



# NEW ZEALAND COLLEGE OF MIDWIVES (INC)

## JOURNAL

### **New Zealand Research**

Maternal request for  
an elective caesarean section

Dianne Arthur and Debbie Payne

Building a picture of labour:  
how midwives use vaginal  
examination during labour

Lesley Dixon

### **Research**

From autonomy and back  
again: educating midwives  
across a century

Sally Pairman

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“I’m ready for you, baby,  
why won’t you come?”  
Further discussion around  
the issue of post dates  
pregnancy and the  
intervention of induction  
of labour

Rhonda Davies

### **Review Essay**

Misconceptions: truth, lies,  
and the unexpected on the  
journey to motherhood

Rhonda Shaw



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- Elaine Gray
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## From autonomy and back again: educating midwives across a century Part 1

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### Abstract

Midwifery education reflects the role and scope of practice expected of a midwife. In the century since midwives were first registered in New Zealand midwifery education has variously prepared midwives for relative autonomy, dependent practice and now, in 2005, for full professional autonomy.

This article traces the evolution of midwifery education in New Zealand across a century and is presented in two parts. The second part will be included in the April 2006 journal.

This article provided the basis for the keynote address given by the author at NZCOM Biennial conference, Wellington, 16 – 18 September 2004.

### Introduction

The way that midwives in New Zealand have been educated has reflected the role and scope of practice that society expects of midwives. Over the century from 1904 to 2004 midwifery practice has shifted from a position of relative autonomy to dependent practice under medical supervision to full professional autonomy. There are many reasons for this change in scope of practice; in particular the changing place of women in society, changes in societal expectations of childbirth, midwifery's relationship with nursing and medicine, and midwifery's professional development. Across the century midwifery education has evolved in response to the changing status and scope of practice of midwifery. This paper offers snapshots of some of these changes and traces the evolution of midwifery education over the century. In so doing it seeks to highlight the importance of education as a professionalising strategy for midwifery.

### Back to the beginning

The formal 'beginning' of New Zealand midwifery education came with the 1904 Midwives Act, the centenary of which was celebrated by midwives throughout New Zealand in 2004. The 1904 Midwives Act itself was a short document of only four pages. It was passed to "provide for the Better Training of Midwives, and to regulate the Practice of Midwifery" (Midwives Act, 1904, p.1). The Act

established midwifery registration, and provided for the establishment of state maternity hospitals, later named St Helens hospitals, in which students were to be trained and prepared for registration as midwives.

Until the Midwives Act was passed there were only a few midwives with formal training they had gained overseas before immigrating to New Zealand. Most were lay midwives who learned their midwifery skills from other midwives or local doctors (Donley, 1986; Rattray, 1961). Women managed childbirth amongst the European population, relying on knowledge gained through experience and observation and passed from woman to woman (Coney, 1993). Most women birthed at home or in local unlicensed single-bed maternity or 'lying-in' homes, owned and operated by midwives (Mein-Smith, 1986). Joan Donley, in her book, 'Save the Midwife', describes those early mid-

wives or handywomen as part of their community, arriving several days before the birth was expected to look after the household while the pregnant woman rested. The midwife cared for the woman through the labour, delivered the baby, helped the mother to establish breastfeeding and stayed on to help for a few days after the birth so the mother could rest (Donley, 1986). Joan Rattray (1967, p.27), in her book titled 'Great Days in New Zealand Nursing' describes Mrs Frampton, a midwife practising in 1897, as

*A typical pioneer midwife, a woman of robust constitution, who walked many miles to attend patients. Like many of her profession, she had a strong sense of humour. When she died at the age of eighty-three she still had an almost perfect set of teeth.*

Most of these early midwives were undoubtedly very skilled but some probably were not. Certainly there were concerns about midwifery practices and untrained lay midwives were blamed for the high levels of maternal and infant mortality during the 1920s to 1930s (Parkes, 1991).

### The 1904 Midwives Act

In 1904, however, the government was concerned at the falling birth rate amongst the 'white' population (Donley, 1986). It was feared that Maori and other non-white races would outnumber the

British settlers and gain advantage in the struggle for resources and power in the new colony (Coney, 1993; Donley, 1986; Mein-Smith, 1986). A Royal Commission, established in 1904, blamed the declining birth rate of European settlers in New Zealand and Australia on the 'selfishness' of women who were thought to be deliberately limiting family size (Coney, 1993; Donley, 1986). The reality of women's lives was not recognised in government policy. Women were idealised as mothers but this image applied only to respectable married women, while unmarried mothers received harsh treatment and were expected to go out to work

as well as bring up their children. Many women and families suffered from economic hardship (Coney, 1993). Despite the sentiment about 'noble' mothers there was little government assistance other than free maternity care that came as part of the Social Security Act in 1938. Legal access to contraception was difficult until the first family

planning clinic opened in 1953 (Coney, 1993). The Domestic Purposes Benefit was not available to single mothers until 1973. For much of the 20th century women's primary role in New Zealand was as a wife and mother. Many of the improvements made to maternity services were to encourage women to do their patriotic duty and have more babies.

