. This has had a powerful affect on women's self esteem

Brief Report of Workshops:

***Consumer Participation In Decision Making** - The main concerns involved lack of effective consultation. Consultation is trendy but there is a lack of action. There is a need for women's groups to be broad based at a grass roots level with greater networking.
This group announced the birth of the Aotearoa Women's Health Council which will work initially as a national network for women's health groups.

***Cervical Screening** - made a number of recommendations ie.
-That the national workshop recommendations be implemented
-That local expert groups be set up in addition to national one
-Need for more detailed research
-Appropriate educ.materials to be available to health workers

***Maori Women & The Cartwright Report** - This group worked on the baseline of partnership as defined in the Treaty and asked that this be considered in all aspects ie. dual positions for health commissioner and patient advocates, and that the concept of bi-culturalism be demonstrated throughout Aotearoa. They want the university to be more humanified and maorified and for more maori women to become politically active.

***Pacific Women & The Cartwright Report** - emphasised the enormous need for interpreters, but that these must be skilled and paid for their services. It should be a legal necessity that interpreters be available, and cultural needs must be recognised and respected within the hospitals and wider community.

***Patients Rights, Patient Advocates & Health Commissioner** -
-demanded that the Health Commissioner be appointed immediately
-adequate funding be available for research of women's issues
-pt.advocates/health comm. be accountable to Human Rights Comm.
-patients should own their own records & hosp. have copies
-pt. advocate should be 1st point of contact for pt. complaints
-interpreters must be made available now

***Research** - demanded consumer input into identifying & prioritising issues, and that at least 50% of ethics committees comprise consumers considering the Treaty, gender and age.
-need support services for women on these committees
-Decision making by consensus
-52% of research funds to women

***The University Response** - felt that women are owed a public apology and that there should be compulsory, universal, anonymous feedback from students to ensure teachers are appropriately skilled and trained. They want to see more emphasis on selection criteria such as social and personal skills, and ethics to be taught in the classroom and on the wards. They want more feedback from women's & ethics groups.

***National Women's Hospital** - want a clear and detailed account of what changes have been made and how the $5 million has been spent. They want outpatient clinics in the community to be established and more colposcopy training to be available to interested GP's. They wish the AHB ban to be lifted.

***Doctors-** changes should reflect consumer needs with a holistic approach, considering patient rights. They felt the medical profession needs to give up power, develop a partnership approach and to listen, hear, respect, inform, educate and give choices. Accountability must be patient centred and consumers must be involved in disciplinary procedures.

***Health Department** - this group identified the lack of consultation by the Dept. and the need for women to be listened to. For any action to happen they felt the Cartwright Report issues needed to be taken out of the Health Dept. They felt the Ministry of Women's Affairs could have a more active role.

***Informed Consent** - was considered to be fundamental to most ethical issues and the sharing of disturbing experiences of women in the group showed that current guidelines are not being observed. Informed consent requires understanding so....
-all forms must be in the language of choice -should be a legal requirement with a national committment to this implementation
-consumers involved in decision making/not just consultation
-no prejudice to anyone withholding consent & if the pt.& next of kin are unable to give consent, pt. advocate be consulted.
-consent to participation in research be separate from consent to treatment

***National Women's Hospital Survivors** - 1500 files of women were involved in the enquiry but very few women are in contact with each other so they have formed a **Patient Support Group** to provide support for women with cancer of the genital tract. They plan to be politically active ,using the media etc. to initially demand what disciplinary action has been taken re. nine Drs in particular who were involved with the experiment.

***Having a Say About Health** - was a workshop for women considering standing for AHB's, and the strong feeling was the need for support of both the person in the job, and the person themselves. They acknowledged the need for more women on boards and for women to recognise their power and make it work for women. Candidates need to be accountable, so it was felt that where possible they should stand on a ticket. Having a say is everyones responsibility & we all need to take this up.

***Health Professionals** - comprising a group of 14 nurses of whom 9 were Tech.Tutors expressed concern that well educated graduates enter a hostile health system & end up being a part of it. As educators they are committed to teaching informed consent as part of everyday nursing practice, and endorse the need for paid interpreters & appropriate cultural practice. They hope to form an ethical action group to prevent individual nurses being victimised & feel the Nursing Council must be opened for public scrutiny & have consumer reps. on it.

The day closed with a maori blessing -

" To cherish life is to cherish women "

FOUR WOMEN MARK MEDICAL MILESTONE

Four women who took on the might of the medical profession were in Auckland yesterday to mark the first birthday of the Cartwright Report on the treatment of cervical cancer at National Women's Hospital.

From left are Judge Dame Silvia Cartwright, Sandra Coney, Clare Matheson and Philidda Bunkle at a seminar run by the Auckland Women's Health Council.

Judge Cartwright's report on the cervical cancer inquiry was released a year ago yesterday, but the Auckland Area Health Board says all her recommendations could take another 18 months to implement.

The report found a failure to adequately treat a number of patients with carcinoma in-situ (which can lead to invasive cancer) as part of a poorly designed research proposal lacking important ethical and scientific guidelines.

Coney and Bunkle who co-wrote the magazine article which triggered the inquiry, spoke to the seminar on the changes — and the lack of changes — during the past 12 months.

Matheson, known as patient Ruth during the inquiry, received a standing ovation.

She was diagnosed as suffering from cancer in 1985 and underwent a hysterectomy after first being referred to the hospital with an abnormal cervical smear in 1964.

She was never told that the constant tests gave any reason for concern and, when a specialist finally recommended surgery, he said her anatomy was so mutilated he could hardly see anything.

Matheson (52) is claiming damages of $1.5 million from associate professor of obstetrics and gynaecology Dr Herbert Green (now retired from National Women's) and four other parties.

Her case is before the Court of Appeal, awaiting a decision over whether the issue can be resolved by the Accident Compensation Corporation as medical misadventure.

Matheson says individuals must take responsibility for what happened.

"Twenty-eight women (involved in the research) have died," she says. "I don't think we should let that be fobbed off as medical misadventure."

— JOANNA WANE SUN STAR 6.8.89

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