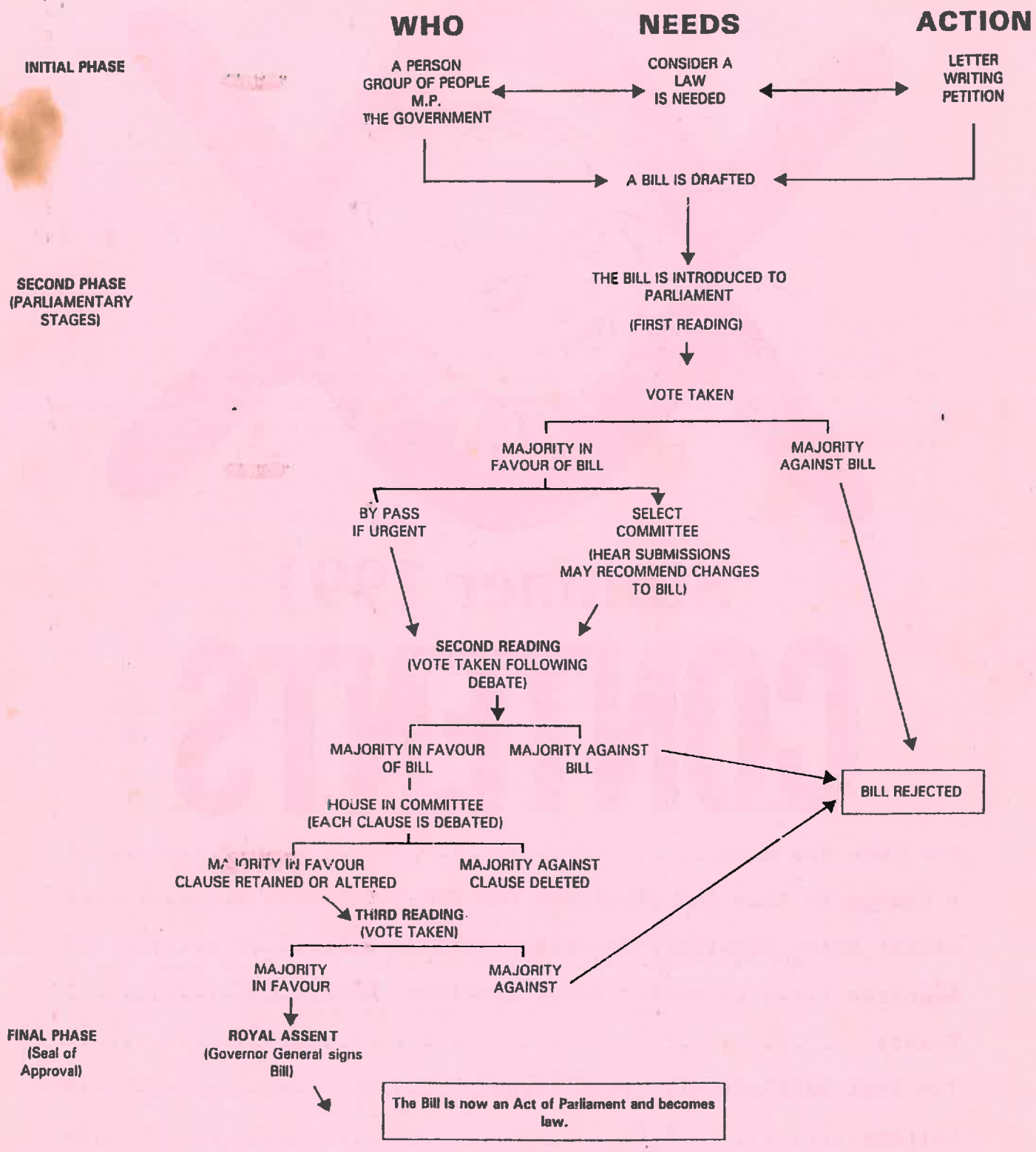
SAVE THE MIDWIVES

#25

Summer 1991

CONTENTS

HOW LAWS ARE MADE



The New Zealand Constitution is also characterised by:

— the fact that much of it is not in statute form and is unwritten;

— the fact that New Zealand has no bill of rights;

— the absence of a second legislative chamber;

— the relative ease by which it can be altered by an Act of Parliament.

The *Constitution* sets up various institutions of government in a system similar to the British (Westminster) model. The institutions are:

— *The Governor-General* who represents the Queen in New Zealand and provides continuity from one term of government to another.

— *Parliament* — consists of one body, the House of Representatives (MPs). The upper house or legislative council was abolished in 1950.

— *The parliamentary parties*, — for example the parliamentary representatives of the Labour and National Parties who meet together in Parliament and separately as the caucuses.

— *The ministers of the Crown* — appointed from the ranks of the Government, i.e. the parliamentary party that has won a majority of seats in the House.

— *The Cabinet* — ministers meeting to make policy decisions and initiate proposed legislation.

— *The Executive Council* — ministers of the Crown together with the Governor-General.

— *The Civil Service* — different Government departments, for example the Departments of Social Welfare and Justice, each under the control of a minister.

— *Public corporations* — corporations,

A CHANGE IN NAME AND DIRECTION

Save The Midwives was formed in 1983 as a response to the crisis in midwifery. The focus then was on the precarious existance of midwives, the lack of them and the need to take urgent action on their training and scope of practice. Domiciliary midwives received very poor reimbursement and most areas were without a homebirth service. This was also a time of encouraging women to participate fully in their pregnancy and birth and to recognise and support the role of midwives as advocates for childbearing women. Midwives also recognised the need to work with women to bring about changes.

A great deal has happened since then. The establishment of the College of Midwives has been a turning point for midwifery, facilitating an increased awareness of the role of midwives and national cohesion for the profession. The College recognises the special partnership between women and midwives and has established powerful credibility nationally and internationally. Strong leadership and direction is provided by Karen Guilliland, with the wisdom and foresight of Joan Donley ever present. MP Helen Clark has both an understanding of childbirth politics and a willingness to bring about change fo women. As Minister of Health, her committment to this resulted in the legislative changes necessary to restore autonomy to midwives and to commence Direct Entry Midwifery training in New Zealand.

As a result, although vigilance is ever necessary, midwives no longer need saving and the objectives of STM as an organisation have essentially been met. The College of Midwives is well placed to address ongoing issues and the only outstanding issue for the STM organisation is the commencement of Direct Entry Midwifery training. Therefore, the name and direction of Save The Midwives needs to change.

The Save The Midwives Direct Entry Midwifery Taskforce will remain as it is until DEM has been satisfactorily established.

However, the rest of the organisation will amalgamate with Maternity Action. We will then be left with the best of both organisations and a more relevant and broader focus. Although this newsletter will be the last to be produced under the name of Save The Midwives those with subscriptions will automatically receive a Maternity Action newsletter. The focus will be on all maternity issues with an emphasis on information provision and networking, plus the political aspects....addressing the issues that directly affect choices and options for women and midwives.

This is a success story. There aren't many organisations that see their aims and objectives achieved in such a short time, so acknowledgement must go to all those who have contributed to made it happen.

Judi Strid

DIRECT ENTRY MIDWIFERY OVERVIEW

by Jilleen Cole

In August 1990 an ammendment to the 1977 Nurses Act provided for the establishment of Direct Entry Midwifery education as experimental programmes. This ammendment also enables a midwife and/or medical practitioner to take responsibility for the care of a woman throughout her pregnancy, childbirth and the postnatal period. Prior to the ammendment it was necessary for a medical practitioner to take this responsibility. The Department of Health recognises childbirth as a normal physiological process and in enabling midwives to practice independently and autonomously this concept is affirmed.

One might be forgiven for thinking that provision of midwifery education without nursing as a pre-requisite would have been accomplished within a relatively short time - not so.

Unfortunately the ammendment to the Nurses Act was passed just prior to a general election and change of government. An ammendment to the Education Act earlier last year caused the introduction of many new regulations relating to all areas of education. These new regulations have resulted in a number of changes and various transitional and organisational difficulties. The new regulations are administered by the New Zealand Qualifications Authority (NZQA).

One other factor which has influenced the introduction of direct entry midwifery was the change in membership of the Nursing Council of New Zealand. The result of these changes all occurring during the 2nd half of 1990 is that there have been many unavoidable delays.

Even before the passage of the ammendment, a number of polytechnics were expressing their interest in setting up a direct entry to midwifery programme. By October 1990 when the new Nursing Council met for the first time, several proposals had been submitted for consideration. At this time the Nursing Council realised there were many decisions to be made which would delay the commencement of these programmes.

In February 1991 following discussion with the NZQA a decision was made by the Nursing Council to invite interested polytechnics to submit their proposals with a curriculum to the Nursing Council by June 1st 1991. This has meant a delay in the processing of Carrington Polytechnics curriculum which was submitted to both the Nursing Council and NZQA for approval and accrediation in early December.

At this stage it is not known how many polytechnics will be submitting curricula, but among those known are:-

Otago Polytechnic
Wellington Polytechnic
Auckland Technical Institute
Carrington Technical Institute

It is very exciting to feel the growing change in attitude towards midwifery education. However, we do not know how many midwifery programmes will be funded by the Ministry of Education. The process which will be followed after June 1st is as follows:-

1. A special meeting of the Nursing Council's Education Advisory Committee will be held to assess the submitted proposals and curricula.

2. Institutions whose written proposals and curricula appear to meet the Nursing Council's criteria for approval of an experimental midwifery programme will then be invited to proceed and make application for course and provider approval from the NZQA.

3. Those institutions which obtain NZQA approval will then proceed with a recommendation from the Nursing Council's Education Advisory Committee to a full meeting of the Nursing Council.

4. If the Nursing Council adopts the scheme under Section 39 of the Nurses Act 1990 Ammendment, the approval of the Minister of Health will then be sought by the Council. If the Council declines a proposal it shall, in accordance with Section 39 give the institution concerned, reasons for that decision, and advise of any ammendments which would make the proposal acceptable to the Council.

5. Institutions approved by the Minister of Health will then seek funding approval from the Ministry of Education.

The process is quite lengthy so one area of great concern is the long and frustrating wait for the many dedicated and committed women who have submitted formal applications to enter the midwifery programme as students. Although the delays have been unavoidable and couldn't have been foreseen, it doesn't lessen the difficulty for those who need to be able to plan their lives accordingly.