Indeed, Grace Neill, Assistant Inspector of Hospitals, utilised these arguments to persuade Premier Richard Seddon of the need to address standards of midwifery practice when she sought to establish the 1904 Midwives Act. According to her son John, Grace Neill had strong socialist beliefs and concern for the plight of women. She was particularly concerned about women birthing in unsuitable surroundings and with little support who could only afford unskilled help for the birth (Neill, 1961). She believed that midwifery training would improve maternity care for women and babies, and that working class women should have access to safer environments for birth (Donley, 1986; Neill, 1961; Parkes, 1991). Grace Neill argued that the way to improve maternity services for women was to require State registration of midwives so that lay-midwives could be phased out and replaced with a new class of competent trained midwife (Neill, 1961; Parkes, 1991).

*This paper offers snapshots of some of these changes and traces the evolution of midwifery education over the century. In so doing it seeks to highlight the importance of education as a professionalising strategy for midwifery.*

This midwifery training took place in the seven St Helens hospitals. These were established between 1905 and 1920 in existing buildings rapidly converted for the purpose. The hospitals provided midwifery services for married women whose husbands earned low wages (Parkes, 1991; Wassner, 1999). However, all women paid a small fee because Grace Neill strongly objected to any implication of 'charity' (Neill, 1961). Grace Neill's successor, Hester MacLean (1932, p. 57) recalled that the hospitals were treated,

*More as maternity homes than as actual hospitals, and to have equipment that would not be so elaborate that nurses working outside afterwards would miss it and would be unable to adapt themselves to poor homes with little to work upon.*

However, the changes to equipment and techniques that were made from 1925 to reduce the risk of puerperal infection created a more hospital-like environment (MacLean, 1932).

## Hospitalisation

Although the midwife-run St Helens hospitals were the beginning of the state maternity system, most women continued to birth at home until after the First World War. By 1926 58% of births took place in hospitals and this had risen to 76% by 1934 (Mein Smith, 1986). The move to hospitalised birthing took place more rapidly in New Zealand than in other western countries such as America and Britain. According to Phillipa Mein Smith (1986) the move to hospital birthing was largely the result of societal concerns for maternal and child welfare and the growing power and expertise of the medical profession. Healthy children were essential to New Zealand and to the British Empire and therefore maternal welfare became an essential strategy as "*on her health ... depended the health of her child, and the stability of the Empire*" (Mein Smith, 1986, p.4). High maternal mortality rates in the 1920s were linked to puerperal sepsis, septic abortion and toxæmia and the resulting campaign for "*safe maternity*" led to rapid medicalisation of childbirth (Mein Smith, 1986).

The campaign for 'safe maternity' was launched in 1924 under the slogan "*Perfect motherhood is perfect patriotism*" (Mein-Smith, 1986, p.23). The campaign emphasised antenatal care, asepsis, hospital policy and training of midwifery and medical students. The main thrust of the campaign was on efforts to eliminate puerperal sepsis, as a major cause of maternal death.

Health Department doctors believed that the cause of puerperal sepsis was exogenous, and that staff could pass on a hospital or home acquired

infection from woman to woman. Obvious methods of transmission were during vaginal examinations or instrumental deliveries or when women in hospitals used the same baths (Mein Smith, 1986). Standardised aseptic techniques for labour and care during the puerperium were introduced through the H. Mt. 20 Regulations. These regulations involved protocols to reduce infection through aseptic techniques such as pubic shaving, enemas, swabbing of the perineum with antiseptics and the use of sterile drapes, surgical scrubbing and the wearing of gowns and masks by all birth attendants (Wassner, 1999). Labour was fragmented and the woman was moved from the admission room to the first stage room and to theatre for delivery. All equipment was sterilised, including packs of sheets and birthing equipment for midwives to use at homebirths (Mein Smith, 1986). In the postnatal period women were kept in bed for up to ten days post-partum and were subjected to four hourly perineal swabbing with antiseptics for the first few days. Babies were kept separately in nurseries, only being brought to their mothers for the strict four-hourly feeding regime (Wassner, 1999). These regulations dominated midwifery practice for the next thirty or so years, with aspects continuing in some parts of New Zealand through to the early 1980s. While aiming to prevent the spread of infection these regulations also had the effect of routinising childbirth and providing a context for birth that must have disturbed normal physiology and almost certainly affected midwifery's ability to promote normal birth.

