AWHC

NEWSLETTER

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a voice for women's health

Looking After Mothers is What is Best for Babies

A look at maternal mental health and maternity services in Aotearoa New Zealand

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In this Issue...

Auckland Women's Health Council has a new website...

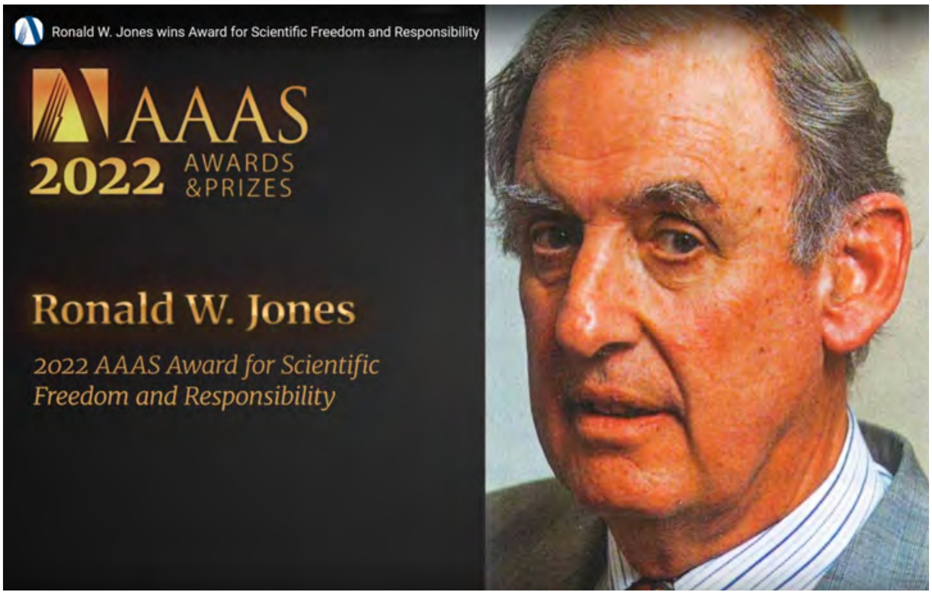
check it out at www.womenshealthcouncil.org.nz

The Auckland Women's Health Council is a voluntary organisation of individual women and women's groups who have an interest in and commitment to women's health issues. The organisation was formed in 1988 to provide a voice on women's health issues in the Auckland region.

The Council has a special interest in patient rights, informed consent and decision-making in health care, health consumer advocacy, the Code of Health Consumers' Rights, the National Cervical Screening Programme, and ethics – issues that were highlighted during the Inquiry into the treatment of cervical cancer at National Women's Hospital in 1987-88 and in the recommendations contained in the report known as the Cartwright Report.

Congratulations, Dr Ron Jones!

AWHC offers its warmest congratulations to Dr Ron Jones, who has been awarded the 2022 Scientific Freedom and Responsibility Award from the American Association for the Advancement of Science (AAAS).[1]



Dr Jones was a junior obstetrician and gynaecologist at National Women's Hospital in the 1970s, at a time when Herbert Green's unethical experiment into the natural history for cervical cancer had been underway for seven years. Dr Jones was never comfortable with what was going on at National Women's. He described himself (in his book *Doctors in Denial*) as initially a silent observer, later becoming "enmeshed in the resulting controversy". Dr Bill McIndoe took Dr Jones into his confidence "sharing his concern about the welfare of an increasing number of women initially presenting with CIS* who were later developing invasive cancer."

Dr Jones was one of four authors (together with Bill McIndoe, Jock McLean and Peter Mullins) of a landmark 1984 paper, published in the journal *Obstetrics and Gynecology*,[2] which discussed Herbert Green's work at National Women's Hospital on women with abnormal cervical cytology. The paper suggested that some patients had been diagnosed with cervical cancer but not treated.

The paper ultimately led to Phillida Bunkle and Sandra Coney's *Metro* article in June 1987,[3] followed in quick succession by the establishment of a judicial inquiry led by Judge Silvia Cartwright.[4]

Thirty years later, Dr Jones published his book *Doctors in Denial: The forgotten women in the 'unfortunate experiment'*. All royalties he received from the sale of the book were donated to gynaecological cancer research and care.

The AAAS in awarding Dr Jones the 2022 Scientific Freedom and Responsibility Award, describe how "Jones has spent much of his life confronting justifications for the scandal he considers revisionist and incorrect. Jones says he believes he had a moral duty to record his personal journey, extending over more than 40 years, and his role in exposing the 'unfortunate experiment.' "

Speaking to AWHC via email, Dr Jones said "My natural response in this situation is to feel a little embarrassed about the fuss. Then I reflect on 40 years of abuse — even rejection — from some corners of my profession."

"I'm told the New Zealand media were given plenty of opportunity to spread the good news but for some unknown reason it isn't newsworthy."

His natural humility meant that when he received the emails informing him of the award he twice thought it was spam and deleted them.

Dr Jones says that the citation says "for defending patients' rights and scientific integrity and for his courage in maintaining the spotlight on these principles." 'Maintaining the spotlight' refers to his continued efforts to fight revisionism.

The award honours engineers, scientists, or their organisations whose exemplary actions have served to foster scientific freedom and responsibility. The bravery of people like Ron Jones, and his colleagues Bill McIndoe and Jock McLean, whistleblowers who take on powerful people and institutions to expose wrongdoing, often go unrecognised, so we are thrilled that he has been internationally recognised for his role in exposed the unethical treatment of women at National Women's Hospital.

*carcinoma in situ

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1 Jilani Z, 2022: Ronald W. Jones Wins AAAS Scientific Freedom and Responsibility Award, American Association for the Advancement of Science, 15 February 2022.

2. McIndoe W, *et al.*, 1984: The Invasive Potential of Carcinoma In Situ of the Cervix, *Obstetrics and Gynecology*, October 1984: Vol. 64, No.4.

3. Coney S and Bunkle P, 1987: An Unfortunate Experiment at National Women's, *Metro*, June 1987.

4. See coverage of the Cartwright Inquiry on the AWHC website.

The Power of Advocacy

By Sue Claridge

Many years ago I was told that advocacy was like banging your head against a brick wall; it feels good when you stop!

That is because the rewards and wins in the work of organisations like the Auckland Women's Health Council can be small, incremental achievements, or making differences in one woman's life at a time. The big wins are often few and far between. So, you get a big win, it is worth celebrating.

The latest win for women's health organisations, and for all the women in Aotearoa New Zealand, is the promise of a women's health strategy as part of the new health system.

Along with other organisations, and no doubt many individuals, in our submission on the Pae Ora (Healthy Futures) Bill we advocated very strongly for the inclusion of a women's health strategy. For the Gender Justice Collective, the announcement that the Government has committed to a women's health strategy must be even sweeter.[1] In 2021 for International Women's Day, they launched a petition demanding a $6 million commitment from the Government for a "health strategy for all women, wāhine and trans women in New Zealand."[2] A mere $2.60 for every woman and girl in the country.