Degree or Diploma?

Of further interest is the most recent debate around midwifery education. This involves whether the qualification upon completion should be a diploma or a degree. There is a strong move towards degrees in nursing so there are those who believe the midwifery qualification should be a degree to follow the nursing trend. However, there are also those who feel that the basic programme should be a diploma with an option of a further year to complete a degree for those who wish. Midwives and others around the country are being asked by the NZ College of Midwives to discuss this and make their views known.

Education for Direct-Entry Midwifery

Statements by the National Coalition of Midwifery Educators and the American College of Nurse-Midwives

National Coalition of Midwifery Educators

Statement of Support for National Accreditation of Midwifery Education, June 1990

California Association of Midwives Newsletter, Summer 1990

We issue this statement of support for the national accreditation of midwifery education. We believe the following to be integral to that process:

- There is wisdom in diverse models of midwifery education.
- There should be varied, available and accessible routes of entry utilizing these diverse models.
- The various educational routes, including at-a-distance learning, conventional classroom format, preceptorship and university-without-walls, should culminate in mastery of core competencies which meet a national standard of midwifery education.
- Midwives should be available for all childbearing women, and diverse models and entry routes are essential in alleviating the current crisis in provision of maternity care.
- A national standard will facilitate reciprocity, consistency, quality education and a common knowledge base. A national examination should include a challenge mechanism that would be available to all midwives, regardless of educational background.
- Methods of evaluation for certification must be culturally unbiased.
- The certification process must avoid time restrictions on education.
- Meeting core competencies in education is the evaluation mechanism of successfully completed basic midwifery education.
- Midwives must be the primary teachers of midwives.
- Midwifery education must be based on the belief that midwives are the guardians of the process of women giving birth and well-women's health.

American College of Nurse-Midwives

Position on Professional Midwifery (Accepted by ACNM Board of Directors March, 1990)

In August 1989, the Board of Directors of the American College of Nurse-Midwives adopted the following position on direct entry professional midwifery:

"The ACNM will actively explore, through the Division of Accreditation, the testing of non-nurse professional midwifery educational routes."

Explanation:

For many years there has been discussion within and outside the ACNM about ways to increase the number of qualified nurse-midwives, including the preparation of non-nurse, direct-entry professional midwives. In July 1989, at the request of interested nurse-midwives and with funding from the Carnegie Foundation for Higher Education, a group of certified nurse-midwives, licensed midwives, educators and clinicians met in Princeton, New Jersey. One result of that meeting was near unanimous agreement that we should have one standard of professional midwifery in the United States, and that the ACNM has set that standard. However, an important part of that agreement was recognition that there are several ways to meet the standard for professional midwifery. Nursing has worked well in the United States and elsewhere as one base for that standard.

In recognition of the tremendous need for more health professionals to care for women and childbearing families, in recognition that nurse-midwives alone will never be able to meet all those needs, and in recognition that professional midwifery is a viable and important profession worldwide, the ACNM is willing to review proposals from groups interested in defining the core competencies in health skills analogous to nursing that are needed in order to prepare individuals with the core competencies in midwifery already defined by the ACNM. These are currently titled *Core Competencies in Nurse-Midwifery*, but since nursing is prerequisite, the "core competencies" are really for professional midwifery. Trusting in the standards for accreditation of nurse-midwifery educational programs, it seems logical and wise to have the *Division of Accreditation* (DOA) be responsible for the review of direct-entry midwifery programs applying for recognition.

Therefore, the ACNM Board of Directors, with support from the Division of Accreditation, has charged the DOA to explore for possible review and accreditation proposals from schools intending to prepare *professional midwives*. The DOA has already begun this exploration. It is the Board's hope that such programs will meet the standards of the DOA with core competencies in health skills reviewed and accepted by them. It is expected that this exploration and testing of core competencies will take a minimum of one year.

It is also expected that these new educational programs will take some time to develop and test, and for graduates to become certified. The Board appreciates the efforts of all nurse-midwives working together with others in order to maintain one standard of professional midwifery in the United States. ■

CARRINGTON POLYTECHNIC

School of Health

ACUPUNCTURE FOR MIDWIVES

29 MAY - 4 JULY 1991

1830-2030 hrs

We are offering this exciting course for Midwives interested in learning more about acupuncture techniques and how to integrate them into practice.

This is a 12 hour course - six sessions x 2 hours

Course Facilitator :	Di Nash General Practitioner MBChB, Dip.Obs Specialist in Acupuncture
Basic Course Cost :	$86.40
Needles :	Approx. $5.00

Students will need to purchase the text :
"Essentials of Chinese Acupuncture".
The cost is approximately $60-00and the book will be available at the commencement of the course.

Course is limited to 16 participants

Please phone 894-180, Ext.8312
to request an enrolment form

Warning on pill and ops

LONDON.— Women on the pill have been warned to stop taking it if due to have major surgery.

Professor Alan Aitkenhead, a consultant anaesthetist, said oral contraceptives should be discontinued a month before major operations because they increased the risk of blood clotting.

The warning followed studies which indicated women talking pills containing the female hormone oestrogen have a higher risk of the blood clotting condition of thromboembolic disease.

Writing in the *Journal of the Medical Defence Union*, Professor Aitkenhead said the degree of risk of thromboembolic disease was two to four times higher in pill users than in non-users and this appeared related to the oestrogen dose.—NZPA-Reuter.

29·10·90

EVENTS

Dr Michel Odent, internationally acclaimed obstetrician, to visit New Zealand

In this tour of major centres in Australia and New Zealand Michel Odent will speak on:

- Hospital birth: needs, dreams and reality
- Colostrum and civilisation
- Scientific approaches in obstetrics
- The ecology of birth and breastfeeding
- Water and sexuality

Dr Odent will be addressing audiences in

Auckland	Thursday April 11
Wellington	Friday April 12
Christchurch	Saturday April 13

For full details please contact the ACE Representative in New Zealand:

Sandy Bedggood
4 Hadfield St
Birkenhead Auckland
Phone: (09) 482 0072

Visiting Professor Dr Judith Lumley

Director, Centre for the Study of Mother's and Children's Health
Monash University
and
Consultant Epidemiologist, Health Department, Victoria

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"MATERNITY SERVICES- What Do Women Really Want?"

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Wednesday 10 April 1991

7.30 p m

Robb Lecture Theatre
School of Medicine, Park Road
(opposite Auckland Hospital)

PUBLIC LECTURE

MANAWATU POLYTECHNIC ANNUAL NATIONAL MIDWIVES WORKSHOP 12 -14 April 1991

Nursing and Health Studies Department
Manawatu Polytechnic
Private Bag
Palmerston North Phone (063) 65030

This workshop focuses on reviewing the context of present midwifery practice as well as examining and encouraging the ongoing development of midwifery. Organised by midwives for midwives, it will be relevant to both hospital-based and community-based midwives.

PROGRAMME

Friday 12 April

Registration
6.30pm - 7.30pm

Dr Michel Odent
Internationally acclaimed visiting obstetrician
7.30pm - 9.00pm

Saturday 13 April

Registration
8.30am - 9.30am

Speaker:
Karen Guilliland
President N.Z. College of Midwives

Speaker:
Hon. Katherine O'Regan
Associate Minister of Health

Lunch provided

Saturday Afternoon and Sunday Morning 14 April

Selection of Workshops
- Essential Teaching Skills
- Clinical Midwifery Skills
- The High Risk Consumer
- Independent Practice
- Natural Approaches
- Midwifery Research
- AIDS/HIV
- Challenges in Antenatal Care
- Cultural & Consumer Perspectives

Sunday Afternoon

Report back/Future directions

Participants may choose from the variety of workshops offered. All workshops offered on Saturday afternoon will be repeated on Sunday morning.

An exhibit area will be included for the first time in association with this workshop.

Lunches, teas and evening meal on Saturday have been included in the cost of the workshop.

Costs:

Total Workshop	$120.00
Saturday only (includes lunch & dinner)	$76.00
Sunday only (includes lunch)	$41.00
Saturday morning only (includes lunch)	$41.00
Saturday afternoon only (includes dinner)	$41.00
Sunday only (excludes meals)	$37.00
Saturday morning only (excludes meals)	$37.00
Saturday afternoon only (excludes meals)	$37.00
Dr Michel Odent Presentation only	$ 5.00

SEMINARS FOR MIDWIVES 1991

The School of Nursing and Midwifery offer Update Seminars for Registered Midwives to assist practitioners in keeping up to date with current knowledge
trends
and maintaining skill currency

TOPICS PROPOSED FOR SEMESTER ONE 1991

The Midwife :	Pharmacology and Prescribing how : what : when : why	Wednesday 13th March Thursday 14th March
The Midwife :	The teacher in everyday practice	Tuesday 26th March
The Midwife :	Taking the Ante Natal Class	Wednesday 27th March
The Midwife :	Examination of the Newborn	Thursday 2nd May
Preparing for Domiciliary Midwifery Practice		Wednesday 29th May
The Midwife and Current Legislation - the Acts revisited		Tuesday 18th June

TIME: 0900 - 1600 **COST:** $40.00 per seminar inclusive of GST

VENUE: Akoranga Campus, Northcote.

Midwives may enrol for either an individual seminar or for a group of seminars.

Further Seminars will be offered in Semester 2 on relevant and topical midwifery issues.

For further information contact

School of Nursing and Midwifery
Auckland Institute of Technology
C.P.O. Private Bag
AUCKLAND
Telephone (09) 497-099

REGISTERED NURSES SEMINARS

WOMEN'S HEALTH WORKSHOP

CONTENT

Why Women's Health? Why do women remain the greatest consumers of mental health services? These questions and more will be explored during the four day workshop. Various women's health issues will be examined including: cervical cancer and screening, breast cancer, hysterectomy, eating disorders, mental health and related issues, sexual abuse and menopause.

Cost:	1 day	$35.56	+ $4.44	G.S.T. =	$40.00
	2 days	$60.00	+ $7.50	G.S.T. =	$67.50
	3 days	$80.00	+$10.00	G.S.T. =	$90.00
	4 days	$100.00	+$12.50	G.S.T. =	$112.50

Venue: Akoranga Campus, Northcote.