Largely as a result of the H. Mt.20 Regulations, the maternal mortality rate significantly reduced by 1935. Mein-Smith (1986) notes the irony that it was the high standards of midwifery care that assisted in the transition to hospitalised childbirth. She states,

*Before the end of the 1920s some hospitals exposed women to greater risks from sepsis than did domiciliary midwifery, but a number, particularly the Department's own St Helen's hospitals set the standards of asepsis which were instrumental in producing a steady decline in puerperal fever after 1927. Hospitalisation became perhaps the only way to effect a rapid change in the high maternal mortality rate (Mein-Smith, 1986, p.64).*

## The seduction of pain relief

The trend to hospitalisation was unstoppable after 1935 as doctors promoted hospital birth with a doctor present as the safest and easiest maternity care. Doctors used the promise of 'pain free childbirth' to lure women to hospitals under their care. Anaesthesia and analgesia in the form of 'twilight

sleep' was only available from doctors, mainly in private medically run maternity homes although some may have used it in homebirths. A mixture of morphine and scopolamine, 'twilight sleep' produced analgesia and sedation as well as amnesia. It was later found not to relieve pain in all cases, but as women could not remember the pain it was promoted as the solution to 'pain free birth'. The Health Department strongly opposed the use of twilight sleep. In high doses it caused almost total anaesthesia and could cause death or respiratory problems for the baby. The Department called it the 'Half-Dead Baby System' and linked it to an increase in the use of forcep deliveries when labour slowed as a result of the sedation (Mein Smith, 1986, p.83; Coney, 1993). The Health Department did not oppose all forms of analgesia and from 1926 midwives were authorised to administer chloroform in small doses during labour. However, the fact that only doctors could offer twilight sleep and other forms of analgesia gave them an advantage over midwives and more women began to seek care from doctors.

Doris Gordon, one of the pioneers of 'twilight sleep', and founder of the Obstetrical Society, encouraged women's groups to lobby government for access to twilight sleep in the St Helens hospitals (Donley, 1986). Women's groups within the Labour Party took up the right to pain relief as an equity issue. They argued that wealthy women in private care could afford modern anaesthetics and this should be equally available to women in public maternity hospitals including St Helens. As only doctors could provide this pain relief, they should be present at every birth.

The conflict over pain relief between the Health Department and the Obstetrical Society characterised the clash in ideology evident in the years between 1920 and 1939. The view of doctors within the department was that,

*Midwifery is branch of preventive medicine because pregnancy, labour and the puerperium are physiological and not pathological states, and the woman at these times is not a sick woman. The whole end and object of midwifery is to maintain the physiological character of these states so as to prevent illness and injury to the woman and secure the birth of a healthy and uninjured child (Tracy Inglis cited in Mein Smith, 1986, p.82).*

On this basis the Health Department promoted a midwifery-led maternity system as the most appropriate for New Zealand. Midwives would care for most women and doctors would only be involved when complications arose. The Obstetrical Society on the other hand declared that,

*continued over...*

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*Labour by the process of civilisation had become 'abnormal and pathological' and was now a 'surgical operation' ... Prominent obstetricians overseas are emphatically teaching that pregnancy from start to finish is a process fraught with danger...* (Mein Smith, 1986, p.82).

The Obstetrical Society led an organised campaign by doctors to argue for a maternity system in which all women would be attended at birth by a doctor, assisted by a midwife or maternity nurse (Mein Smith, 1986). It was the focus on pain relief in normal labour that eventually saw doctors winning their campaign for the control of childbirth and led to the dominance of the medical model approach to birth on the provision of maternity services in New Zealand that continues today. The introduction of pain relief in normal birth established a role for doctors within public maternity hospitals. This was cemented with the 1938 Social Security Act that provided for free medical care for all women in childbirth. As a consequence of these changes the role of the midwife reduced to one of assistant to the doctor.

### The role of the midwife

Within this context the role of the midwife changed rapidly. Under the 1904 legislation midwives had some autonomy in relation to normal childbirth. Without actually stating what midwives were able to do the Act made it clear that the midwifery scope of practice had limitations. Midwives were not authorised to *"grant any medical certificate or any certificate of death or still-birth, or to undertake the charge of cases of abnormality or disease in connection with parturition"* (Midwives Act, 1904, p.3). By the 1925 Nurses and Midwives Act this clause had disappeared, perhaps because by then medical involvement in all births, including those with complications, had become the norm (Mein-Smith, 1986). Instead the scope of practice of a midwife now read, *"to attend a woman in childbirth in any case where a registered medical practitioner has not undertaken responsibility for the care of the patient"* (Nurses and Midwives Registration Act, 1925, p.21).

Although midwives could practice autonomously in 'normal' childbirth, both Acts still gave significant powers of supervision and surveillance to doctors (Papps & Olssen, 1997). The 1904 Midwives Act established the Registrar (a doctor) with responsibility for registration of midwives and in 1925 this role was taken over by the Nurses and Midwives Board (consisting of two doctors, two nurses and only one midwife). District Health Officers (also doctors) were given powers to supervise midwives, to suspend midwives to prevent the spread of infection and to investigate charges of professional misconduct against mid-

wives (Midwives Act, 1904; Nurses and Midwives registration Act, 1925; Papps & Olssen, 1997). The 1925 Nurses and Midwives Registration Act largely placed control of midwifery into the hands of nursing and from that point onwards midwifery became increasingly subsumed into nursing until in 1971 the Nurses Act removed the word 'Midwife' from the title altogether and required midwives to practise only under the supervision of doctors.