Of course, the GJC were not the only organisation nor the first calling for a women's health strategy. In 2014, Women's Health Action published *A Case for a National Women's Health Strategy in Aotearoa New Zealand*.[3]

In our submission on the Pae Ora (Healthy Futures) Bill we argued that:

"Many women in this country do not have accessible, affordable, available, and culturally appropriate and acceptable health care. Beyond this, an unacceptable number of women are harmed in some way — often extremely seriously — by their experiences of health care, and many more have their basic health care rights breached. In addition to needing a women's health strategy to address the inequities and disparities experienced by women, we recommend: a health needs assessment for women be conducted as a part of the assessment of the current state of health outcomes and health system performance; the New Zealand Health Plan includes gender analysis in its assessment of population health needs; and the Expert Advisory Committee on Public Health includes gender experts and advisors in women's health and well-being."

In their final report the Pae Ora Legislation Committee recommended "amending the bill to also include a Women's Health Strategy as a new clause 40A. The provisions for our proposed amendment would be similar to those in the existing strategies in the bill."[4]

However, it is not enough to just say we are going to have a women's health strategy. We need more than just lip-service to addressing women's health needs. How it is done is as important as it being done. Our women's health strategy must be by women for women.

In our submission we recommended that:

- a health needs assessment for women be conducted as a part of the assessment of the current state of health outcomes and health system performance in Part 2, Subpart 5, Section 37(3).
- the New Zealand Health Plan (Part 2, Subpart 5, Section 45) includes gender analysis in its assessment of population health needs;
- the Expert Advisory Committee on Public Health (Part 3, Subpart 5, Section 86) includes gender experts and advisors in women's health and well-being.

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Update on Pae Ora

It feels a bit like we're flying in an old, tatty, running-out-of-jet-fuel, but familiar 747, with cabin crew we've come to know. A voice comes over the speakers:

"This is your Captain speaking. We will soon begin our transfer of all passengers to a brand-new supersonic jet. The inflight service is amazing; everything that everyone wants and needs."

It sounds great, but we don't know how its all going to work. How, at 800km an hour, ten kilometres above the Earth are all the passengers actually going to get from here to there? And we're wondering if the manufacturer installed the seats and the toilets before the brand-new supersonic jet actually got its licence to fly and left the ground.

What do we know:

- The Pae Ora (Healthy Futures) legislation is due to be enacted at the end of June after the third reading in the House.
- Day 1 of the new Health New Zealand and Māori Health Authority is the 1st of July. Each will have a Board of up to eight members. In theory the DHBs cease to exist on the 1st of July, but in practice it seems that it will be a gradual transition. For staff, joining from a DHB, shared services agency or Te Hiringa Hauora, very little will change on Day 1 other than that they will be working for Health New Zealand or the Māori Health Authority. Presumably for consumers that means that very little will change on Day 1 for them either.
- The internal organisation of Health New Zealand will include four regional divisions with regional commissioning boards within Health New Zealand to ensure the provision of primary and community health services. Hospital and specialist services will be consolidated into four regional networks but planned nationally by Health New Zealand. The regional boundaries are not yet known.
- Over the next few months, the functional and operating structures that sit under the tier two national leadership roles will be evolved and developed as part of a design process.
- A high-level summary of the New Zealand Health plan is expected to available for public comment in early June. This is vitally important, because this is our next opportunity to have a say. The purpose of the plan is to provide a three-year costed plan for the delivery of publicly-funded services by Health New Zealand and the Māori Health Authority.
- Health New Zealand and the Māori Health Authority are placeholder names and these entities will have new names. The aim is to launch a permanent website for Health New Zealand at the beginning of July, with a new Māori Health Authority website coming a little later. Each website will bear the new name and visual identity of that organisation and work is underway on the 'visual identity' for these entities. These new websites will not replace other health sector websites on Day 1. A digital toolkit is being developed that will help DHBs, shared services agencies and other health sector organisations to "share the Health New Zealand story" through their own websites and social media accounts. Work is progressing on a public information campaign to tell the story of the health reforms and what's changing in Aotearoa New Zealand. This will target Māori, Pacific, Disabled People, rural and LGBTQI+ communities as well as other people with high-health needs in particular.

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The Power of Advocacy

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So, how does the Pae Ora Legislation Committee final report fare on those recommendations? To be honest, better than we might have expected. In the new Clause 40A (page 28 of the report[4]) it states:

(1) The Minister must prepare and determine a Women's Health Strategy.

(2) The purpose of the Women's Health Strategy is to provide a framework to guide health entities in improving health outcomes for women.

(3) The Women's Health Strategy must—

> (a) contain an assessment of the current state of health outcomes for women and the performance of the health sector in relation to women; and
>
> (b) contain an assessment of the medium and long-term trends that will affect the health of women and health sector performance; and
>
> (c) set out priorities for services and health sector improvements relating to the health of women, including workforce development.

(4) Subsection (3) does not limit what may be included in the Women's Health Strategy.

In *Clause 41 Process for making health strategy*, they say that the Minister must consult health entities or groups, individuals, and organisations that the Minister considers are reasonably likely to be affected by the health strategy. You'd have to assume that women would be consulted. What we want to see is a women's lived experience survey. It is not enough for health providers and practitioners to say what women need. There needs to be a thorough investigation, not only of women's health needs, but their experience in the health sector, to inform the development of the women's health strategy.

Additionally, the Minister must regularly monitor and review all health strategies; and assess how the health system sector has performed against the health. (*Clause 42*)

However, there is no mention of a gender analysis in its assessment of population health needs in *Clause 45 Content of the New Zealand Health Plan*. This is disappointing; we cannot continue to assess population health needs through a patriarchal lens!

Likewise, there is no mention in the Expert Advisory Committee on Public Health (*Clause 86*) of inclusion of gender experts and advisors in women's health and well-being. Again, this is very disappointing. How will the new Health New Zealand entity properly serve half the population without inclusion of experts and advisors in women's health?

The apparent commitment to a women's health strategy is a win for women/wāhine, but it doesn't go far enough. As Angela Meyer, one of the founders of the Gender Justice Collective said:

"We need to ask women what they need and want. It's not really rocket science, I don't think we're asking for too much."[2]

References

1. Russell E, 2022: Govt commits to including a women's health strategy in new Pae Ora legislation, *New Zealand Herald*, 13 April 2022.
2. Shahtahmasebi Z, 2021: Petition launched for a $6 million women's health strategy, *New Zealand Doctor*, 17 March 2021.
3. WHA, 2014: *A Case for a National Women's Health Strategy in Aotearoa New Zealand*, Women's Health Action.
4. Pae Ora Legislation Committee, 2022: Pae Ora (Healthy Futures) Bill, final report of the Pae Ora Legislation Committee, 14 April 2022

Update on Pae Ora

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- There will ultimately be between 60 and 80 localities – geographically defined areas for the purpose of arranging services – by July 2024For now nine areas have been identified as pilot localities. These are Ōtara/Papatoetoe, Hauraki, Eastern Bay of Plenty, Taupō/Tūrangi, Wairoa, Whanganui, Horowhenua, Porirua and West Coast. A locality plan must: a) set out the priority outcomes and services for the locality; and b) state the plan's duration, which must, as a minimum, be three consecutive financial years; and c) give effect to the relevant requirements of the New Zealand Health Plan. Localities are being rolled out as a key mechanism for organising health and social services to meet the needs identified by whānau, community and mana whenua. The purpose is to deliver informed healthcare that focuses on prevention and promotion, fostering healthcare provider collaboration, and a more holistic approach to people's wellbeing. How this will work in practice remains to be specified.