If you would like further information please telephone (09) 497 - 099

Please tear off and return application slip below to:

School of Nursing & Midwifery
Auckland Institute of Technology
C.P.O. Private Bag
AUCKLAND

Wellington Women's suffers Fawlty flaws

MARY VARNHAM

JOHN CLEESE once explained that he was inspired to invent the brilliant comic character Basil Fawlty of Fawlty Towers after staying at a hotel in Folkestone.

The attitude of the proprietor, Cleese observed, was that it would be a great job running a hotel if only you didn't have to have guests cluttering up the place.

It's beginning to look as though the Wellington Area Health Board feels the same way about Wellington Women's Hospital.

The hospital that women did not want in the first place — and fought against in a long bitter struggle to retain St Helens Hospital — is now discharging mothers and babies so fast they barely have time to cut the umbilical cord, let alone establish breastfeeding routines or gain elementary know-how about caring for a baby.

Wards which once oozed the ambience of Bombay Station in the rush hour now echo the eerie emptiness of the wreck of the Mary Deare, as though their inhabitants had suddenly and mysteriously evaporated.

This vacuum effect is what you get when the most human of experiences, birth, runs up against the least human of philosophies, right wing economics and its benchpeople — razor gangs and strategic planners.

There's a bit of artistic licence in my description of Wellington Women's Hospital. It is not fair to suggest that care of mothers or babies is negligent. It isn't: nursing staff work hard to provide adequate care. But there are fewer and fewer of these nurses, just as even in the midst of a minor baby boom, there are fewer and fewer women left in hospital to care for.

If the board's finance committee gets its way, Wellington Women's two remaining postnatal wards will soon be deftly concertina'd into one, with the loss of yet more beds. Not everyone, though, thinks this is a bad thing.

The story is of a happy (for the area health board at least) coincidence of growing interest by many women in more natural, less medicalised birth and growing interest by the board in slashing costs.

Why, the argument goes, keep new mothers in hospital when they would be better off at home? Advocates paint a compelling picture of mother and baby supported by caring partners, relatives and friends.

Midwives Marion Lovell and Carey Virtue, who set up the Domino scheme under which women go home from Wellington Women's just two hours after giving birth, say the scheme has been even more successful than they hoped.

Mothers get more rest away from hospital routine, they say. They rarely have problems breastfeeding and are more comfortable in their own environment.

Domino women get regular visits from a midwife during pregnancy. The same midwife usually stays with them during the birth in hospital and visits them at home almost daily for the next two weeks.

But this scheme presently caters for just 24 women a month, only a tenth of the women who give birth at Wellington Women's. For the rest, there is mounting pressure to leave the hospital after two or three days.

A community midwife may visit them at home for a few days and there are the usual Plunket check-ups but many doctors claim this is no substitute for the five to 10 days of complete hospital care and rest new mothers used to get. More and more they are seeing medical and social problems they believe could have been avoided.

Dr Julia Carr, of Newtown Union Health Service, says in the past very young mothers or others ill-prepared for a baby were often able to pull their lives together, given the necessary support.

Now this is getting harder. Women are falling through the widening cracks in the health system. Her concerns are echoed by Pregnancy Help's Sue Tuck. Tuck says the agency, run almost entirely on voluntary labour, has seen its workload triple in the last three years.

"White middle class women will find support. They're assertive and can stand up for themselves. But the women most affected are at the bottom end of the scale.

"Most live in horrendous conditions. They go into hospital unprepared — a number haven't even got basic provisions for the baby. Because of cuts, there aren't always the staff around to help them at Wellington Women's and some go home with few parenting skills."

Nobody is taking any notice. Tuck worries. Nobody official, that is. Last October, 28 local doctors were concerned enough about the situation to send a stern letter to the board's general manager Dr Karen Poutasi, board members and managers at Wellington Women's.

Staff reductions were "eroding the quality of care available and approaching unsafe conditions" leading to "family dysfunction, parenting problems and breastfeeding problems". The doctors suggested other ways of making savings and requested that users of the service — women — be involved in decision making. A reply from the women's health services manager at the hospital accused the doctors of behaving unethically.

In November a public meeting expressed grave concerns about the effect of deteriorating services.

Somewhere along the line, the Wellington Women's Health Council was asked to contribute to the strategic plan for women's health services for the next five years — only to find that decisions were already being made elsewhere to cut costs by 10 percent and close wards.

Ignoring the voice of women has been one of the constants in the vexed saga of Wellington's maternity services.

The decision to close St Helens, a low-cost, purpose-built maternity hospital which women liked, and to build in its place a high-cost, 10-storey hospital with many features — such as shared rooms — which women did not like, was based on a report by a Users Committee.

The "users", though, were not women having babies, but doctors. The women were referred to only as "clinical material" suitable for teaching postgraduate medical students.

Hospital administrators will still defend to the death the decision to build Wellington Women's. This is a worry because the fact is that the 10-year-old hospital has been a hugely expensive mistake. Two of its 10 floors are empty. One has not been used for years, the other only intermittently, most recently as a temporary ward for cancer patients.

The closure of another postnatal ward, if it happens, will mean three floors are empty. On top of this, Dr Poutasi has admitted there could be times when gynaecological and antenatal patients end up in the same ward — a situation described by lobby group Maternity Action as inhumane. Stronger words could be used.

It's hard to escape the conclusion that women are bearing the brunt for the asinine decisions of a decade ago — decisions in which they had no say. Health activist Phillida Bunkle has sardonically described Wellington Women's Hospital as voicelessness solidified.

Lamentably, the lesson has patently not been learnt. The "clinical material", like Basil Fawlty's hapless guests, is still being studiously ignored, or at best tolerated as a necessary nuisance.

With any luck the free market will come up with a more economically appropriate way of reproducing the human race. But when it does, it may have to go private.

Home Birth Conference

Nelson, 17, 18 and 19 May, 1991

The Nelson Home Birth Association welcomes those attending the 1991 National Conference. People outside the association are cordially invited to register.

The conference venue is the Bridge Valley Christian Ranch, Wakefield, Nelson, in a beautiful valley setting. Accommodation for over 100 delegates is on site but they will need to bring bedding. Transport from airport and bus depots will be provided by Nelson H.B.A. members.

We look forward to the conference as a time of sharing with all the New Zealand Home Birth Associations.

With the recent amendment to the Nursing Act allowing midwives to practice on their own responsibility, the 1991 Conference will focus on this and what it means to all those with an interest in childbirth.

The theme of the Conference is: "HOME BIRTH – EVERY WOMAN'S CHOICE".

Registration Form

Send to: Nelson H.B.A., PO Box 59, Nelson

Cheques payable to: Nelson H.B.A. Conference 1991

Registration Fee $50 _____

Accommodation and Meals $30 _____

Total _____

Do you require childcare YES/NO

How many children? _____

Age(s) _____

Are you arriving Friday night YES/NO

Saturday morning YES/NO

Do you require transport to venue YES/NO

from airport YES/NO

from bus depot YES/NO

Name(s) .....

Address .....

.....

Telephone .....

I am a Midwife in a dilemma. I am a N.Z. Registered Midwife. I hold a current practising certificate. I am on the N.Z. Register of Midwives. I have had 17 years of midwifery experience. It fit into the description of the W.H.O. definition of a midwife. I do not have the same choices of practice that most other Midwives have in N.Z.

I am one of the 178 Registered Obstetric Nurse/Midwives equalling 4.8% of all Midwives practising in this country. We are a dying breed! There are 29 overseas Direct Entry Midwives making up 0.7%.

Direct Entry Midwives (N.Z. and Overseas trained) have legislative restrictions limiting our practice. We are governed by Sect 54(3) which states "only Registered General Nurse and Registered Comprehensive Nurses are able to attend women in childbirth." We are able to practise antenatal and post natal care in the community but Sect 54(3) restricts us from giving continuity of care when consumers demand. Our Midwifery care is fragmented. We are unable to take responsibility for homebirth, and at this stage there is a query over our ability to gain a contract with Area Health Boards (for Domino births). There is a demand for both in my community.

Direct Entry Midwives working in the community before 1984 were rightly protected by the Act. These Direct Entry Domiciliary Midwives have exactly the same education as all other N.Z. Direct Entry Midwives. All completed the 18 month maternity programme (terminated early 1970's) and graduated from the 6 month Midwifery programme (terminated for Obstetric Nurses around 1979). Direct Entry Midwives still practising would be more experienced and would be familiar with current Midwifery practice.

Our education is as follows:

18 month: Maternity programme (Base Hospital) approved by Nurses and Midwives Board (now Nursing Council)
12 month: (at least) Staff Nurse in a Maternity Hospital.
6 month: Midwifery programme (approved by Nursing Council) same programme as RGNS.

All of the above equate to:
3 years: Education in all aspects of ante-natal, birth, post-natal and at least 10 years or more Post Graduate Midwifery experience if continuance of practice.

Domiciliary Midwifery is care of the low risk women, being able to detect deviation from the normal and consult and refer as necessary, and be familiar with emergency procedures. I believe our training and experience did prepare us for the above.

Our status is diminished. We are N.Z. Registered Midwives on the register with all other Midwives in N.Z. New Zealand is short of Midwives.

Domiciliary Midwives are reviewed annually by the Domiciliary Midwifery Review Committee which consists of: 4 consumers (chosen by the Homebirth Association), 1 Domiciliary Midwife, 1 Hospital Midwife, 1 Area Health Board Doctor.

My history of practice is as follows:

4-65 Commenced Maternity programme
2-67 Gained Registration as an Obstetric Nurse.
4-67 Staff Nurse Taranaki Base Hospital. All aspects of normal and abnormal obstetric care.
9-67 Staff Nurse 10 bed Level One Maternity Unit Taranaki Hospital Board. Low risk maternity care.
67/68 Staff Nurse Hutt Hospital. Neo Natal Special Care Unit and Post Natal. Resigned to have family.
71/72 Staff Nurse Hutt Hospital. Neo Natal Special Care Unit and Post Natal.
72/73 Student Midwife St Helens Wellington
8-73 Gained N.Z. Registration as a Midwife
73 Staff Midwife Elderslea Hospital Wellington Area Health Board.
Elderslea was a Level One hospital in Upper Hutt. I practised there until the unit was closed in December 1989.