### Midwifery education

The 1904 Midwives Act provided three routes to midwifery registration. Women of good character with no formal training, but who had been practising midwifery for at least three years prior to the introduction of the Act, could apply for registration within the year following enactment of the legislation (Hill, 1982; Midwives Act, 1904; Papps & Olssen, 1997). Likewise, midwives with formal training from recognised training schools overseas could be registered (Midwives Act, 1904). Lastly, women could gain registration after successfully completing training through the state maternity hospital programmes (ibid). There was a six-month course in midwifery for nurses registered under the Nurses Registration Act 1901 and a twelve-month course direct entry course (Hill, 1982).

Interestingly, in the 1904 Act midwifery students were referred to as *"pupil nurses"* whether they were actually nurses or not (Midwives Act, 1904, p.2). On payment of the prescribed fee pupil nurses could, through a State Maternity Hospital (later named St Helens Hospitals), *"be carefully instructed in all duties required for the welfare of mother and infant during and immediately after childbirth"* (Midwives Act, 1904, p.2). This 'instruction' was to be given to pupil nurses by *"means of lectures and practical teaching in and outside of the hospitals and by a period of midwifery work"* (Midwives Act, 1904, p.2). In order to be registered, pupil nurses were required to attend lectures at a State Maternity Hospital for the required period of time, attend the prescribed number of cases of labour and through an examination in the prescribed subjects satisfy the examiners as to their proficiency.

These requirements continued under the 1925 Nurses and Midwives Registration Act although the Nurses and Midwives Registration Board prescribed a syllabus for midwifery training in 1927. The syllabus closely followed the H. Mt. 20 Regulations and included such topics as the duties of a midwife, the principles of asepsis and anti-sepsis, the management and aseptic techniques of labour and the puerperium, methods of preventing

the spread of infection, antenatal diagnosis and treatment, the management of normal pregnancy, vaginal examination, the prognosis of labour, the conduction of labour, the management of the puerperium, the elements of house sanitation, the cooking and preparation of food. There were set numbers of clinical experiences such as 30-40 vaginal examinations, 20 rectal examinations, 20 conductions of labour, 60 antenatal patients examined, and 10 puerperal patients nursed (Hill, 1982).

The Nurses and Midwives Registration Board also instituted linkages between midwifery and nursing education. By 1925 both nurses and direct entry students were required to complete a course in maternity nursing before entering midwifery training. Registered nurses completed an eight-month course while untrained (direct entry) women completed twelve months. It then took a further four months for both groups to obtain midwifery registration. This was later extended to six months and by 1930 nurses had to complete six months maternity nurse training and then six months midwifery, while untrained (direct entry) women completed an eighteen-month maternity course and six months midwifery (Hill, 1982).

Despite the linkage in training there were recognised differences between midwives and nurses in relation to their scope of practice. Midwives could take sole responsibility for maternity cases (especially those in rural and remote areas) and only involve a doctor for complications; midwives could run private maternity homes; and midwives alone were eligible to take up positions as staff nurses or matrons in maternity hospitals and would thus be responsible for training pupil midwives (Donley, 1986; Hill, 1982). Maternity nurses worked with doctors in the provision of the majority of maternity care thereby reducing the need for all nurses to hold midwifery registration.

In 1956 maternity training was integrated into the three-year general nursing curriculum, leading to a double certificate as a registered nurse and registered maternity nurse (Donley, 1986; Wassner, 1999). This new general and maternity nurse training heralded the end of the separate 18-month maternity nurse training which was gradually phased out over the next 20 years bringing the direct entry route to midwifery to an end (Donley, 1986; Wassner, 1999). Fortunately midwifery training and registration remained but the training was available in only three St Helens hospitals (Auckland, Wellington and Christchurch) while the other public and private hospitals with maternity facilities provided the training of nurses and the remaining maternity

nurse programmes. Midwifery graduate numbers were insufficient for the maternity service and midwife shortages remained, particularly in rural areas (Hill, 1982).

The result of these changes in midwifery education was the slow integration of midwifery with nursing. It became common practice for registered nurses, who had no intention of practising midwifery, to obtain midwifery registration in order to gain promotion to positions of authority such as that of matron (Hill, 1982). Indeed, according to her son, even Grace Neill had envisaged that “no nurse would be eligible for the higher ranks of the profession unless she held the certificate of registration in both nursing and midwifery. The [St Helens] hospitals would therefore be staffed mainly by women who had already completed their nursing training” (Neill, 1961, p.51).

Despite starting with separate legislation it appears that most midwives did not see themselves as members of a profession that was separate to nursing. Indeed it seems likely that it was only the imminent demise of midwifery following the 1971 Nurses Act and the active opposition of the Nurses Association to midwifery’s attempts to protect its definition, its scope of practice and its education that provided the impetus for midwives to take a stand together to try and claim their separate identity from nursing. I will return to this later.