Periods Aiding Injury Recovery Research?

Amazing Study Being Done in Aotearoa New Zealand

By Sue Claridge

Health research focussed on women. Research on periods. Better yet, research done here in Aotearoa New Zealand!

We have oft lamented the fact the women have traditionally been left out of medical research.[1, 2] For centuries women's health and women's bodies have largely ignored, found to be far too complicated to include in medical research. We have "weird" organs, and "difficult hormones" and we menstruate! Essentially, when it comes to medical research, women are put in the "too hard basket", never mind that we are 50% of the population.

Now, in ground-breaking research being undertaken here in Aotearoa New Zealand, not only is it not a problem to involve people who bleed on a monthly basis, it is critical to the research.

"For the first two weeks after you get your period your oestrogen builds in your body, and oestrogen is basically a female version of testosterone, so it helps us recover and repair from resistance exercise."

"We'll measure these changes by measuring knee strength using a knee extension machine and we will measure function using validated functional scales," Emma explained.

The existing knowledge base that underpins this research is that:

- females have inferior quadriceps strength post ACLR compared to males;
- the ACL re-injury rate is higher for females compared to males;
- females have inferior functional outcomes post ACLR compared to males;

"A Female Specific Menstrual Cycle Phased ACL Rehab Programme"

Researchers from AUT and Waikato University, headed by Ph.D. candidate and trained physiotherapist, Emma O'Loughlin, are conducting a study to understand how the menstrual cycle affects rehabilitation after anterior cruciate ligament surgery. This randomised controlled clinical trial aims to investigate if a female-specific programme for ACLR rehabilitation, timing strength exercises to a particular phase of a female's menstrual cycle, affects quadriceps strength and self-reported function post-ACLR. The study is being conducted within the AUT Sports Performance Research Institute New Zealand.

When AWHC contacted Emma to talk about her research, she entirely understood our concerns about women being ignored in medical research.

"Yes, I know," she said. "Even now when I am undertaking research on women, I get a response like I'm undertaking research on a minority population — even though, as you mention, we are 50% of the population!"

The primary hypothesis of Emma's research is "that the intervention group (those who carry out resistance exercise during the follicular phase* of their menstrual cycle, following their surgery) will achieve greater quadriceps strength changes compared to the control group (regular exercise following their surgery). The secondary hypothesis is that the intervention group will have greater self-reported functional outcome changes compared to the control group."

- current best practice recommendations for rehabilitation do not have any female-specific guidelines or approaches to rehabilitation;
- research has shown high volume strength training programmes completed in the follicular phase (low hormone) phase of a female's menstrual cycle may significantly improve strength outcomes compared to regular training.

Emma is looking for more participants for her research. She needs women 16 years or older who are not on the contraceptive pill and have an anterior cruciate ligament injury. If you are interested in finding out more about this research or taking part in it, contact Emma O'Loughlin at ccq8275@autuni.ac.nz or on 022 172 3949, or get more information on the study webpage.

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* The follicular phase starts on the first day of menstruation and ends with ovulation. Prompted by the hypothalamus, the pituitary gland releases follicle stimulating hormone (FSH), which stimulates the ovary to produce follicles one of which will mature into an egg. During the follicular phase, the developing follicle causes a rise in the level of oestrogen.

References

1. Claridge S, 2020: Women's Health: invisible, ignored, misdiagnosed, *AWHC Newsletter March 2020*.
2. Claridge S, 2022: Outcomes Worse for Women When Their Surgeon is Male, *AWHC Newsletter February-March 2020*.

Looking after Mothers is what is best for Babies

By Sue Claridge

If want to look after our babies we must focus on the health and needs of their mothers.

The recent focus on Roe v. Wade in the United States, and imminent restriction of legal abortion in there, has stimulated the so-called pro-life lobby in New Zealand to advocate for rescinding the abortion legislation — only passed in March 2020 — that removed abortion from the Crimes Act and made it simply a health issue.

There has been a lot of discussion in the mainstream and social media about what is going on in the US and the removal of the rights of women to make decisions about their bodies. In the era of #MeToo and #mybodymychoice, in an era where few sane people would deny woman the right to say no to sex, it seems entirely, astonishingly wrong that some would deny women the same right to decide whether or not to bear a child, the right to bodily autonomy over all of her body and its functions.

It is outrageous to be in a position to have to ask, but where are the mothers' rights in any of this discussion?

Our 2020 abortion legislation belatedly gave women the right to decide to end a pregnancy — for her own profoundly considered reasons — without it being deemed a crime but for the benevolence of two doctors who are prepared to say that her physical or mental health will be significantly adversely affected. Despite this long overdue right, many women in Aotearoa New Zealand still face a truly terrible period of their lives in order to bring a new human life into the world, so terrible that some will not survive.

In 2021, 58,659 babies were born[1] to about 56,000 mothers (allowing for the approximately 1000 mothers per year who have multiple births[6]). In contrast, we have about 13,000 abortions per year; since the abortion legislation was enacted in 2020, 45% of abortions were accessed before eight weeks' gestation.[3]

Before embarking on a review of some recent reports into the state of maternity services and maternal mental health in this country, it is worth considering a couple of the items that I have come across recently in response to the abortion debate in the US (see side bar on page 9).

Why?

Because our attitudes to abortion and our attitudes to a woman's right to bodily autonomy, to choose when, how, and where she has a baby, are woven together. These attitudes go some way to explaining why having a baby in Aotearoa New Zealand can be such an awful, and physically and mentally harmful, experience for some women.

It's easy to take the side of the unborn; so much harder to stand up for the rights of the women who make most of the sacrifice – financial, career, independence, health and well-being, and 18+ years of their lives – to have a baby. Having a baby should be an amazing, fulfilling and joyful time of a woman's life, and for many it truly is. But for many, it truly isn't.

If the abortion debate was really about the babies, where are the "pro-lifers" after the babies are born? What are they doing to improve the lives of the 56,000+ new mothers and babies every year, because

Being Pro-life – Women's Lives!

Anti-abortion is not the same as pro-life no matter what the anti-abortionists would have you believe, whether they are in the US or here in Aotearoa New Zealand. Being pro-life should be about the lives of women as much as it is about the lives of babies. As US Methodist Pastor David Barnhart says, "the unborn are a convenient group of people to advocate for. They never make demands of you; they are morally uncomplicated."

He goes on to point out that, unborn babies, "unlike widows, they don't ask you to question patriarchy; unlike orphans, they don't need money, education, or childcare; unlike [migrants], they don't bring all that racial, cultural, and religious baggage that you dislike; they allow you to feel good about yourself without any work at creating or maintaining relationships; and when they are born, you can forget about them, because they cease to be unborn."

"You can love the unborn and advocate for them without substantially challenging your own wealth, power, or privilege, without re-imagining social structures, apologising, or making reparations to anyone. They are, in short, the perfect people to love if you want to claim you love Jesus but actually dislike people who breathe."