All staff Midwives had equal status at Elderslea (until the last 2 years of its existence). I worked afternoon and night shift mostly. My first eight years at Elderslea I worked part time night duty. Most of that time I was the only Midwife on duty and worked with an untrained Nurse Aide. On other duties I had full responsibility for clients antenatally, during labour, birth and postnatally with assistance of one or two other staff members who may have been Registered General Nurse (not Midwife) Obstetric Nurse, Enrolled Nurse or untrained Nurse Aide.

Work at Elderslea included all low risk care, recognising the abnormal and consulting with or referring to medical staff and making decisions to transfer women or babies to level two or level three hospital as required. We regularly dealt with epidural anaesthesia, intravenous therapy and general anaesthesia as required.

This clearly indicates my ability to take responsibility and take decisions as required of a Domiciliary Midwife.

In 1989 my application for a contract with the Minister of Health was approved. Two other Midwives and myself set up an independent Domiciliary Midwifery practice. We had a hiccup in 1990 for three months when the legality of my practice was questioned by the Medical Office of Health. This was resolved through legal process. Finally at the end of 1990 we resumed our domiciliary practice after three months of no work and no income.

My ambition was to become a Domiciliary Midwife including home births when family commitments allowed. Health problems prevented me from working independently until 1985. By then the law had changed.

I am the same person, with the same qualifications that I was before 1984 when the Nurses Act Sec 54(3) was amended. The only difference is that I am now more experienced, have been practising in the community, attended home births and regularly update my knowledge in all aspects of Midwifery i.e. courses, reading, seminars etc. My colleagues and myself have set up a successful, respected safe practice in our community.

Lynne Legge, D.M.W.
Upper Hutt

It makes no sense for midwives to have to become nurses first, when midwifery is truly its own profession.

Reprinted from National Homebirth Newsletter Summer 1991

LETTERS

Dear Save The Midwives,

A very big thank you for the $200 you sent to us to put toward our costs. This gesture is very much appreciated. Thankyo too for all the support. It is the support from consumers and other midwives that helps to keep us going (and dedication to the cause).

Our lawyer has sent a lengthy submission to the Nursing Council to be discussed and hopefully a decision will be made so we can return to domiciliary midwifery. We are awaiting the outcome. Thank you again for your support.

Lynn Legg RM
Meta Brand RM
Gerry Hutchings RM
Anna Zambon RM

(All from Wellington)

(The Health Department have since granted permission for these midwives to attend women antenatally and postnatally under the domiciliary midwivery contract with the Minister of Health)

Dear Save The Midwives,

I enjoy reading the STM magazine but would like to comment on the Elizabeth Noble article. I disagree with her views which question the value of teaching women how to breathe and what to do during birth. I totally disagree that women just know how to do this if they trust their bodies and the birth process.

I am a strong advocate of teaching women how to use breathing levels to their benefit and to teach them to relax during contractions. This most definitely does not come naturally. I am speaking from my experience as a mother, midwife and antenatal educator. I have run antenatal classes for 22 years and women have always appreciated learning the proper breathing and relaxation techniques. They say they would have got out of control during their labour had they not been taught these things.

I am absolutely convinced that breathing and relaxation techniques should be taught antenatally from the fifth month of pregnancy onward.

Noortje Yates Bruins - Christchurch

WOMEN AND CHILDBIRTH

by Henny Ligtermoet
Midwifery Contact Centre, Shoalwater, Western Australia

There are many women in top positions; in business, teaching, health departments, the ministry.....in all areas of life, who have had children. These women are usually intelligent, highly trained, often with university degrees. Yet, despite all that, the majority of them have had horrible births. Why???

Most of them thought they had prepared themselves very well for the event either by going to classes or reading a lot about childbirth and how to cope with it. The answer to the question, to put it bluntly is: because they went to what they thought were the best specialists in town. What they did not know and what has been very cleverly hidden for many years is that specialists and obstetricians know very little, if anything at all about normal birth.

And despite remarks like: " I asked for a caesarean because I was told it was better for the baby ", or " I asked for an epidural because I'm a coward and I can't stand pain ", or I wanted to be induced because I had to get back to work at a certain time ", I am certain that ALL women want to have a natural birth. Yet most of these women have a disappointing, often excrutiatingly painful birth experience. It must be the reason why you rarely hear women talk about their birth. They talk about what happened before and after, mostly jocularly, but they remain silent about the actual event.

It is a pity, because it could have been so different. Many women also, if they honestly examine their feelings feel guilty about their birth experience, and yet they should not do so. The blame for the way it went lies with their birth attendants. Tens of thousands of women have dreadful memories of the way the birth went. Their hospital birth attendants completely dominated the event and they knew what to do. They knew how to interfere safely; they gave "guidance" and lipservice. They gave lipservice because they knew from their experience that a natural childbirth is a myth! It is far too painful to consider. They know that.....they've seen it.

BUT.....I must tell these attendants that they are wrong, totally wrong. They have put tens of thousands of women through torture-like labours, because they did not want to listen to the man who enabled women not only to have a natural, drug-free birth but also to have an experience they could look back on with gratitude, satisfaction and wonder.

That man was Dr Grantly Dick-Read, the natural birth pioneer, vilified and scorned by his colleagues but greatly admired by the women he attended. I have taught his programme for more than 30 years and I know from that experience that he is right, that childbirth does not have to be the horrible, painful event that it is for so many. I know that it can be a satisfying experience for women. For years I have tried to make the "specialists" understand this, but they will not budge.

Amsterdam Vertically Speaking

By Linda Oliver

"Life should either be a daring adventure or nothing" so said Helen Keller in one of my favorite quotes. My life has been full of daring adventures and this year was no exception.

I was drawn to read "The Midwife Challenge" by Sheila Kitzinger and was totally inspired with the chapter, Midwifery in the Netherlands written collectively by Beatrijs Smulders and Astrid Limburg. I decided to write to enquire as to the possibility of a visit and Astrid wrote back in her capacity as President of the Foriegn Midwives Association and informed me tha June was "open". With great excitement and fervour I replied in the affirmative.

I arrived via the Rhine into the heart of Amsterdam and was greeted most warmly by Astrid with whom I then spent the next two days eagerly listening to her words of great wisdom re Midwifery practice and in particular home birth with the use of the much used and famous birthing stool (designed by Astrid and Beatrijs). Astrid drove me to my living "space" for the next month where, having made my nest, I then farewelled two American midwives who filled me in on the Amsterdam scene and current cycling trends. I was given a beeper and two much used maps outlining the geographical area the two practices covered, so I began the process of orientation.

Two days later and several canal trips I was paged to attend my first birth at the Burger Zeikenhuis (hospital). I miraculously arrived via the tram on time, beaming with somewhat subdued joy to welcome Simone to the planet. The besotted parents after some time welcomed me in English to this privileged occasion and Tiba, a most caring and loving midwife spoke in great detail about the labour to me. Almost everyone speaks English....after the birth, and were keen to ask about the Australian way of life. I found that the more Dutch I listened to, the more I understood...to their amazement I began to talk in slightly broken Dutch! It helped knowing the topic I might add. I was invited to many unique birth experiences over the next few weeks and became very adept at carrying the birth stool up typical Dutch staircases often 3 or 4 flights and extremely narrow.

One particular home birth occurred in the "wee small hours" (how unusual!) where the family dog was an integral part of the proceedings. She was very protective of the other small child, dutifully sniffed me out and when the new baby emerged via the birth stool keenly observed the whole proceedings like a high court judge. She certainly had a vital role and provided a truly wholistic approach to an already spiritual moment. I found the majority of mothers in complete control of their situations and had carefully planned all aspects of the birth and so for me to be there was especially wonderful and I felt quite humbled.

One woman who I had previously met at Astrid's practice, would not have her husband near her during contractions but had a female friend as support whom she clung to and maintained eye-to-eye hypnotic breathing throughout the labour until the birth. The husband then poured the Champagne and made the mouijes on round crispbread. This is a Dutch custom; mouijs are pink and white or blue and white aniseed mouse-tail like confectionery - hence the name. The aniseed stimulates the breast milk supply. Very tasty at any hour....

What the breast milk or the mouijs, Linda?!

The majority of women I met had male partners, however the much recognised freedom of sexuality in Holland was very apparent. I attended one birth were a woman lived with her male friend, the donor of the sperm, but had a female lover and he a male lover. The relationships were all very different but again I experienced another highly emotive birth and we were all tearful and joyful together.

Between Beatrijs' and Astrid's practices, 60 births were pending for the month of June but obviously I did not expect to be invited to all of them. Three midwives worked at Beatrijs' practice rotating between the clinic or "controls" (as they described it), days off and on call for births. I sat in on various clinic sessions when it was convenient and did the occasional palpation, locating and recording the heart beat. These sessions were invaluable, particularly if I was fortunate enough to be invited to their homes then I was thus not a total stranger.

At Astrid's practice, 10 minutes away by reliable bicycle, 4 midwives worked and not surprisingly the clientele differed slightly. tThere were more Moroccan women attending Astrid's practice for example. The midwives I met were generally marvellous, highly competent practitioners in their own right. They appeared to be worked off their feet with not much time for other demanding pursuits. Of course the training for midwives in the Netherlands far exceeds the Australian training. It is a Direct Entry course of three years and they emphatically state they are not nurses but midwives....there is considerable difference. There are 800 applicants a year and 60-66 are accepted for three schools; Amsterdam, Heerlen and Rotterdam. Criteria include being 19 years old, minimum, having 5 years secondary education with A levels in chemistry, biology and preferably English. These students are taught a vast amount of knowledge and 80% of them work in a sole practice or in group practices.

I note here that male students are not exempt but I did not meet any.

A major emphasis and mandatory focus in Dutch midwifery is the paramount importance of pre-natal care and the screening, physiology and pathology (performed by the midwives themselves) of all women who attend the clinic. They believe as I do that whoever conducts the pre-natal care should also conduct the birth. There are certain examinations that are not performed routinely, namely; vaginal examinations, ultrasounds, B.S.L's and medical interventions. These exemptions are adhered to because the Dutch midwives do not believe that extensive medical examinations done routinely, will give a better outcome. Also routine checks tend to allow the care-giver to lose her alertness and of course it's too expensive. Maybe the healthy woman could get the feeling that she is not healthy, she is at risk and lose confidence.