### **St Helens hospital midwifery training**

As an environment for midwifery training, the St Helens hospitals must have been reasonably ‘midwife-friendly’, not because the midwives didn’t have to work extremely hard, but because there was a considerable degree of midwifery autonomy and control over practice, albeit that this was exercised by midwives in a hierarchical system. The medical profession had opposed both the 1904 Midwives Act and the establishment of the St Helens hospitals, because they saw midwives as competitors for patients, and also because they feared state control over their practice (Donley, 1986). Despite this opposition the St Helens hospitals flourished, and for twenty years provided midwifery training, midwifery-led care in the hospital and the community, and a female dominated maternity service, as it was Health Department preference to appoint female doctors to work in the St Helens hospitals (Donley, 1986; MacLean, 1932). Midwives staffed the hospitals, providing most of the care although the medical officers were called in for emergencies. Hester MacLean described the position of medical officer in St Helens hospitals as part-time and non-resident, saying,

*The matron and her staff carry on all normal confinements, and only send for the medical officer if necessary. They (medical officers) also deliver lectures to the nurses preparing them for the State examinations, apart from that, they have no share in the management of the hospitals, but are, of course consulted frequently and visit regularly (MacLean, 1932, p.60).*

The St Helens hospitals trained only midwives, while maternity nurses were trained in other private and Hospital-Board controlled maternity facilities. Midwifery students lived on the premises, received no pay for their work and keep, and in the beginning had to pay a fee of ten pounds (or twenty pound for the twelve-month course) towards their training (Hill, 1982; Lambie, 1956; Neill, 1932). Mary Lambie, Director of Division of Nursing from 1927 to 1949, recalled her midwifery training at St Helens hospital in Wellington in 1926 in her memoirs (Lambie, 1956). She noted that students had to provide their own uniforms, one for indoors and one for outside work, as well as their own bag and equipment. They worked ten-hour days and night duty on top of this, and Mary had only one day off in her ten-month training (Lambie, 1956). The medical officer and registered midwives provided the teaching, most without any formal teaching skills. Students attended women in the hospital and at home. If a woman was having a normal birth then a midwife and trainee took responsibility. Many homebirths took place in poor conditions, lacking means to boil water or make a clean bed. Linen was provided from the hospital and taken away afterwards for washing (Lambie, 1956). Mary Lambie found the domiciliary experience to be “*excellent and the patients were certainly given individual consideration*” (p. 55).

This early midwifery training was focused on tasks and routines and the acquisition of knowledge through lectures and through experience. Marion Shepherd trained at the Christchurch St Helens from 1922 –1923 and she wrote of her experiences,

*A trainee began literally on her knees. There was daily washing of all the linoleum or bare board floors in the corridors, labour ward and general wards. Three or four times daily a large pile of nappies were washed by hand and put through the wringer, boiled, and hung out to dry, if fine. The hopper had to be stoked with coal to heat*

*the coppers in which the nappies were boiled. If the handyman was not on duty the trainee nurses saw to the fuelling (Shepherd, 1989, p.94).*

Marion Shepherd told of 12 hour days that began at 5.30 am and an expectation that trainees would be called during the night even when they were off duty. There was only one telephone and the train-

ees took turns sleeping in the ‘telephone room’ in case there were night births. Trainees worked in the hospital and in the community visiting women in their homes by bicycle. She talked of sheer exhaustion, broken sleep, early mornings, shift work, long hours and hard physical work. Study had to be fitted in around these duty hours. Of the

district rounds she said this,

*Rising was even earlier as we had to leave by 5.30 am in order to begin our first case by six as we sometimes fitted in eight for the day. “After treatment” meant sponging the mother, making her bed, bathing the baby and rinsing all soiled linen. Two or three visits were completed before breakfast at the hospital around 8.30. We replenished our supply bags and set off again on our bikes and hopefully finished by 2pm. A hot dinner would be kept for us at the hospital. After tea we cleaned and sterilised our bags, wrote charts and reports and made gruel for the patient’s 7pm supper (Shepherd, 1989, p.96).*

### **Competition with medical training**

While the St Helens Hospitals were established as a training ground for midwives, conflict with the training needs of medical students soon came to a head (MacLean, 1932; Neill, 1961). Dunedin provided the first centre for medical training in New Zealand and when the Dunedin St Helens opened in 1905 the Otago Medical School demanded access for medical students. Grace Neill and Richard Seddon opposed this access, arguing that the St Helens hospitals were not charitable institutions, but institutions provided by the State to which women paid fees to attend. Therefore women using these services had the same rights as women who paid for private maternity care from a doctor and midwife. This included the right not to be cared for by medical students (Donley, 1986; MacLean, 1932; Neill, 1961).