Tallulah Magilicuddy, a US anti-adoption campaigner, writes that she is not pro murdering babies, but pro women's lives, the women who have to make a difficult decision to end a pregnancy, women like:

- Becky who found out at her 20-week anatomy scan that the infant she had been so excited to bring into this world had developed without life sustaining organs.
- Susan who was sexually assaulted on her way home from work, only to come to the horrific realisation that her assailant planted his seed in her when she got a positive pregnancy test result a month later.
- Theresa who haemorrhaged due to a placental abruption, causing her parents, spouse, and children to have to make the impossible decision on whether to save her or her unborn child.
- Melissa who's working two jobs just to make ends meet and has to choose between bringing another child into poverty or feed-ing the children she already has because her spouse walked out on her.
- Lindsay who lost her virginity in her sophomore year with a broken condom and now has to choose whether to be a teenage mom or just a teenager.
- Courtney who just found out she's already 13 weeks along, but the egg never made it out of her fallopian tube so either she terminates the pregnancy or risks dying from internal bleeding.

She says "You can argue and say that I'm pro-choice all you want, but the truth is I'm pro-life. Their lives. Women's lives."

"It's not about which stories you don't agree with. It's about fighting for the women in the stories that you do agree with and the CHOICE that was made."

"Women's rights are meant to protect ALL women, regardless of their situation!"

if you are pro-life surely there is work to be done here that will benefit thousands more babies than the number they claim to want to "save".

The reality is that the incredible role that women have as mothers and as midwives in creating, carrying and birthing the next generation of New Zealanders — the next generation of taxpayers for the politicians just focussed on cost — is grossly undervalued in this country. Our maternity system, with women able to choose their lead maternity carer, is lauded internationally. But the truth falls far from the image that the rest of the world has been sold.

The truth is that our maternity services are in crisis and worsening by the day, and the perinatal period is a torrid time for far too many of our women/wāhine.

Maternal Mental Health

In their 2021 annual report, the Perinatal and Maternal Mortality Review Committee (PMMRC) reported on maternal suicide. Between 2006 and 2018 there were 30 maternal deaths by suicide reported by the PMMRC.[4] In comparison with the UK, we have five times the maternal suicide rate, while the differences in other causes of maternal death between the two countries were statistically insignificant.[4]

While the majority of maternal suicides occur in the postpartum period (56%), a significant proportion occur during pregnancy (41%). The PMMRC said that "in contrast to previous thinking, pregnancy is not necessarily protective of death by suicide."[4]

In our *Newsletter* in which we reviewed the PMMRC report we pointed out that it did not provide a complete and up-to-date picture of maternal suicide in New Zealand. The PMMRC only consider deaths up to 42 days postpartum and we cited a New Zealand Herald article that found that “one in seven new mums suffer postnatal depression after giving birth” and the issue may have escalated in the year of Covid, particularly for mums giving birth during lockdown in 2020.[5] Emma Russell reported that “first-time mums have described being left alone after traumatic births during lockdown,” a period of time when women were left without the support of partners and whānau during labour and birth because of visitor restrictions owing to the pandemic.[6]

The Helen Clark Foundation

Āhurutia Te Rito
It takes a village

How better support for perinatal mental health could transform the future for whānau and communities in Aotearoa New Zealand.

A REPORT BY **HOLLY WALKER**
May 2022

A year on, and the report *Āhurutia Te Rito | It takes a village*[7] was released. Author, Holly Walker was driven by her own experiences to ask “how mothers and birthing parents are supposed to cope with the myriad stresses and challenges that can accompany the birth of a new baby in contemporary Aotearoa.”

She wrote in her ‘Author’s Note’ that in 2019 she attended a meeting at which Professor Sir Peter Gluckman said that maternal mental health (particularly during pregnancy) was emerging as perhaps the single biggest factor in determining long term child health and wellbeing.[7]

Holly Walker writes in response “Wait, so we need to support mothers and birthing parents better? … Well, blow me down with a feather.”[7]

She goes on to say “in most modern, English-speaking, so-called ‘Western’ nations like Aotearoa New Zealand, healthcare and maternity policies and services have come to be strongly dominated by a focus on the baby, sometimes at the exclusion of the birthing parent. It’s as if we think the baby’s interests and needs can somehow be separated from those of their whānau.”

Āhurutia Te Rito | It takes a village[7] found that:

- perinatal distress in Aotearoa is widespread, complex, and linked to systemic inequities such as poor housing, low income, food insecurity and domestic abuse;
- 55% of Māori and 30% of non-Māori report significant life stress in late pregnancy;
- disabled women face multiple barriers to appropriate maternity care and many feel ill-prepared and unsupported to manage their pregnancies and births;
- making sure parents and whānau have access to support is the best way to protect perinatal mental health, and contributes directly to wider whānau well-being;
- better support for perinatal mental health would be transformational for whānau and communities in Aotearoa New Zealand.

The report stated that “perinatal distress can have myriad other severe consequences. It can impede emotional and physical wellbeing, healthy parenting, family functioning, employment status, and household financial well-being”, and that having a parent experience perinatal distress — even before they are born — can have lifelong implications for babies.[7]

Research, including some undertaken in this country, has found that “symptoms of maternal distress during pregnancy can have a significant negative impact on child brain development. Antenatal distress can impede both the structure and connectivity of a child’s brain, and functional outcomes for that child, like working memory, attention, and sensory processing.”[7]

Perinatal distress disrupts critical attachment bonds between parents and children (including fathers) and the results can “lock in intergenerational disadvantage.” Impaired executive functioning, sub-optimal brain development, insecure attachments with caregivers, and early health disadvantages all have lifelong consequences.” Conversely, warm supportive and attentive parenting is strongly protective of lifelong health and well-being.[7]

Clearly, the mental health of women has a critical impact on the long-term health of their children, whānau and communities.

The report finds that responsibility for reducing perinatal distress should not fall on individuals.

As the drivers of perinatal distress are systemic, so must be the solutions: "social determinants of mental health — poverty, racism, gender disadvantage and other structural inequalities, food insecurity, gender-based violence, poor housing, limited education and social networks — are all of critical importance for women in the perinatal period."[7]

Among a number of recommendations, the report concluded that political leaders, policy makers, and those designing the new health system should prioritise policies that:

- alleviate or remove background stress for new parents by making sure they have warm, secure, affordable housing, adequate food, and that they are safe from violence and abuse;
- make it easier for whānau/family to spend time with and support new parents and pēpi;
- ensure birthing parents have access to continuous, holistic maternity care, supportive birth environments, and tailored assistance, to reduce the risk of birth trauma and resulting distress;
- provide parents with hands-on practical support for aspects of parenting and daily life when required;
- provide fast access to affordable, culturally appropriate therapeutic support to parents with early signs of distress, and guarantee immediate access to best practice specialist help if they become unwell.[7]

Maternity Services and Midwifery in Crisis

The *Āhurutia Te Rito | It takes a village* report concluded what we have known for some time. Not only are "current supports for new parents and babies not meeting current needs" but our midwifery workforce is in crisis. Our internationally highly regarded lead maternity care system is in disarray, with "many parts of the country currently experiencing chronic midwifery shortages, and many DHBs report being unable to fill critical vacancies. Anecdotal reports from midwives themselves suggest many are leaving the profession, citing stress and burnout."[7]

On top of the workforce crisis, we a have a crisis in birthing facilities. In the June 2019 *AWHC Newsletter*[8] we reported on the closure of primary maternity units and cited the MoH *2017 Report on Maternity* (published in April 2019);[9] buried in the Appendices of the report was the fact that 11 primary birthing units closed between 2008 and 2017.