Obstetricians are almost entirely supportive in this particular area of Amsterdam. If they do not support the midwives in private practice then they are not chosen for referrals if the woman has a complication. Sometimes an obstetrician will keep the woman but in most cases she will undergo a consultation and subsequently return to the practice, providing she still remains in the low-risk group. A prominent Obstetrician/Gynaecologist Professor Kloosterman, has greatly influenced the position and education of midwives and has encouraged them to be involved in research and to publish their own articles. (Caroline Flint was saying just this on her recent tour of Australia).

All women who are pregnant in Amsterdam book into a midwives practice initially and depending on the assessment the women remain in that practice or are referred to an obstetrician if necessary.

Women have a choice between birthing at home or at hospital and during my stay, 80% opted for a home birth when possible. If a woman chooses hospital she has a choice to stay in the hospital for 36 hours at the most following the birth.

There are approximately 180,000 children being born each year in the Netherlands and the home birth rate is currently 36.8%. In 1974 however, 50% of babies were born at home, in 1980 the figure dropped to 35% and now appears to be increasing. The declining trend earlier is accounted to the fact that technical possibilities concerning diagnosis and monitoring have greatly expanded with an emphasis on medical aspects of birth. But more women are becoming aware of their own needs and demands especially in Amsterdam with the greater emphasis on psychological and emotional advantages when a birth occurs at home. A very interesting study conducted by Damstra-Wijmenga in 1981 (in the city of Groningen), posed the question"Where is the safest place to give birth? and "Where is the safest place to be born?" In the city of Groningen. In her conclusion Damstra shows that morbidity both in the mother irrespective of the number of previous parturitions and in the newborn was less among those who had opted for a delivery at home than among those birthing in hospital. Both from the Damstra study and that done by Van Allen, it becomes clear that if good prenatal care is assured and there is appropriate co-operation between first and second tiers of health care, the decision to give birth at home is highly justified and entails the least risks for mother and baby.

Another very important aspect I found essential to Dutch obstetrics was the reliance and the vital role the maternity nurse played in the scheme of things. Their duties include assisting at the birth, taking care of the mother and baby, giving information and instructions to the family and helping in the household, which may even include walking the dog! The pregnant woman applies to the maternity nurse agency, where two oprtions exist: A maternity nurse who helps all day or one who comes in twice a day. On several occasions if the agency was fully booked, I performed some of those tasks which I thoroughly enjoyed and promoted more involvement on my part. One nurse,I remember quite vividly, was contacted late at night. She cycled at great speed and having to forge ahead up 4 sets of narrow stairs arrived flushed and panting to find that she had torn the zipper from the front of her pants! A suitable cover-up garment was soon found and she carried-on undaunted. Maternity care is insured by both National and private health insurance companies, I hasten to add for up to 8 days post partum.

So the Dutch obstetric care system is characterized by these five points.

1. An independent highly qualified training for midwives.
2. A substantial number of independently practising midwives.
3. Extremely competent maternity nurses.
4. Generally accepted screening system for risk pregnancies.
5. Choice between home or hospital births for women who have had excellent pre-natal care and have low-risk pregnancies.

Significant is the very low perinatal mortality rate indicative of a highly competent style of practice at 11.2%, one of the lowest in Europe.

This brief account is just a snippet of my experience in Amsterdam. I acknowledge how fortunate I was to make the journey and allow myself to be part od some wonderfully intimate and enriching birth experiences.

I note that Syntocinon was only given once to a woman who had a previous post partum haemorrhage and this instruction came via an obstetrician consultation. Torn perineums were not sutured unless absolutely necessary, instead Calendula oil was soaked into a gauze swab and placed between the labia and changed when needed. I'm told the perineums heal beautifully. Babies were given Vit K drops diluted in water instead of injections and rather curious hot water stainless steel tubes were used to heat the babies clothing.

Overall impressions of this amazing experience will be everlasting and I applaud the midwives for their confidence and inspiring style, their superb training and for allowing and promoting the natural miracle of birth to happen with the least amount of intervention possible.

It was a truly joyous time in my life which has confirmed in my heart and spiritual self that I am a home birth midwife who gives credence to natural miracles and the joy of being "with woman".

Independently Practising Midwives Communique

Vol 3: No 1 Summer 1991

Boom in babies near record

6-2-91

More than 60,000 babies were born in New Zealand last year, nearly matching the record for the baby-boom years.

The Department of Statistics yesterday released figures for births and deaths in New Zealand last year.

In 1990 60,159 live births were registered in the country, compared with 65,390 in 1961.

The Acting Government Statistician, Mr Len Cook, said that because of the baby-boom years there were more women of child-bearing age around which accounted for the high birth rate.

However, there were fewer babies born to each woman.

The figures also showed that women were having children at a later age.

In the mid-1970s New Zealand women had one-third of their children at ages 20 to 24 years and about one-seventh at ages 30 to 34 years.

But in 1990 women had more children in their early thirties than in their early twenties.

The average family size, because of the annual birth rates, went up slightly from 2.1 children to 2.16.

Fewer people died last year compared with 1989. In 1990 deaths totalled 26,532 compared with 27,042 in 1989, a drop of 510.

News

Anger at midwife course opposition

1-12-90 Christchurch Press

By PETER THORNBURY

A CANTERBURY Area Health Board member, Ms Karen Guilliland, has criticised Health Boards New Zealand's opposition to the establishment of a direct-entry midwifery course.

Ms Guilliland, who is also president of the New Zealand College of Midwives, questioned what business such a course was of Health Boards New Zealand. It had no business dictating how women had their babies, she said. The group was treating the matter as an economic issue, not one about quality of care.

The board was told at a meeting on Tuesday that Health Boards New Zealand, an organisation set up to lobby on behalf of area health boards, had resolved that it was opposed to direct-entry courses and that midwives should have another qualification, such as nursing.

It said that health professionals should be multi-skilled and any move to a single qualification would be a retrograde step as it would reduce cost-effectiveness and flexibility. It could mean that two nurses needed to be employed where only one, with dual qualifications, was now employed.

Ms Guilliland said that if midwifery was thought of as just a branch of nursing then training as a nurse was necessary, but that attitude went against national and international opinion.

Midwifery was a recognised profession in Britain, Europe and Scandinavia.

Midwives did not need to learn about the male anatomy or how to treat hip-replacement patients as they would never have to deal with such things. "It's like saying a physiotherapist has to first learn flower-arranging," she said.

To force midwives to first train as nurses was a waste of time and money.

Ms Guilliland said Health Boards New Zealand was totally out of step with what was happening and was against progress. It did not reflect the opinion of area health boards, only the thinking of a group of board heads.

She was critical that the matter had been discussed and a stance taken yet it had not come before the Canterbury Area Health Board.

One in five home from maternity ward in two days

EVENING POST

By JAY LOUISSON
Health reporter

21.2.91

An estimated 20 percent of women who had babies in Wellington hospitals in 1989-90 went home less than 48 hours after giving birth.

A draft childbirth services policy paper tabled at Wellington Area Health Board's planning and access committee meeting said that, out of a total of 6845 women, about 1382 were discharged early from hospital.

The average length of stay at West Coast, Wairarapa and Hutt hospitals was 4-5 days. At Wellington, women stayed for 2-3 days.

The shorter stays at Wellington Women's were attributed partly to the transfer of patients to hospitals in other districts after they gave birth.

The policy paper said it was necessary to look at better use of low-risk (level 0) facilities at Kenepuru and Paraparaumu.

"Wellington Women's Hospital is obviously overloaded with women from outside their district who could have safely delivered in a level 0 facility in their own district."

The paper said many low-risk pregnant women still chose to have their babies at units which had emergency back-up facilities.

General practitioners outside the Wellington district who did not provide maternity care often referred women privately to other GPs or consultants at Wellington Women's, which also increased that hospital's caseload.

The paper recommended further analysis of the levels of care required in each district. The draft policy is to be distributed to community health committees for comment.

Birth Position and Perineal Tears:

Among the many aspects of birth detailed in Home Births in Australia 1985-1987, was information on the position for birth. Almost half the women (48.9%) in the study delivered their babies in one of two positions; squatting (26.5%) or on all fours (22.4%). Just under one in four women (24%), who used either of these positions experienced a perineal tear that required stitches. Episiotomies were performed for 1.8% of women who squatted and 2.1% of those on all fours. Overall, perineal tears which needed to be stitched were less likely for women who delivered their baby lying on their side. About one in six women (17.2%), who used the lateral position needed to be stitched due to tearing, though the rate of episiotomy was higher (3.3%). Women using birthing stools were more likely to need stitching either from a tear(30.9%) or from an episiotomy(3.3%). *D.Horey*

Reference:

Bastian H. & Lancaster PAL Home Births in Australia 1985-1987 NPSU/HBA Apr 1990

Homebirth Australia Newsletter

Wright, J. Don't Microwave Breast Milk Amer Baby 51(3):79, March 1989

Tests at Stanford University Hospital, by by John A. Kerner, Jr. showed that microwaving breast milk may destroy its anti infective properties, particularly at temperatures above 53°F. Slow thawing in the refrigerator or in a pan of warm water is recommended.

Canberra Homebirth Association Newsletter

Having a baby — privately

A comfortable bedroom, a gourmet dinner at a reasonable hour and, perhaps, a glass of wine.

They may not seem features commonly available to women close to giving birth.

But from May 1 they will be, for about $1200 for a three-day stay, at a new Auckland maternity hospital.

Auckland midwives Jan Clifton and Toni Vail have wanted for years to open a private maternity hospital to give women and their families an alternative to hospital stays or home births.

Now their project, the Auckland Birth Centre, is almost finished.

By KAREN HOLDOM

The builders are due to leave the Gillies Ave site in about a month and the centre is to open on May 1.

Jan Clifton said that there was a time when there were quite a number of private maternity centres in the region. But they had all long since closed.

The only one left in New Zealand was in Christchurch.

Despite its distance away, she had heard of Auckland women who had flown there and stayed in a hotel until they went into labour, rather than give birth in a public hospital.

The centre would operate like any other private hospital, she said.

Patients would be referred through their doctors, usually 20 to 24 weeks into their pregnancy when it was clear they were expecting a normal birth and baby.

Although they have 20 years' experience between them, Jan Clifton and Toni Vail emphasise that the centre is not one where babies will be delivered by midwives.

"We provide the building and the service and the woman brings the doctor with her."