A solution was found when Dunedin Hospital authorities and the Medical School were permit-

*continued over...*

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ted to buy the Refuge in Forth Street and convert it into the Forth Street Maternity Hospital (later renamed 'Batchelor Maternity Hospital') (Wassner, 1999). The refuge for unmarried mothers had closed in 1904 and was converted into a maternity hospital for the teaching of medical students and nurses by 1907. Labourer's wives and unmarried women were to be admitted (Wassner, 1999). Women were expected to agree to allow attendance by students as, "objections to this are purely sentimental" (Otago Daily Times report 20/5/07, cited in Wassner, 1999, p.25). Eventually medical students also gained access to other hospitals throughout New Zealand including the Salvation Army hospitals such as 'Redroofs', in Dunedin. In 1929 medical students gained access to the St Helens hospitals, but competition between midwifery and medicine in the areas of education and practice has remained through the century.

### Competition with nursing

So too has competition between nursing and midwifery. As far as doctors were concerned maternity nurses provided the ideal assistant for childbirth and their preference for maternity nurses over midwives was one factor in nursing's promotion of maternity nurse training. In 1937 midwives, with the support of the Health Department, managed to retain midwifery training programmes against strong medical and nursing arguments for a single maternity-nursing workforce to support doctors (Lambie, 1956). By 1957 when maternity nursing was incorporated into general nurse training and the direct-entry route to midwifery came to an end, doctors objected even to the maternity nurse training because it impacted on the 'clinical experience' available for medical students (Donley, 1986). The number of midwives training was reduced to make way for sufficient numbers of maternity nurses, but even so there were shortages in both groups. By the passing of the 1971 Nurses Act midwifery was virtually indistinguishable from nursing and there was little to set it apart as a separate profession.

### Women fight back

As described the management of childbirth in hospital under the H.Mt. 20 regulations was a rigid and highly medicalised surgical procedure (Parkes, 1991). Women were not happy with this care and in 1937 the National Council of Women complained to the Committee of Inquiry into

Maternity Services about the treatment of women. They cited frequent rectal examinations performed without consent or explanation, the sterile hospital environment, the lack of support for women, the lack of privacy, the separation of women from their babies and the streamlined procedure of four hourly pans and swabs for the ten days after birth (Parkes, 1991). None the less this approach to childbirth became the norm, particularly after the Nurses and Midwives Board incorporated it into the midwifery curriculum in 1927. It was not until the 1960s that protests from women resulted in some softening of this approach.

During the 1960s both the midwifery and general and maternity nurse curricula underwent modifications to reflect new knowledge within obstetrics, psychology, physiology and pathology and society's changing views on childbirth. There was a greater emphasis on antenatal care and antenatal education, which included physiotherapy classes in preparation for labour (Hill, 1982; Wassner, 1999). Women, through newly established consumer groups such as the Federation of New Zealand Parent Centres, had begun to question the attitudes and regimented procedures they encountered. They demanded more involvement in their own care and a more family-friendly and humanised approach to childbirth services (ibid). Heidi Wassner (1999, p.93) summarised the key areas of change between 1960 and 1972 as,

*A softening of the harshly clinical environment in the labour wards, less bed rest, early mobility, showering, rooming-in, demand feeding, participation of husbands during pregnancy and labour, and child visiting.*

By this time New Zealand was leading the world with its low maternal death rate and the advent of antibiotics further reduced the fear of cross-infection and the need for rigid aseptic procedures (Hill, 1982; Wassner, 1999). However, despite the more relaxed and 'home-like' approach of the maternity hospitals, advances in obstetric knowledge led to greater intervention in birth in other ways. For example, new forms of analgesia such as diamorphine and pethidine were administered in four-hourly routines; caudal blocks and epidural injections were used for forcep and caesarian section deliveries; the availability of the synthetic oxytocic, Syntocinon, meant that labour could be augmented and shortened (Wassner, 1982). The

context was one of contradiction and conflicting perspectives.

On the one hand maternity-nursing training (and possibly midwifery training) focused on birth as a normal life event. On the other hand it was still treated as a regimented procedure where each woman experienced the same strict routine care that took no account of her individual needs or wishes. Heidi Wassner's account of the midwifery and medical care given to women through the 1960s and 1970s provides some insight into these conflicting attitudes. For example, she said of episiotomies,

*(They) were performed more and more often. From a midwife's point of view, they were not always essential, and they were often detrimental to a woman's comfort and recovery* (Wassner, 1999, p.95).

As the context for pregnancy and birth became more medicalised there was increased reliance on technology to the detriment of clinical assessment skills.

*The trends which emerged during the 1960s to 1970s were: more teamwork, more frequent observations of pregnant women, women in labour and babies, and more interventions. During labour the fetal bear rate and maternal pulse were recorded half-hourly, and maternal blood pressure and urine were checked two-hourly. The mother's temperature was recorded four-hourly. Many women were monitored with a 'cardiotocograph', which measures uterine contractions, and makes the fetal heart beat audible. The eyes replaced the hands, to the extent that some midwives wondered how medical students conditioned to such high technology, would manage outside an obstetrical environment like the one at Queen Mary Hospital.* (Wassner, 1999, p.101).