The MoH Report on Maternity isn't published in that format any longer, and is now an online Report on Maternity web tool.[10] Neither the online tool nor the associated *Report on Maternity: further information* document appears to provide any information on actual birthing facilities, in particular the number of primary birthing facilities that are still open. Perhaps the Government and the MoH are too embarrassed to openly publicise how many more have closed down.

However, online research has revealed that since 2019 a further five primary birthing units have closed. One of these, Charlotte Jean in Alexandra closed with a promise to local women that two new birthing units in Wānaka and Clyde were to be built. However, it appears that the Southern DHB chose to close the Alexandra unit before they had given final approval for the new birthing centres, which are still years away from being built much less being operational.[11]

A new birthing unit opened by the Wright Family Foundation – Ngā Hau Mangere Birthing Centre in Mangere – appears to receive no DHB funding, and another Wright Family Foundation birthing centre in Lower Hutt has now closed because the Hutt Valley District Health Board refused to help fund it.[12] In August 2021, the purpose built three-year old Te Awakairangi Birthing Centre in Lower Hutt, the region's only birthing centre outside a hospital setting, closed indefinitely. At the time Te Awakairangi Birthing Centre told *Stuff*:

"The directors have decided to 'mothball' the centre to give the Ministry of Health sufficient time to consider ring-fencing funding to follow women's health needs and choice of provider."[12]

We hope that the directors are not holding their breath on funding from MoH; primary birthing facilities seem to be anything but a priority.

If primary birthing facilities were a priority, then perhaps the last remaining primary birthing centre in Christchurch, our second largest city, would not have been facing closure. Burwood primary birthing unit closed in 2016, leaving the private St George's Maternity Hospital* as the only primary birthing unit in Christchurch. In March it was announced that St George's was to close. Chief executive Blair Roxborough said that closure was an operational matter.[13]

There was an outcry over the plans, with a 30,000 signature midwife-initiated petition, and high profile parents Gemma and Richie McCaw throwing their weight behind the fight to keep it open.[13] At least the petition and feedback had some impact. As we go to press it has been announced that St Georges is to stay opne, for now at least.

"St George's Hospital chief executive Blair Roxborough said it will endeavour to maintain maternity services for the duration of the existing contract with the Canterbury District Health Board. The contract runs until June next year."[14] However, the maternity unit still faces significant staffing shortages that led to the review in the first place, and the will still have to "scale back birthing at the hospital".[14]

Canterbury District Health Board has said that construction would begin on a new community birthing unit in the central city in the second half of 2022. Although they say that the new facility is expected to open in mid-2023, one would have to question that expectation, given existing issues in the construction sector that have been seriously exacerbated by the Covid pandemic, leading to severe shortages of materials and workforce.

Women and their families should not have to fight to keep primary birthing facilities open. They should not have to wait years for new facilities to be built. These are birthing choices that are being taken away from them, forcing them to choose between home birth and often highly medicalised hospital birth. Where are our internationally lauded maternity services now? Primary birthing units offer better outcomes at lower cost to women with uncomplicated pregnancies – maintaining these centres seems to be a no-brainer for women and the health system.

The New Zealand College of Midwives (NZCOM), in their press release addressing the proposed closure of St George's, couldn't have stated it more succinctly:

"[W]omen's health always seems to be at the bottom of the funding barrel. Let's keep what we have and get on with looking ahead at what's best for women and babies. The health system should be prioritising investment in maternity services as a key foundation for a healthy start to life. We need more primary birthing units, not fewer."[15]

As I write this article, it has been announced that Bethlehem Birthing Centre had to shut its doors this week (27 May) due to a shortage of midwives.[16]

Midwifery shortages have been a critical issue in the provision of maternity services for years. In April 2021 it was reported that there were 211 midwife vacancies across the nation's hospital wards.[17] When we spoke to NZCOM,[18] they didn't know the exact number of current vacancies as that information is gathered by DHB. Additionally, there are hospital midwives and community midwives, so DHB or hospital information doesn't tell us much about any midwifery shortage in the community.

But we can start to get a picture of how dire the situation is looking at reports in the media. In December 2021, Radio New Zealand reported that Invercargill Hospital had just 17% of the midwives it needs and Dunedin only half the number it needs.[19] While some of these positions are filled by nurses NZCOM says that is not a satisfactory

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* St Georges has a contract with the Canterbury District Health Board to provide publicly funded maternity services.

Midwives and their supporters should not be in a position where they have to protest for fair pay and safe work conditions.

solution because nurses are not trained in midwifery, they don't have the training and experience in maternity and birth and that could potential put the safety of mums and babies at risk.[18]

It is interesting to note that job vacancy website JORA (formerly Jobseeker.co.nz) listed 407 midwifery jobs in New Zealand as at the 27th of May.

On the 11th of May, the Government announced "rebalanced" immigration settings with a new "Green List which will incentivise and attract high skilled migrants to New Zealand, by providing a new streamlined pathway to residency for those globally hard to fill roles. The list features 85 hard to fill roles including construction engineering, trades, health workers and tech."[20]

But that Green List of 85 hard to fill roles is overwhelmingly, eye-wateringly in male dominated skills and professions. Midwives are not on the list! Neither does any sort of nursing, including nurses and carers for desperate aged care providers.

Midwifery has been placed on the Work to Residence pathway, which is not fast-tracked.

Alison Eaddy, CE of NZCOM, says it is unbelievable that midwifery has not been placed in the fast-tracked group with doctors and specialists.[21]

"Given the level of midwifery shortages and vacancies we are experiencing nationally, it is unbelievable that midwifery has not been placed in the first group with doctors and specialists," said Ms Eddy.[21]

"Our workforce shortages have been a long time in the making, some of our maternity services are on a knife edge as a result. We need a range of solutions, short, medium and long term to address these issues. Reducing immigration barriers for overseas recruitment, such as including midwives on a list that offers the most attractive immigration option, would make an immediate difference," she added. [21]

The Green List is a slap in the face coming immediately after a new $230 million apprenticeship boost scheme announced the same week which will provide ongoing financial support for those in trade apprenticeships.[22]

Again, NZCOM are horrified that the midwifery profession has been left out in the cold, yet again.

"The fact that midwifery hasn't been considered let alone included in the apprentice scheme, is yet further evidence of discrimination," said Jill Ovens. "It was women who predominantly were negatively affected by covid, losing jobs and income. Why wouldn't the govt consider attracting those women into a predominantly female profession with a similar campaign and funding to that seen in the trade apprenticeship drive? It just doesn't make sense. It's like women are invisible."[21]

When AWHC spoke to Claire MacDonald, Midwifery Advisor with NZCOM, she was clear that they are focussed on solutions to the issues with maternity services. Although the frustration is palpable, people working in maternity services just want issues to be properly addressed and the obvious solutions applied, for there to be some fairness in women's health. NZCOM provided AWHC with a swath of solutions for the existing problems of retention and recruitment and maternal mental health (see page 14).