From the moment women book into the centre they are introduced to a midwife who will see them all the way through the labour.

There are eight suites, all equipped with the gear needed for a delivery as well as emergency equipment.

However, the centre is not geared up to do such surgical procedures as caesarian section. If that became necessary a patient would be transferred to the Southern Cross Hospital next door or to National Women's Hospital.

Accommodation will be complete with home comforts such as reclining easy chairs, bean bags and an open shower.

The centre also has facilities for antenatal and postnatal care and education.

Jan Clifton and Toni Vail expect that their first clients will be affluent because, at present, medical insurance does not cover private hospital deliveries.

However Jan Clifton said she hoped insurance companies would take their cue from their counterparts in Britain, the United States and Australia and revise their policy on this.

She expected some women would strive to save the money merely because they knew exactly what they wanted for their delivery and baby.

Jan Clifton said there had been a mixed reaction from doctors and the community to the centre.

While many had been enthusiastic others wanted to reserve judgment until the facility was up and running.

The centre has already received about 20 bookings and is holding an open day on April 27 and 28.

Toni Vail (left) and Jan Clifton outside their new maternity home. Jan is holding Morgan Towers, aged 5 months.

21·1·91

Bathing a Kiwibaby

By SANDI PATERSON

Michael Daily is screaming — loudly. The four-day-old baby is about to have a bath — a time when most infants start up a wail.

But times have changed. On a new physical development programme introduced by the Waikato Sports Foundation to hospitals in the central North Island, babies are no longer splashed with lukewarm water in a shallow bowl.

Michael is lowered into a deep bath of water around 38 deg C — the same temperature an adult would enjoy.

His mother, Christine Carmichael, of Taupo, rolls him on to his stomach. Within seconds the tiny fists uncurl, and the screaming stops. Many babies fall asleep during the deep bathing.

The organiser of the Kiwibaby programme, Mrs Gael Muthu, said the bathing techniques were just part of the baby exercise guide which aimed to stimulate development in the first 12 months.

The programme, on trial through the Waikato Health Board area and the Hillary Commission for Sport and Recreation, includes massage and exercises to be practised from as early as six weeks old.

"A lot of the ideas will not be accepted straight away because they differ from the traditional way," said Mrs Muthu, a Hamilton physiotherapist.

A nurse at Taupo Hospital, Ann Hamilton, said mothers and babies using the techniques were more relaxed — and bathing was less traumatic.

Kiwibaby will be assessed by the Hillary Commission before being introduced throughout the country.

18·12·90

Chlamydia – 'The Silent Epidemic'

Chlamydia trachomatis is thought to be the most common sexually transmitted disease (STD) in New Zealand. Infection rates have been described as epidemic. But most women with chlamydia don't know they have been infected. Many find out too late – after they discover that they are infertile.

Screening for the disease could save much distress for women as well as release valuable resources for other priority health issues. The Ministry of Women's Affairs, therefore, is currently investigating the technical issues as well as the wider issues involved in establishing screening procedures for chlamydia. We will make our findings available when they are complete. Meanwhile, *Pānui* backgrounds the status of chlamydia in New Zealand and describes the disease and its effects.

What is chlamydia?

Chlamydia is a bacterial infection which is passed from partner to partner, between men and women, during sexual intercourse. For women it can be a persistent, dangerous and, on occasion, even a deadly infection.

In about 70 percent of infected women there are no symptoms. Often it is not until infertility problems are investigated that the disease is discovered, which is why it is called the 'silent epidemic'.

When symptoms do exist they can be mild to severe and are often like those of other infections. They can include lower stomach pain similar to menstrual pain, vaginal or rectal discharge, abnormal menstrual periods, pain on urination, and pain during or after sexual intercourse. There appears to be no relationship between the severity of the symptoms and the damage caused.

Obvious symptoms are less common in men but there can be a slight discharge from the penis, pain on urination, or painfully swollen testicles.

The results of chlamydia

Chlamydia can lead to complications such as pelvic inflammatory disease (PID), infertility, ectopic pregnancies and pneumonia in newborn babies. Left untreated chlamydia can travel up the uterus into the fallopian tubes, where it causes inflammation which in turn can cause scarring. The scarring can block the fallopian tubes causing infertility. At its most extreme, tubal blockage may cause an ectopic pregnancy which sometimes results in death. PID can also cause death.

Chlamydia may occasionally cause male infertility. Infants exposed to maternal chlamydia may develop conjunctivitis, pneumonia or infections of the gastro-intestinal tract.

A single episode of pelvic infection leaves 10–15 percent of women infertile. After three episodes, 75 percent are infertile. Many women have more than one episode, particularly if their partner is not simultaneously treated.

Prevention

Barrier methods of contraception and safe sex practices effectively prevent transmission of the disease. The AIDS prevention campaign will impact on the incidence of chlamydia and other STDs, as well as AIDS. But low self-esteem and inequalities in relationships must be dealt with before women are able to insist on protection.

Detection and treatment

Until recently, laboratory tests were tedious and lengthy, involving culturing specimens over several days. Now quick, simple and economic tests are available which give results within a few hours, but there are still some problems with accuracy.

Treatment is a ten-day course of antibiotics. The partner must also be treated to avoid re-infection.

Incidence of chlamydia in New Zealand

Information on the incidence in New Zealand is incomplete. It is believed, however, that we have a rate twice that of the incidence in Australia and three times that in Britain. There is some evidence now that this is beginning to plateau.

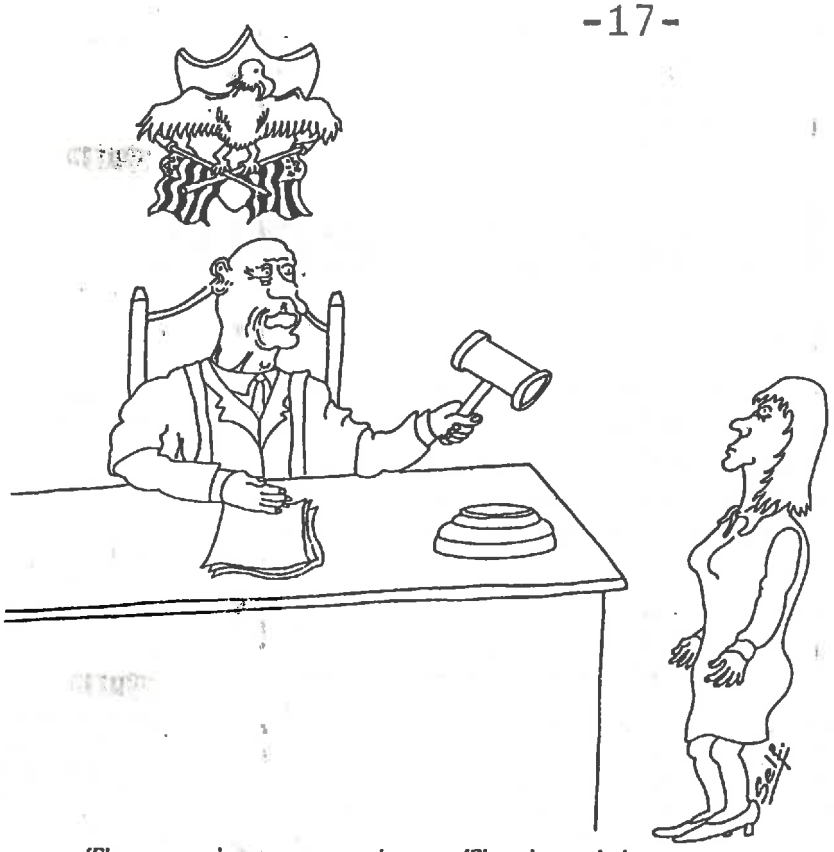
Health Department figures indicated that in 1985 chlamydia infections were double the incidence of gonorrhoea. An average of 20 percent of people attending STD clinics were infected. The national population incidence was 500 per 100,000 people, but in some areas such as South Auckland this was doubled.

Higher rates of infection are found amongst young people under 25 years (especially young Maori women) people with other STDs, people who have had multiple partners and pregnant women.

Young Maori women are over-represented at STD clinics. Maori PID admission rates for 1985/86 were nearly 430 per 100,000 person years compared to about 160 for non-Maori.

A 1987 study of women attending a family planning clinic in Christchurch showed an overall infection rate of 17.5 percent. Pregnant women had a higher incidence (23 percent) than non-pregnant women (16.8 percent). Twenty-two percent of women under 20 were infected compared to 9 percent of women over 25 years.

NOTE:
An ectopic pregnancy is a pregnancy that begins to develop in the Fallopian tube rather than in the uterus (womb).



The court orders you to conceive next Thursday and give birth to twins by natural methods on 26 April next year

Third MIP calls for more midwives

A subject receiving particular attention at the Third Meeting of Interested Parties (MIP) held in Geneva, 18-19 June 1990, was the need for effective training initiatives to combat the increasing global shortage of midwives.

Dr Mark Belsey, Chief of WHO's Programme of Maternal and Child Health and Family Planning, told more than 90 participants: "The number of nurses and midwives is falling, and mid-level care - where the midwife should be - is disappearing."

The meeting heard that evidence gathered at WHO shows that it is not until coverage reaches at least seven out of every 10 births that substantial reductions in maternal mortality can be achieved. "In countries that have at least 70% of deliveries attended by a trained individual, maternal mortality is less than 100 per 100,000 live births," Dr Belsey said.

He said that the appropriate person to deal with all normal deliveries was the midwife and that she should be trained to identify high-risk mothers and to play a key role in the management of these deliveries. WHO's Dr Barbara Kwast said that the midwife serves as the first referral point to whom traditional birth attendants (TBAs) can send problem deliveries.

Professor Robert Leke from the Cameroon, described how midwives had played "a key leadership role" in reducing maternal mortality by 60% at the University Centre for Health Sciences in Yaoundé over the past ten years.

He said that in 1979, he and his colleagues had shown that 70% of obstetrical complications occurred in the one in four mothers who could be identified as "high risk" before their delivery. "So we set up a high-risk clinic to identify these patients as early as possible and to monitor them as closely as possible," he said. Success was achieved by leaving the midwives to run the services, while obstetricians provided back-up when complications arose.