By the early 1980s maternity consumers were expressing concern about the increasing technology and intervention characterising the maternity services, and the lack of control for women and their families over their birth experiences. Consumer groups such as Parents Centre New Zealand and the Home Birth Association identified the threat to midwifery of inadequate education and lack of professional autonomy. Without well-educated and autonomous midwives, women feared they would have no chance of reclaiming birth as a natural process over which they had some control and could make their own decisions. Maternity consumer groups actively campaigned for changes to midwifery education that would produce a midwife capable of working within the full scope of midwifery practice and supporting women to have the birth experiences they sought (Dobbie, 1990; Kedgley, 1996; Strid, 1987).

*To be continued in April 2006*

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## Erratum

The journal regrets a printing error in Sandra Elias' article in the April 2005 journal entitled "VITAMIN A – WHEN TOO MUCH OF A GOOD THING ISN'T". In parts of the text, the sign for "less than" which is recognised as the symbol "<" was replaced by other symbols. The journal staff regret any confusion that this may have caused.

# "I'm ready for you, baby, why won't you come?" Further discussion around the issue of post dates pregnancy and the intervention of induction of labour

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## Abstract

Prolonged pregnancy (PP) continues to avoid consensus of approach amongst midwives, obstetricians and researchers. Establishing solid evidence-based practice is probably ethically beyond our reach. Midwives exist to keep birth normal; to maintain normalcy of other aspects, within any intervention process. The issue of PP is complex and the intervention not without risk. The woman's feeling about waiting, and about choosing to end the wait, are known to be significant in the success of the management. Critical to her feelings is her understanding. In this second article on prolonged pregnancy the author discusses the associated terminology, the current understanding of the spontaneous, natural end to a pregnancy and reports on sequelae of the choice of induction to end the pregnancy when the only, and dubious, deviation is that the woman is 'post dates'.

## Introduction

How to best 'keep birth normal' when the pregnancy is post dates is an issue for midwives and women. The first article addressed the lack of precision that characterises methods of dating a pregnancy (Davies, 2003). This article continues the aim of enabling midwives to support women in their choices around prolonged pregnancy. It:

- discusses the terms used in the context of post dates pregnancy
- explores the impact of labelling pregnancies as 'too long', or 'overdue'
- considers the sequelae of choosing induction of labour to resolve the post dates situation.

## Predicting the onset of labour

The onset of labour can occur any day 14 days prior to, and 14 days after, the estimated due date (EDD), AND that due date, if calculated by early

scan, may actually be 5 days on either side of the date declared. Hence predictions of pregnancy end dates are a range rather than a specific date. Some women find it hard to tolerate waiting past their "due date" and may expect induction of labour in order to end the sense of being in a "time-limbo". Or they have genuine concerns that something may go awry if they are "left" beyond a certain time.

In order for midwives to work with women and medical practitioners to plan pregnancy and labour care "post-dates", their approach should include helping women to understand the meaning of "post-dates" and the implications of any actions such as induction of labour. Whilst induction of labour may appear a simple solution to a pregnancy that appears overdue, appreciation of the complexity of the situation is needed to inform decisions that are made by the woman, her family, midwife and obstetrician.

*Date calculations as indicators  
of maturity represent a range  
rather than an absolute date*

In the first instance, women may need some appreciation of the factors which contribute to the ending of pregnancy and initiation of labour. For example, what sets labour in motion? What is currently understood about the biochemical and physiological triggers which initiate labour? There has been debate about the source of the initial trigger including theories about activity in the fetal hypothalamus and an increased need for nutrients, a hunger stress, acting as signals to the placenta (e.g. McMillen et al., 1995; Smith, 1999). Whatever the original trigger is there have been excellent explanations of the effects in terms of initiating labour with changes such as the activity of the involuntary muscles of the uterus (e.g. Penny, 1999 and texts such as Blackburn 2003; Sweet, 2000). These have not been re-presented in this article and the reader is encouraged to read such materials. What we do know could be paraphrased for most women by saying: when the fetus is mature or, as some people think, when the baby's need for energy exceeds the provisions of the uterine environment, a complex chain of hormonal reactions is set in motion. These reactions actually take place over an average of 2-3 weeks. This period of latent labour, popularly known as

*continued over...*

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'false labour' is an absolutely essential part of the process. A case can be made for antenatal educators to pay attention to discussion of this phase equal to that which is paid to first, second and third phases in antenatal classes.