In addition, an AWHC Committee member, who has recently returned to work from maternity leave and had to navigate childcare and continuing her career, says that more support is needed to improve maternal mental health. She believes two practical options that will make a difference to maternal mental health are: to fund and encourage the use of simultaneous non-birthing parental and/or family support leave: and extend funding for ECE/childcare support to children from six months of age.

When you consider the short and long-term impact on the health of babies, mums, families/whānau and communities of a maternity sector that is broken, it should be clear to our politicians and policy makers that the investment in women's and maternity health will have a significant down-stream cost benefit. Drag women's health out from the bottom of the pile and put it at the top; the benefits will flow down to benefit the entire country. Looking after mothers is best for everyone!

Fixing Maternity Services in Aotearoa New Zealand – focusing on solutions

Retention:

- The establishment of a new contract model which is fit for purpose for community midwifery practice replacing Section 88.
- Resolution of the MERAS (Midwifery Employee Representation & Advisory Service) pay equity process currently under negotiation for employed midwives.
- Adequate funding for locum services and enabling LMC midwives to have more funded locum days.

Recruitment:

- Support for midwifery students to align with the funding that has been put into apprenticeships for male-dominated professions since the Covid pandemic (including in this year's Budget)
- Overseas midwife recruitment, including moving midwifery to the immediate residency arm of the Green Stream in line with doctors, engineers, etc. (professions with privilege derived from having previously been male-dominated)

Maternal mental health:

- Invest in maternal mental health services to follow on from the Maternal Mental Health Stocktake report.
- Implement a national strategic approach to maternal mental health service provision and access for those with mild, moderate and severe needs.
- Address the social determinants of health, and start with income and housing. Ensure women and whānau have enough so they can focus on parenting.
- Continue to increase paid maternity/birthing parent leave.

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NZ Medical Association on its Last Legs

The New Zealand Medical Association (NZMA) – formed in 1886 – is on its last legs, is virtually bankrupt with income unable to meet expenditure for six months of the year. In early May the Board unanimously agreed to recommend to its membership to liquidate the Association,[1] and on the 30th of May its members voted to go into liquidations.[2]

The NZMA describes itself on its website[3] as "the country's only pan-professional medical organisation in New Zealand representing the collective interests of all doctors. Our members come from all disciplines within the medical profession, and include specialists, general practitioners, doctors-in-training and medical students."

Part of their problem is declining membership and therefore declining income. Membership currently sits at around 4812, down from 5,046 in May 2021 and 5,626 in May 2018, according to an NZMA Financial Position document[4] on their website. A large proportion of that membership are students; only just over 1200 members are full fee-paying members, "less than 10 per cent of the 17,000-strong New Zealand medical workforce." More than two thousand members are students who pay less than $10 per year. Added to the membership woes is the non-payment of membership fees by 632 members to the tune of $192,729.

Is the state of the NZMA symptomatic of the parlous state of the health sector generally in this country? It is an indictment on the sector and the way that it is managed on numerous levels that the NZMA cannot survive and is so unsupported by the medical workforce.

So, why should we care?

The NZMA is not just a professional organisation that represents its members. Board Chair, Dr Alistair Humphrey said in a press release that the NZMA "are producers and custodians of several important assets that will need to be carried on by other organisations – including the *New Zealand Medical Journal*, the Code of Ethics, the Benevolent Fund and New Zealand's membership of the World Medical Association."[1]

The loss of the *New Zealand Medical Journal*, first published in 1887, would be a travesty. While medical researchers in Aotearoa New Zealand can publish in other international medical journals – and do – there is a distinct benefit in retaining a medical journal that is focused on our own country. It is a peer reviewed journal and while it is not up there with the likes of the Tier 1 journals, such as the big four – the *Lancet*, the *BMJ*, *JAMA* and the *New England Journal of Medicine* – the *NZMJ* is ours, it focuses on medical and health research relevant to New Zealanders.

Otago University epidemiologist Nick Wilson said New Zealand health workers and scientists "really do want to do get coverage in a local audience, to be able to discuss things that are uniquely relevant to the country."[5]

Professor Sue Crengle, also of Otago University, said "in recent years the journal had published a lot about health inequities, for Māori and other groups, and now had a Māori editor… Māori issues would likely not get the same level of coverage in a journal shared with Australia."[5]

In early May, the NZMA Board said that they were in discussion "with other sector organisations on how to pass these assets on"[1] including the *New Zealand Medical Journal*, so hopefully the *NZMJ* will continue albeit under the auspices of another organisation. It would be very disappointing for the journal to disappear entirely.

After the vote on the 30th of May, NZMA Chairman, Alastair Humphrey said "it was now seeking expressions of interest from people "willing and financially able" to create a new organisation to run the journal."[2]

New Zealand's membership of the World Medical Association (WMA) is another issue. Through the NZMA, Aotearoa New Zealand has ratified and/or signed a number of declarations, resolutions and statements that cover a wide range of subjects, including research on human subjects and the Helsinki Declaration (perhaps the best known of the WMA documents), an International Code of Medical Ethics, the rights of patients, care of the sick and wounded in times of armed conflict, torture of prisoners, the use and abuse of drugs, family planning and pollution. It is unclear what the implications are for Aotearoa New Zealand and our relationship with the WMA if the NZMA ceases to exist.

AWHC has repeatedly tried to contact the NZMA via the phone and email provided on their website with-out success. There is no facility to leave a voice mail message and our emails have gone unanswered. While we understand that this must be a difficult time for the NZMA staff, these are significant issues and it is disappointing that they seem to be entirely unwilling to discuss the implications of the dissolution of the NZMA.

One can't help but think that the parlous state of the NZMA mirrors the parlous state of the health sector generally in this country. It is an indictment on the sector and the way that it is managed on numerous levels that the NZMA cannot survive and is so unsupported by the medical workforce. Does it say more about the organisation itself, or the state of medicine in Aotearoa New Zealand?

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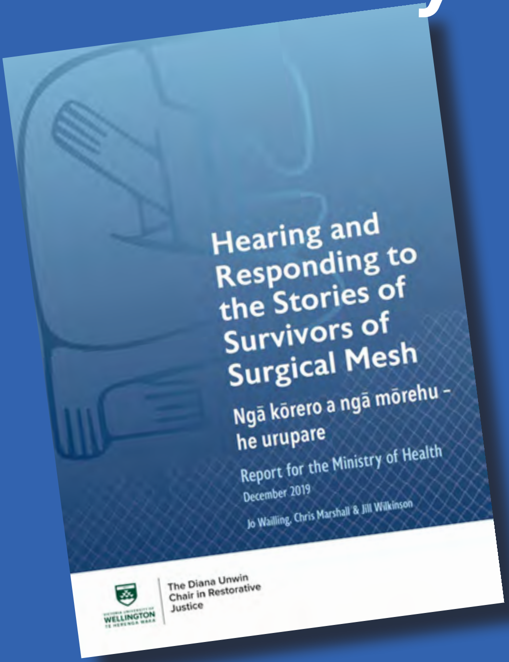
Calling all New Zealanders Affected by Surgical Mesh!



