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Editorial

Bearing Responsibility: Ethics and Maternity Care

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I write this at a time when maternity services in New Zealand have just undergone a major review. The resulting document, *The National Health Committee Review of Maternity Services in New Zealand*, September 1999, was released last week. In the hours following the release of this document a flurry of protest and concern was voiced by a number of groups who felt that it did not meet their particular needs.

In the ten years since the Nurses Amendment Act (1990), which gave autonomy to midwives, maternity services in New Zealand have been plagued by some very public infighting between providers of care. This is partly fuelled by a paradigm difference between midwifery and medicine. Midwifery has, as its underpinning philosophy, the concept that giving birth is a normal event in a woman's life, whereas medicine tends more to the view that birth has the potential for risk and harm and so requires measures to reduce that risk. This difference is further fuelled by changes to funding arrangements that some see as unfair or that promotes competition between these two groups. One of the briefs of the Maternity Services Review Committee (MSRC) was to discover if changes to the delivery of maternity services had affected women's access to a high quality service which meets their needs. The views of more than 12,000 women were canvassed and the satisfaction level of these women runs at 80 per cent, indicating that the system as it stands has many positive attributes. However the MSRC has revealed that some women are not satisfied with their care. Some of the problems identified are: inability for some to access the type of Lead Maternity Carer that they want, problems with access in rural areas, lack of services meeting the cultural needs of Maori, women being charged contrary to Section 51, gaps in services, and tension between providers impacting on the care of women. In the summary of recommendations of the MSRC there is a strong emphasis on the need for high quality services that meet the particular needs of women, and a call for a more co-ordinated service and monitoring, and also for the encouragement of co-operation between midwifery and medicine to benefit women. Neither main provider group has been particulary pleased with the findings or the recommendations made by the MSRC, as we see from the two responses to the Maternity Review in this issue of the *Otago Bioethics Report*.

It was against a backdrop of unease between providers and uncertainty about the findings of the MSRC that I proposed an issue devoted to maternity ethics. This has been, by far, the most difficult issue to pull together. Nonetheless the articles in this issue of the *Otago Bioethics Report* are both interesting and pertinent. Ethical issues raised by policy implementation is the topic of the first article. Lynda Williams looks over the last ten years exploring policy change and the implications for women accessing maternity services. Obstetrician Gary Fentiman then examines the difference between private and public care and reflects upon his move between the

Continued page 2, column 3

IN THIS ISSUE

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Response One: Maternity Review Spells the Demise of General Practice Obstetrics

Dr Pippa MacKay,
Chairman, New Zealand Medical Association

The National Health Committee's long awaited Review of Maternity Services in New Zealand,[1] released in October, was an extreme disappointment to the New Zealand Medical Association (NZMA). The National Health Committee (NHC) has accepted the demise of general practitioner obstetrics and does nothing to reverse the situation.

The NZMA had hoped the report would look seriously at the major problems with the current system and attempt to come up with some serious solutions. As well as making submissions to the NHC, the NZMA and Royal New Zealand College of General Practitioners together produced a paper to outline some possible and workable systems.

Instead the *Review* 'aims to consolidate, refine and render consistent what is already a workable and potentially equitable structure',[2] by 'encouraging' teamwork among professionals.

The NZMA believes it is simplistic to blame problems with the maternity system on a lack of teamwork between doctors and midwives, and to ask them to work together co-operatively. There is clear evidence that the fault lies with the system – which puts doctors and midwives in competition with each other – and the lack of fairness in the funding arrangements. Without fundamental changes to the system, improvements will not happen.

On the positive side, the NZMA was pleased the *Review* attempted to reduce the barriers currently in existence to prevent a woman seeing her GP during her pregnancy if that GP is not the Lead Maternity Carer (LMC). The NZMA is not particularly happy with the detail of the approach being suggested, but the principle is very welcome. Hopefully this will lead to a reduction in the number of medical problems and unwell pregnant women that hospital physicians are seeing referred to them by midwives.

The *Review* was deeply disappointing in a number of regards. It accepted that General Practitioner Obstetricians (GPOs) were giving up in droves, but said that was in line with overseas trends and changing GP attitudes and willingness to work the hours required. The number of remaining GPOs now is nearer 150 than the 470 quoted by NHC Maternity Review committee head Maggie Barry, who used figures from Health Benefits Limited, which are far from currently accurate.

Health Minister, Wyatt Creech, has been quoted as saying of the exodus of GPOs 'I think the present system will cope with it fine. Other health professionals – the midwives – will just fill the gap.' So, it appears that pregnant women have lost the choice of having GPOs involved in the birth of their children, with no acknowledgement of the contribution they make.

The *Review* will make the maternity situation even more difficult in rural areas, which already face problems securing and retaining health professionals. With GPs giving up obstetrics and no incentive for young doctors to take it up, there will be fewer people willing or able to take on the burden of working in rural areas.

The NZMA was also very disappointed that the *Review* failed even to acknowledge or address any of the serious issues facing secondary maternity services, especially the increasing pressure facing specialist obstetricians, some of whom are already leaving or considering leaving the practice of obstetrics to concentrate on gynaecology.

The NHC weighted its report very heavily towards the results of several surveys it carried out, which purported to show a high level of satisfaction among women with the current system. The *Review* itself highlights problems with the surveys and the NZMA is aware of other flaws. The NHC, in its report, said a questionnaire and a telephone survey were not representative of the overall group of eligible women. Maori, Pacific Island and other non-European ethnic groups were under-represented, as were women aged under twenty-four and those from lower socio-economic backgrounds.

The NZMA believes the heavy reliance on the surveys is unwise. In any case, women are likely to be satisfied with the maternity system if they take home a healthy baby (as the vast majority do), but this in itself does not mean that all is well with the system. Since the NHC chose to accept the survey results, the NZMA believes it should have focused on the 10–20 per cent of respondents who were not satisfied with their maternity experience.

Finally, the NZMA hopes the NHC and Health Minister take note of the intense criticism of the *Review* from health professionals and consumers, and acknowledge that much of it is flawed. To dismiss the criticisms as health professionals protecting their 'vested interests', as has happened, is a tactic to avoid grappling seriously with an issue of extreme importance to the women of New Zealand.

Notes

1 Review of Maternity Services in New Zealand. The National Health Committee, September 1999.
2 *ibid.* p. 5.

Continued from page 1.

two. The next two articles look at when women make choices that are perceived by others as not being in the best interests of themselves or their foetuses. Midwife Jackie Pearse argues that most conflict between women and their carers can be avoided if the midwife trusts the mother to want what is best for the foetus. The last article by Professor John Seymour examines legal and ethical issues when women are taking illicit drugs or when they choose to ignore medical advice and refuse a caesarean section. The case commentary and corresponding responses provide some differing views of a situation when a woman is not accepting medical advice.