• Referring to the global estimate made five years ago that 500,000 maternal deaths were taking place each year, WHO's Ms Erica Royston said that there was no indication of any reduction in maternal mortality rates from community studies in countries or regions where the rates are high. ■

New Zealand College of Midwives

National Conference - Women in Partnership

WHERE TO NOW IN MIDWIFERY?

Joan Donley

Before we can determine where we are going we first have to figure out what we are.

For the past 10 years or more we have been developing political awareness as we lobbied to have first, the ICM definition of a midwife accepted, then to have our independent status restored which was taken away in 1971. Now, we are confronted with the need to put our money where our mouths are.

Are we ready for the challenge?

More than 80% of us work in hospitals. These bureaucratic heirarchies are structured on the medical model of childbirth where the need is for obstetric nurses who respond to the doctors' decisions. We have been trained in this system which views pregnancy and birth as medical crises. This has disempowered both women and midwives. In fact, part of the process of disempowerment has been to pit women and midwives against each other. Now we have been offered a challenge which can only succeed if women and midwives are allies.

Admittedly we have taken our first tentative steps towards independence by forming our College and speaking for ourselves; and by including consumers in our membership and on our executive - the first professional body to do so! And in the case of domiciliary midwives, by including consumers on an equal basis with health professionals in our monitoring body. That's the kind of progress that can be made outside the bureaucratic structure with grass roots support.

But, inside the bureaucracy how can we relearn and reclaim our midwifery skills and the art of midwifery after years of dependence on doctors and technology and when most of our experience is based on interventions?

How do we propose to overcome OUR fear of childbirth and actually regain a belief that birth IS a normal process? We have to seriously address that issue before we can become independent practitioners. If we don't genuinely believe that birth is normal and trust a woman's innate ability to give birth, we will disempower her. A labouring woman is exceptionally perceptive and quickly picks up on a midwife's anxiety and apprehension. This undermines her own, perhaps fragile self-confidence, fear takes over and the woman is driven back into the waiting arms of the doctor.

So before we can develop strategies we have to analyse our attitudes and beliefs as well as the structures that hold us in bondage.

After fear, I would suggest that the 'team' is the next strongest rein on independent practice. As an independent practitioner a midwife should assess a perceived problem, discuss it with the woman and her partner and make the necessary referral. This is co-operative teamwork between people of equal status, based on shared and honest information - now referred to as 'informed consent'.

The 'team' we have become used to is a heirarchy based on well entrenched role relationships with the doctor as leader and gate keeper. In this situation, if a midwife in her true role as the woman's advocate should challenge the doctor's decision to intervene, or support the woman in questioning a procedure, she is assuming the primary role, i.e. she is pushing the doctor off his pedestal. The midwife is then seen as being disloyal to the team, or even of disrupting team relationships.

On the other hand, the 'team' has some advantages. Here, the midwife seldom has to assume final responsibility for decision-making, therefore, she is seldom truly accountable. If she feels unsure of her skills or fears childbirth, the 'team' is a security blanket.

In fact, the entire bureaucratic structure of institutionalised childbirth has some advantages. Here there is a graded career structure with ensured awards which have been negotiated over many years. There are regular rosters, sick leave and holiday pay. Life styles and mortgages have been developed on this structure. Now, who in their right mind wants to give this away to become a down-at-heel domiciliary midwife?

A British community midwife, Mary Cronk, claims the U.K. midwives made a mistake in becoming salaried employees of the National Health Service rather than remaining independent practitioners as GPs did.

There's no doubt in my mind that the only place that a midwife can become a truly independent practitioner is in the community. In fact, both the medical profession and the NZNA have for years tried to curb domiciliary midwifery because of its 'relative independence'.. And during the discussion over this Bill, medical interests have equated midwifery independence with domiciliary midwifery.

If more midwives are going to become independent practitioners, it will be necessary for them to be better paid. At present, being a domiciliary midwife means living at or below the poverty line. Of course, the pay of domiciliary midwives has been held deliberately low in order to discourage the practice - starvation is more sophisticated and civilised than buring at the stake!

Fortunately, amendments to other Acts favour better conditions for independent midwives. Amendments to the Social Security Act, 1964 Part 11 allows "registered midwives to claim maternity benefits, pharmaceutical benefits, other benefits relating to buildings and equipment, allowances and expenses, and grants in relation to services provided; to claim payments and refunds normally claimed by medical practitioners in respect of maternity care." (1)

The second SOP (No 30, 23.7.90) amending S111 of the Social Security Act, places the registered midwife in the same position as the GP in the 'fixing of fees' in relation to maternity benefits, i.e. the scale of fees may ne fixed in agreement between the Minister and representatives of the N.Z. Medical Association (for doctors) and N.Z. College of Midwives (for midwives).

The doctors' maternity benefit is currently negotiated by a Tribunal comprised of two GPs, an obstetrician, a paediatrician, and an anaesthetist - all of whom are entitled to a maternity benefit. This Tribunal should now have two independent midwives added to it.

A remit to this effect should go from this Conference.

Also, in view of the pay equity legislation, what better place to start than with the Maternity Benefit?

The GPs have recently negotiated an increase, back-dated to 31 August 1989. They now receive: first antenatal visit - $41.30, subsequent antenatal visits - $20.65; attendance at birth - $285 for the first 1½ hours, then $69.80 for every half hour or part thereof; postnatal exam - $41.30, after hours call out - $40.

In comparison domiciliary midwives receive $16 for each of three antenatal visits and each of 12 postnatal visits; for labour of up to six hours - $225 plus $37.50 per hour thereafter.

Improved benefits would open up a number of independent midwifery options:

1) Domiciliary midwives working in groups so that predictable rosters can be organised;
2) Working in a free-standing birthing centre;
3) Working as part of a team from a medical clinic doing births either at home or in hospital as DOMINO.

DOMINO births would require a contract with the area health board but this is now possible through the amendment to the Area Health Board Act 1983.

Northland AHB set up the first pilot DOMINO scheme -- an unsuccessful bid to undermine home births. Probably because the domiciliary midwife was also a part time Board employee, the Board paid the midwife for labour and birth on the basis of the domiciliary midwife Maternity Benefit. Most other boards have not been prepared to pay for this even if the midwife is a part time employee.

On the other hand, doctors with contracts use the board's facilities and are paid by the Government. There is no reason why midwives should not be similarly paid especially since the second SOP amends S 106 of the Social Security Act 1964 entitling every woman to the services of a medical practitioner or a registered midwife or both -and "all fees and other money payable in respect of maternity benefits shall be paid by the Department". Of course, this would not apply if the midwife is a board employee.

A remit to consolidate this should go from this Conference.

EDUCATION.

Also to be economically viable there has to be an adequate pool of women who want to have their babies at home or DOMINO. This requires publicity to let women know that the service is available. It also requires education to overcome the fear of childbirth.

Here we actually have some support. The Department of Health's (still unpublished) Policy Recommendations for Care for Pregnancy and Birth states that "Pregnancy and childbirth are part of the normal life experience of women. The majority of women have the ability to conceive, undergo pregnancy and give birth without problems....:

This is the first time since 1927 that the DOH has officially declared that birth is normal. Then, Maui Pomare, Minister of Health, Truby King, Director of Child Welfare and Dr Valintine, Inspector of maternity hospitals toured the Dominion and from public platforms proclaimed that birth is a normal physiological process and if women wanted to have babies without sepsis, not to have doctors at their births, but to have midwives. This was in response to the heavy toll of maternal deaths from puerperal sepsis related to forceps deliveries resulting from 'twilight sleep' - the beginning of the medicalisation of childbirth! The reaction of the doctors was to form the Obstetrical Society.

Midwives need to get out into the community and acquaint women with their HIStory. Organise seminars, speak to students at secondary schools, speak to women's groups and finally conduct community-based antenatal classes of a new kind; places where women learn about informed consent, assertiveness training, preventive measures, nutrition and where they and their partners can establish supportive networks. These should be subsidised by area health boards which are legally responsible to promote primary health care.

Midwives also need re-education to help them overcome their fear of childbirth and learn about the right of consumers to be involved in decision-making and evaluating their maternity care. Target your area health board to organise inservice education.

Fortunately the midwives coming out of out three new 'separate' midwifery courses see themselves as independent practitioners. Their education is based on the ICM definition of a midwife - thanks to 10 years of hard work on the part of numerous progressive midwives. As independent practitioners these midwives are trained to function in hospitals or in the community.

The Report of the Social Services Committee states: "The Committee is aware that the issues of knowledge and safety in practice are clearly related to training of midwives and their accountability both to their peers and to their clients.....The Committee is satisfied that the New Zealand College of Midwives has the capacity to set appropriate standards of training to permit registration as a midwife and to ensure that no diminution of standards of safety occurs."

It concluded that those competent to practice are those registered by the Nursing Council and further recognised "that standards are more appropriately incorporated in guidelines than in legislation". (p6)

In view of this, one wonders why some midwives are presently involved in drawing up protocols for domiciliary midwives. Is this based on their own fear of childbirth, or is it a means of preserving an existing power structure?

Any midwife can attend a woman at home. The purpose of her contract is to enable her to claim the Maternity Benefit With independence, Helen Clark has questioned whether domiciliary midwives still need their 1987 contract with the Minister? She feels we should be able to establish ourselves in practice as GPs do The second SOP has repealed S 19 of the Nurses Amendment Act, 1983 (S 58 Nurses Act 1977) which gave the Medical Officer of Health supervisory power over 'obstetric nurses' operating outside an area health board

One educational issue which should be raised at this Conference is clinical experience for student midwives. This is difficult to come by as medical students and post graduate Diploma of Obstetrics GPs have priority. Independent midwifery is hollow unless there is a committment to fair allocation of clinical experience.

The Area Health Board Act, 1983 says that an area health board may enter into an agreement with any educational institution in N.Z. for provision of access or service for students. (S 46(d)) Students already have access to the hospitals and to limited clinical experience. In view of medical priorities it will no doubt require some political pressure to gain sufficient experience.

There are innovative tactis to gain clinical experience such as continuity of care. Students arrange with women in the antenatal clinic to support and follow them through pregnancy and labour. This has worked well in Auckland. The South Australian tech advertised for pregnant volunteers who would like to be supported by a personal students nurse to share the pregnancy, labour and delivery and during the early days home from hospital.

As independent midwifery practice increases there should be scope for organised community experience.

This Conference should pass yet another remit urging that student midwifes be guaranteed sufficient clinical experience to fulfill their roles.