Hearing and Responding to the Stories of Survivors of Surgical Mesh

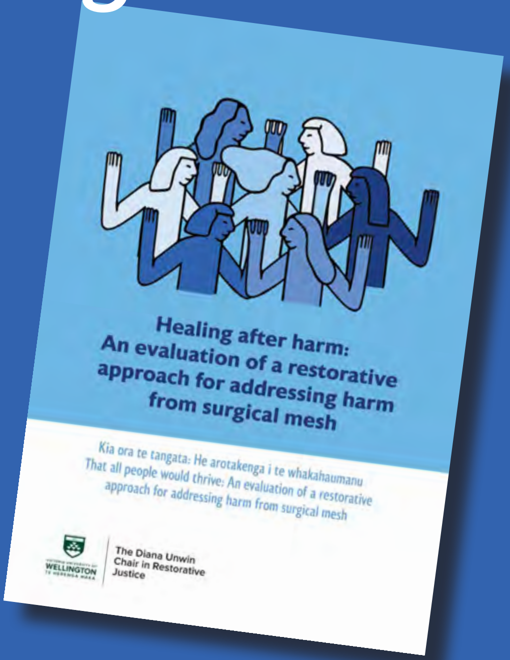
Ngā kōrero a ngā mōrehu – he urupare

Report for the Ministry of Health

December 2019

Jo Wailling, Chris Marshall & Jill Wilkinson

The Diana Unwin Chair in Restorative Justice



Healing after harm: An evaluation of a restorative approach for addressing harm from surgical mesh

Kia ora te tangata: He arotakenga i te whakahaumanu

That all people would thrive: An evaluation of a restorative approach for addressing harm from surgical mesh

The Diana Unwin Chair in Restorative Justice

Have you been affected by surgical mesh? If so, the Surgical Mesh Roundtable — the agency responsible for addressing surgical mesh harm — want to hear from you.

In 2019, a restorative justice process was undertaken to listen to people adversely affected by surgical mesh. An evaluation of this process was published recently — *Healing after harm: An evaluation of a restorative approach for addressing harm from surgical mesh* — and the Surgical Mesh Roundtable wants to know what this report means to those affected by surgical mesh. If you have any comments regarding the release of this report, please communicate these to occo@health.govt.nz. Your comments will be anonymised and shared with the Surgical Mesh Roundtable to inform the Ministry's ongoing work programme to prevent future harm by surgical mesh.

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HSC Have “Washed Their Hands”

Health Select Committee pass the buck on HDC appeals

By Sue Claridge

The Health Select Committee have effectively “washed their hands” of any responsibility for addressing the inadequacies of the existing Health and Disability Commissioner legislation and have “passed the buck” back to current Commissioner, Morag McDowell, to deal with.

We have reported several times on a significant piece of work that AWHC has been involved with over a period of eighteen months; supporting Renate Schütte’s petition to Parliament requesting that the “House of Representatives amend the Health and Disability Commissioner Act 1994 to give complainants, and those that are the subject of complaints, the right to appeal decisions made by the Health and Disability Commissioner.”[1]

In May, the Health Select Committee finally reported back to Parliament on the petition and submissions.[2] Unfortunately — but not surprisingly — the HSC took the easy option of referring the issue back to the HDC Morag McDowell, encouraging her to “address the complexities of creating a right of appeal” when she next reviews the HDC Act and Code of Rights in late 2022 or 2023.

The report summarises the views and arguments of the submitters, including those of the AWHC, Cartwright Collective, Federation of Women’s Health Councils, past HDC Prof. Ron Paterson and current HDC Morag McDowell, among others.

The HSC reported that Ms McDowell is not opposed to the right to appeal but that she believes that the matter is complex and requires careful consideration. She observed that operational changes are relevant considerations that can broaden access to justice for consumers and address some of Renate Schütte’s concerns.

The HDC “supports broad public, health sector, and stakeholder consultation to ensure that all options are considered and the effects of any changes are well understood,” and that “consultation is also needed to prevent unintended consequences, particularly for consumers, providers, and the wider sector.”

Beyond the lack of right to appeal HDC decisions, other issues were raised in the making of submissions, in particular the current dearth of investigation within the office of the HDC that would identify clusters of complaints that would indicate issues with particular practitioners or roups of practitioners/services providers, institutions or DHBs.

This was specifically raised by Prof. Paterson in his submission, in which he said:

“I note that the Commissioner has an important power (under the HDC Act, s 40(3)) to commence an ‘own initiative’ inquiry. Such an inquiry is particularly appropriate where a significant number

Renate Schütte, whose petition to Parliament requested thate the HDC Act be amended to give complainants, and those that are the subject of complaints, the right to appeal HDC decisions.

of complainants raise similar serious issues, as in the surgical mesh cases. In my opinion the own initiative power has been under-utilised in recent years. This is a missed opportunity to promote and protect consumers' rights."[3]

While the HSC covers this in their summary of Prof. Paterson's submission, they do not address this in their recommendations, tacitly leaving that in the hands of the current HDC, along with the issue of the right to appeal decisions.

The response of the HSC is disappointing. They have had the opportunity to address deficiencies in the HDC Act and ensure that our complaints system offers more fairness and greater justice to consumers, that it better promotes and protects the rights of consumers, and importantly is made more accountable for the decisions that it hands down. They have chosen to absolve themselves of the responsibility of addressing deficiencies in the legislation — a role that one could strongly argue is best suited for a Parliamentary committee — and sheeted it back to the agency that is governed by that deficient legislation to review.

As Prof Jo Manning has pointed out, "asking the HDC to advocate for an appeal right from its decisions is, with respect, like 'asking turkeys to vote for Christmas'."[4]

However, this is the situation that the submitters in favour of a right to appeal HDC decisions find themselves in and we must prepare to argue our case in submissions to the HDC when she undertakes her regular review of the HDC Act and Code of Rights.

Given that Ms McDowell has raised concerns about the complexities and unintended consequences, and we must address these concerns in future submissions. Additionally, in her submission on the petition, Ms McDowell also said that any changes to introduce a right of appeal would need to take into account a range of factors. These include the need to:[5]

- be consistent with the HDC's purpose, be people-centred, and balance the four statutory factors for complaints resolution (fair, simple, speedy, and efficient);
- avoid unnecessary complexity, fragmentation, or undue delays for people;
- consider the threshold for appeal;
- to reflect commitments under Te Tiriti o Waitangi, be accessible, and not compound existing inequities.

We will continue to monitor this issue and update readers with any notification of the HDC review of the Health and Disability Commissioner Act and the Code of Rights. We encourage all those with any concerns about the health and disability complaints process in Aotearoa New Zealand, the lack of right to appeal HDC decisions, or the lack of appropriate investigation of complaints in order to understand broader systemic issues in the health and disability sector, to make submissions when that opportunity arises.

