All District Health Boards

20 April 2022

Dr Susan Calvert
Tumu Whakahaere me te Pouroki: Chief Executive and Registrar
Te Tatau o te Whare Kahu | Midwifery Council

By email: feedback@midwiferycouncil.health.nz

Dear Sue,

Re: Scope of Practice feedback

Please accept this feedback on behalf of the DHB Midwife Leaders.

This feedback represents the majority view of the 20 DHB Midwife Leaders (Deb Pittam and Chris Mallon both declared conflict of interest and therefore are exempt from this feedback). In preparing this feedback the group has considered the aspirations of the Council and the CRG for a broader and more comprehensive scope, alongside the realities of our current workforce and the exceptional pressure we experience in providing safe maternity services to our communities.

Overall we are very supportive of the proposal to align the scope with Te Tiriti o Waitangi, and the desire to pursue more equitable and culturally safe midwifery care.

Our feedback draws attention to some concerns we have about the proposed changes and potential unintended consequences that should be considered by Council. We then make some suggested wording changes that may satisfy these concerns.

1. Expanding the scope to include all sexual health, all infant health, and all whānau health significantly expands the role of the midwife and will inevitably see midwives working exclusively in these new fields. This will lead to the dispersion of the workforce over the scope of the role and will result in fewer qualified midwives being available for pregnancy; labour and immediate postnatal care, which has been the unique domain of a midwife. Resulting in an increased risk to public safety.

2. Expanding the scope to include all sexual health, all infant health, and all whānau health significantly expands the role of the midwife resulting in a much larger knowledge and skills base required to qualify. The impact of this is either to expand the undergraduate programme to cover the new knowledge and skills resulting in a significantly longer undergraduate programme acting as a barrier to enrolment, or to accepting that midwives will be under-qualified at the point of registration with a consequent risk to public safety.

3. Expanding the scope to abandon time parameters for the role i.e. from preconception to six weeks postpartum, leaves employed midwives vulnerable to redeployment into non-maternity wards to fill nursing shortages. Resulting in staff disenfranchisement and increased attrition, increasing risk to public safety.

4. Lack of clarity around what care can be provided on the midwife's sole responsibility and what can be provided as part of a wider health care team. This potentially creates problems when practitioners step outside the intention of the scope and deliver care they are not

qualified to provide for example prescribing anti-hypertensives, or treating asthma. Similarly it may give the impression that care is only delivered under the supervision and delegation of a doctor.

5. The scope makes no mention of locations of care, this in the past has protected the right of midwives to provide homebirth, and while this protection may not still be needed, would it be a problem to include this just to be on the safe side?

6. The use of the word whānau to replace the words woman and pregnant people was not well understood and is likely to be open to confusion. Whilst we understand that the CRG had a high level of comfort with this term to be a generic term for pregnant people the word whānau has a much wider use in Aotearoa and is therefore is likely to be open to significant misinterpretation. Inevitably this confusion will lead to a legal challenge at some point in the future.

The scope could be written as follows without changing the intent:

Te Tiriti o Waitangi is embedded in the practice of a kahu pōkai / midwife in Aotearoa New Zealand. The kahu pōkai / midwife provides culturally and clinically safe care, drawing upon evidence to enable wāhine / women / people sexual and reproductive health, preconceptual, pregnancy, birthing, postnatal and infant health and wellbeing within the wahine journey from preconception to 6 weeks postpartum on their own responsibility and in any context including home.

The Council may also wish to consider adding sexual health, infant health, and whānau health as an extended scope with accompanying credentialing programme for those that wish to do this as occurs with other workforces.

Yours sincerely

Carolyn Coles
National Chair, DHB Midwifery Leaders