ACCOUNTABILITY.

Already midwives have established and published Standards of Practice, Service and Education. As a member of AAHB Maternity Task Force Working Party on Training & Education, we were dumfounded to find that the medical profession did not have any defined standards of practice. Our committee recommended that all professional groups within the maternity services should define and publish their standards of practice.

Area health boards are legally required to formulate and enforce quality assurance protocols. (2). Midwives with contracts with area health boards will come under these protocols.

Domiciliary midwives realised early in the piece the necessity for accountability - but primarily accountable to the women and their babies. This is a very effective form of quality control because a domiciliary midwife who is not providing the woman with good care as defined by her, soon finds herself without bookings. She either has to shape up or ship out!

As the Medical Association, the O&Gs and the NZNA were united to try and bring the domiciliary midwives under the Obstetrics Standards Review Committee (OSRC) we and the Homebirth Association established the Domiciliary Midwives Standards Review Committee (DMSRC) in 1988. These are regional committees which comprise four health professionals and four consumers - the only professional body in New Zealand which has acted in accordance with the Cartwright recommendations concerning consumers on monitoring bodies.

One of these health professionals is the principle public health nurse (pphn) as the agent for the Medical Officer of Health (MOH). Now that S 19 of the Nurses Amendment Act 1983 is being repealed

it could leave us open to a take-over bid from the hospitals. As part of the primary health care team it is important that the pphns maintain their role as the primary health care officer of the area health board, in monitoring the quality of domiciliary care.

A remit should go from this Conference to that effect.

Each domiciliary midwife is required to present for an annual review with a written report of her year's work plus a self-assessment. These are well established in all areas where home births are occuring, except Waikato where the formation of a DMSRC is being blocked in an attempt to incorporate domiciliary midwives into the hospital secondary care services and under the OSRC.

While the DMSRCs have been commended by Helen Clark and by the Social Services Committee, it has been recommended that the membership and functions of the OSRC be reviewed to ensure wider representation and greater accountability and to take account of changing trends in childbirth services. In fact, it is recommended that boards establish Maternity Services Coordinating Committees on which 50% of the health professionals should be women, and that consumers be represented by women nominated by community consumer groups actively engaged in health issues, with accountability to those groups. (3)

Also, legislation is to be introduced before the election to establish the Office of Health Commissioner and a nationwide patient advocacy system as recommended by Cartwright. Since women are the main users of the health care system, the Health Commissioner will probably be a woman, assisted by a Tribunal. The Health Commissioner will protect patient rights in both the public and private sector and in both clinical and administrative matters. While there is seen to be a continuing role for health professional disciplinary bodies, the Health Commissioner will prevent unnecessary duplication of the complaints system.(4)

Last year, on the basis of the Report of the Working Party on the Establishment of a Health Commissioner, I made a submission to the Minister of Health urging that the DMSRCs as presently constituted by given statutory recognition under the umbrella of the Health Commissioner.

When this Bill goes to the Select Committee it will be essential for all NZCOM regions and individual midwives to make submissions on the role of the Health Commissioner and on the National Standards on Informed Consent and the maintenance of and support for the DMSRCs - if you want to practice independently!

LEGAL ACCOUNTABILITY

As independent practitioners, midwives become liable to the same legal mechanisms that apply to doctors.

There are two issues here - medical misadventure and indemnity insurance.

Re medical misadventure, the Report of the Social Services Committee on the Nurses Amendment Bill says, "In the case of medical misadventure, the Committee was assured by its departmental advisers that patients should be able to claim compensation in case of personal injury resulting from an accident caused by a midwife". (p6). Note the word 'should'.

Although N.Z. has a 'no faults' system embodied in the Accident Compensation Act, patients don't just routinely 'claim' compensation for medical misadventure. On occasion they have to take the practitioner to court to prove medical misadventure. Informed consent plays a crucial role in this.

According to the Medical Council in 'A Statement for the Medical Profession on Information and Consent', June 1990, due to a recent judgement (5) medical misadventure is now defined as an "inclusive" word, and from the perspective of the patient "if her case was mishandled it was her misfortune or ill luck. This falls squarely within the idea of medical misadventure" (p22) This judgement tackled "the key question of what forms of medical misadventure are barred under the Act in S.27(1) from civil actions and become exclusively ACC matters". Prior to this judgement, negligent advice and incomplete information leading to faulty consent would not be regarded as misadventure and could be the subject of civil action.

The recent Commonwealth Law Conference noted in reference to N.Z. ACC scheme that where the right to sue doctors has been removed that other mechanisms to ensure accountability had to be strengthened. (NZ Herald 19.4.90)

The Medical Council considers that the recent judgement removes litigation on consent further than ever from the Courts and restores the role of setting standards and criteria to them - unless the Government introduces special legislation.

The Government is doing just that. In addition to the National Standards on Informed Consent, the Medical Practitioners Act is under review as part of occupational licensing. The recent increase to general practitioners subsidies contract is tied to a committment to development of quality assurance which is part of the new primary health care policy.

One of the issues involving litigation on consent which could affect midwives is, who provides the normal standard? The Medical Council asks: "Is it the professional one based on experiences and knowledge of usual practice among peers, or a standard based on what the average person needs to know to proceed to a decision?" (p 27)

It answers its own question saying that since there is no N.Z. legal precedent, we tend to follow British law which is based on "the professional standard of the reasonable doctor rather than the more difficult concept of the reasonable patient" (p28) Judge Cartwright defined the reasonable patient as 'the woman in the National Women's Hospital clinic waiting area'.

In the area of childbirth this takes no cognizance of the changing trends in childbirth. Rather, decisions would be based on the criteria of 'reasonable skill, knowledge and judgement' based on the medical model eg EFHM, routine partograms, etc. This is defensive practice based on fear instead of non-intervention and a woman's needs. Neither does it take into account the vested interests and values of the new public health being debated in the market place.

We midwives need to be in there making submissions on what is reasonable midwifery care.

Finally, <u>indemnity insurance</u>, do we need it?

In view of the medical opposition to the Amendment(s), I think we can expect a witch hunt. In fact, judging from the Auckalnd climate, I would say it has already commenced.

The Report of the Social Services Committee says, "midwives who are members of the New Zealand Nurses' Association are covered by personal indemnity insurance which is designed to meet the costs of any civil or statutory liability that a nurse/midwife may incur in the practice of his/her profession".

N.Z.N.A's Professional Liability Policy is with C.E. Heath Casualty & General Insurance (NZ)Ltd, The broker is Mark Koschek (04 850 124) (Policy No PI/PL 01626)

It will indemnify, with the underwriter's written consent and pay limited costs in relation to:

1) disciplinary action or dispute;
2) coroner's inquest;
3) ACC hearing or enquiry.

Indemnity is limited to $200,000 for any one claim and to $400,000 in the aggregate per member, subject to an aggregate per all members of $5m. (Item 5)

There is also provision for deduction of $1,000 in respect for each claim of professional liability and $100 in respect of general liability.

The NZNA sub is based on 1% of a staff nurse's basic salary. The current subscription is $213.20 p.a. Out of this NZNA is paying approx $1.50 per sub for indemnity insurance and paid $26,022.36 to the underwriter for the year 1989/90 (Annual Report).

It has not been possible to find out what has been paid out in claims. The insurance companies are very coy about releasing this information, but the claims have been minimal

The N.Z. Nurses Union also carries an indemnity insurance which is paid out of the annual sub which is $3.80 p.w. ($197 p.a.) In addition to covering disciplinary action, coroner's inquests and ACC medical misadventure, it also includes claims for exemplary damages in court; claims for error, omission or negligence which result in injury, damage or death; and public liability against damage to property. It is viable up to three years after leaving the Union. The monetary limits are the same as those for the NZNA insurance. There are no deductions.

Polytechs have negotiated their own scheme for cover for their own staff and students. No doubt this will affect the viability of NZNA insurance.

Canadian nurses formed an independent Nurses Protection Society because the insurance companies were not meeting their needs. Coverage was not comprehensive, nor readily available and premiums did not reflect the low claims history of nurses. Over a period of eight years approximately $5.8 m was paid to the insurance industry with only $106 883 paid out in claims, that is, 98.2% of premiums went to insurance administration and profits. (6)

The Independently Practising Midwives in Australia (NSW) have organised a professional indemnity policy available for all registered midwives. The premium is $215 p.a. It provides up to $1m p.a. which includes up to $15,000 per case or $30,000 per member per year for legal representation. An excess of $500 is payable if the midwife is found liable.

N.Z. docotrs are covered by the British Medical Defence Union. This costs each doctor $298 p.a.(inclusive of GST) and provides legal advice and representation in all matters of professional practice and reputation.

Wendy Savage told a British midwifery conference that in 100 years of practice the Medical Defence Union had never been sued over a home birth.

In North America, on the other hand, a number of home birth midwives have been hauled into court, generally at the instigation of the medical profession for practising medicine without a license; and in cases of perinatal deaths, for manslaughter.

Today we stand on the threshold of independent midwifery. We're here as a result of a number of factors:

World-wide women are rebelling against the medicalisation of childbirth. They are reclaiming their bodies and their birthing experiences. Because we have changed our attitudes and have embraced women as our allies, we have grass roots support - but this will last only so long as women see us as their advocates and supporters.

We are here because of the international trend towards primary health care. Midwives are primary health professionals. We are also cost effective which is a very important aspect in today's global economic crisis. Let's go for a decent wage but let's not get greedy.

We are here because we have a very well informed and supportive Minister of Health who has been prepared to take a stand against the medical power brokers on our behalf. We owe her our unqualified support in October.

We are here because we are enthusiastic, we've established good networks - nationally and internationally; we have become politically aware and we are united. It's very important that we maintain our solidarity. There is no room for complacency. This is just another round in the battle that has been going on since the Middle Ages.

But, we can do it! We're midwives - not moas!

References:

1) Report of Social Services Committee on Nurses Amendment Bill 1.13.A 1990 p8
2) Area health Board Act 1983, S. 38(2)
3) Department of Health Policy Recommendations for Care for Pregnancy & Childbirth
4) Report of Working Party on Establishment of a Health Commissioner, Feb 1989
5) Court of Appeal 27.10.89 in Green vs Matheson
6) The Canadian Nurse, May 1989.