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Hippocrasy: how doctors are betraying their oath

By Rachelle Buchbinder and Ian Harris

New South Publishing

A book review by Sue Claridge

Hippocrasy is not the first book to expose the medicalising of normal life, over-treatment and over-diagnosis among other things. That it is not the first and no doubt will not be the last is an indication of just how much medical practice and health has become an industry and not a calling. It will come as no surprise to many that health and wellness is not the bottom line for the practitioners on the frontline of the pharmico-medical industry that governs our health system, but repeat business and therefore profit.

Rachelle Buchbinder — a rheumatologist — and Ian Harris — an orthopaedic surgeon — put their reputations, their livelihoods and possible their lives on the line in their determination to expose the truth about modern medicine. Highly published professors of medicine, their advocacy of evidence-based medicine has brought down upon them numerous personal attacks. For example, Rachelle Buchbinder was once advised to put her head in a microwave oven and turn it on, all because she published a paper criticising a treatment that was no better than placebo for heel pain.

Such personal attacks go with the territory; nowhere more than in medicine is there an increasing tendency to shoot the messenger, especially when criticism, and proponents of evidence-based medicine threatens the flow of money and the blind faith in doctors that many patients have.

It is unlikely that the book will endear Buchbinder and Harris to many of their colleagues; the book takes a look at the Hippocratic Oath — both the original attributed to Hippocrates and the modern version by Louis Lasagna in 1964 — and dissects modern medicine's record on upholding the principles enshrined in the Oath. The use the pledges of the modern Hippocrcatic Oath "as a focus for each chapter, [covering] the way doctors are harming not helping people by betraying the Oath."

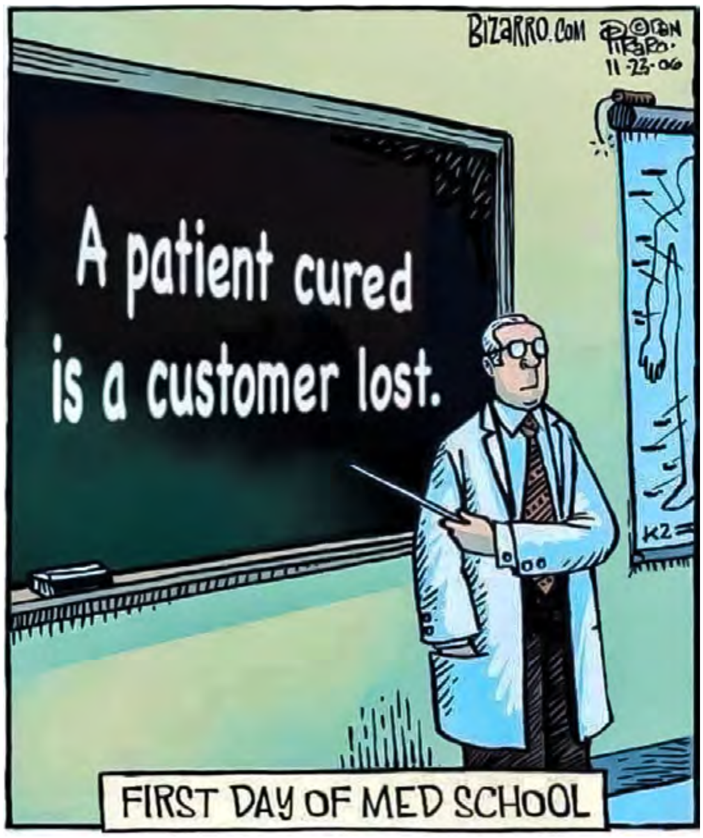
Chapters in *Hippocrasy* include:

- First, do no harm
- Science matters
- Overtreatment
- Warmth and Sympathy
- I Know not
- Birth and death
- Treating the problem
- Prevention
- Medicalising normal
- Healing

In their introduction that say that their "own experience as doctors and researchers has shown that much of modern medicine doesn't do what it is supposed to do: improve health. Modern medical care is designed to maximise the number of encounters with the system, constantly prescribing, operating, testing and scanning, and prioritising business over science."

They go on to say that "Medical care has not universally or consistently improved health or quality of life…. Astoundingly, it has been estimated that *about one-third of medical care is of no value while another 10 per cent is actually harmful.*" [their italics]

Buchbinder and Harris point out that most of the advances in health and life expectancy over the



"past couple of hundred years weren't due to modern medicine, but to public health, political and industrial achievement, such as clean water supply, sewerage separation, having enough food and avoiding war."

The authors explore particular themes that often recur in each chapter:

- medicalisation of normal human conditions, such as aging, menopause, sadness and grief, slightly elevated blood pressure — and who wouldn't have elevated blood pressure dealing with our health system;
- overdiagnosis, where treatment does more harm than good, where 'abnormalities' are detected that would not have caused any symptoms ro clinical problems in a person's lifetime;
- overtreatment where healthcare (consultations, tests, drugs, procedures, etc.) that provides no benefit (except maybe to the bank balance of the provider);
- medicine as big business in which healthcare as a commodity incentivises processes over outcomes, the complex over the simple, and treatment over prevention.

If I have a criticism of this book, it is that, as a rheumatologist and orthopaedic surgeon, many of the examples that the authors focus on are concerned with musculo-skeletal medicine; I would have liked to see a broader exposé across a wider range of medical and health disciplines. They do tend to return to the same examples, such as the vertebroplasty, a procedure in which acrylic cement is injected into fractures in the spine, and which is lucrative for device manufacturers and doctors who perform it. The procedure was introduced in the 1980s, but the first two randomised blinded controlled trials of the procedure weren't published until 2009, twenty years after it had been introduced into practice. The results showed that the patients in the treatment arm and the placebo arm improved by about the same amount.

However, the narrow disciplinary scope is is a minor criticism.

As Aotearoa New Zealand faces the biggest shake-up of our health system in two decades, possibly much longer; as we face a paradigm shift in the way that our health and disability services are managed, this book should be required reading for those tasked with transitioning to the new Health New Zealand and those responsible for getting the biggest bang for our health buck.

You would have to have been living under a rock to not be aware that our health agencies are under-funded and under resourced; that our GPs are burnt out and the workforce declining; that our nurses are underpaid and increasingly likely to be attracted to better paid jobs across the Tasman; that our midwifery workforce is chronically underpaid and understaffed; that allied health workers are underpaid, some are working for less than the living wage and less than a KFC employee; and that Pharmac never has enough in the budget to provide the drugs that are needed by all New Zealanders, and so is forced to choose who gets life-altering and life-saving medications and who does not.

If we stopped spending money on the medicalisation of the normal human condition; if we eliminated overdiagnosis and over treatment; if we spent money on simple effective treatments and prevention, imagine how much money would be left to pay the workforce what it is worth and ensure that money goes where it is need most, where it can truly make a difference. Imagine if we had a health system that was the fence at the top of the cliff, not the ambulance at the bottom, and if we ceased allowing medicine and healthcare to be "big business" and we stopped treating health and wellness as a commodity.

Imagine if we took back the control of our health system from Big Pharma and the device manufacturers and all the people in this massive industry that are making huge profits, and put that control in the hands of people truly prepared to uphold the Hippocratic Oath.