This activity results in increased levels of natural prostaglandins, which are necessary to ripen the cervix slowly, especially when the uterus is labouring for the first time. This ensures that the baby is mature enough to survive extra-uterine life and supplies natural oxytocin which, together with the stretching effect of the baby's head on the cervix (or firm forewaters bag), eventually provokes the contractions which are active labour. The concern, then, for women, midwives and obstetricians is knowing WHEN the baby is mature. As I noted in the first section of this article, date calculations as indicators of maturity represent a range rather than an absolute date. Hence the importance of midwives helping women to appreciate that induction of labour on the basis of date calculations, and universal guidelines, and local protocols (Wood, 2004) might still result in trying to induce labour before the fetus and pregnancy have reached maturity. This issue is best illustrated by considering the range of terms and definitions currently in use.

### An unhelpful plethora of terms and definitions

Midwives need clarity about what they, their colleagues, the obstetricians, the research reports, maternity texts, and the woman, **mean** by the multitude of terms used during the discussion. I find there is continuing confusion surrounding the approach to the management of post dates pregnancy. This confusion is associated with the use of more than one term when referring to the state of going **past** the due date. Practitioners and researchers have a tendency to interchange both terms and definitions. This blurs the understanding of the research and blunts the sharpness of the ramifications that the "good" research should have.

The definitions supported by the International Federation of Obstetricians and Gynaecologists (FIGO) and the World Health Organisation (WHO) imply that a *term* pregnancy is from 38 weeks through to 42 weeks, i.e. 266 days until 294 days. They define *post-term* as a pregnancy lasting 42 weeks or more. A *post dates* pregnancy is one lasting 40 weeks (i.e. at *dates*) plus one or more days, and *prolonged pregnancy* is any pregnancy which exceeds 294 days from the first day of the last menstrual period, i.e. *after* 42 completed weeks (FIGO, 1980; WHO, 1977, cited

in Cooke, 1997). In this definition prolonged pregnancy *is the same as* post-term pregnancy.

In addition, unfortunately, the term *post mature* is used loosely and interchangeably with the above terms. I believe this adds to the confusion, causes concern, and can be misleading for both woman and caregiver. 'Post mature' denotes a pathological condition relating to the pregnancy and the fetus, but not necessarily associated with gestation. Gibb (1984, p.111)<sup>1</sup> lists the features as:

- *Absence of vernix caseosa - cheesy, creamy, white substance which coats the skin of fetuses, usually still evident on the skin of newborns, especially in body crevices*
- *Absence of lanugo hair - thin layer of hair seen on the body of new born infants*
- *Abundant scalp hair*
- *Long fingernails*
- *Dry, cracked, desquamated skin*
- *Body length increased in relation to body weight*
- *Alert and apprehensive facies*
- *Meconium staining of skin and membranes.*

Chua and Arulkumaran (1999) give a similar list of features of post maturity. They also state that this is a syndrome, only diagnosable after birth and not exclusively characteristic of 'prolonged pregnancy'. These authors, contributing to a chapter of a modern (relative to Gibb's text) obstetric textbook, acknowledge that all of terms that I have defined above have been used to mean a pregnancy lasting longer than the 294 days, and state that all of the terms denote a risk situation for the fetus. However, instead of devising a different, separate, neutral term for the time when an 'overdue' woman moves into the period of being 'overdue and at risk', they settle on the term "*prolonged pregnancy*" to refer to the chronological entity so as to distinguish that from the pathological inferences of the other terms!

More than once on my journey through the literature I encountered some careful writers who took time out in their report to comment on the confounding aspect of the definitions associated with the phenomenon of being 'overdue' (Alfievic & Walkinshaw, 1994; Chua & Arunkelman, 1999; Enkin, 2000; Wood, 2004). There are a number of terms, which do actually have specific meanings, or did originally, but even well established researchers tend to use them interchangeably. It

is understandable that confusion, ambiguity and imprecision rule. This, I believe, undermines any definitive *accounting/assessment* of the situation within first and second world countries, let alone worldwide. It follows logically that there can therefore be no accurate compounding of the quantitative data. Despite FIGO's consensus definition of 'prolonged', it is evident from the Canadian Multicentre Study (Hannah et al., 1992), that these researchers considered 40 weeks and 10 days as the demarcation between term (lower risk) and post term [aka

prolonged] pregnancy (higher risk). In 1994 the Australian Council of Healthcare Standards together with the Royal Australian College of Obstetricians and Gynaecologists (re)defined prolonged pregnancy as greater than 40 weeks and 10 days, i.e. 41 weeks and 3 days from LMP (Robson, Pridmore & Dodd, 1997). However there are other scholarly reports and publications that blur the definitions and refer to due date plus ten days as post-term when, officially, 'term' is not 'over' until 294 days, 14 days after the 'due day' (e.g. Augensen, Bergsjø, Eikeland, Askvik, & Carlsen, 1997; Divon, Haglund, Nisell, Otterbad & Westgren, 1998; Dyson, Miller & Armstrong, 1987; The National Institute of Child Health and Human Development Network of Maternal-Fetal Medicine Units, 1995). This is how Enkin et al. (2000) summarise this situation:

*Contradictory findings and conclusions about the risks associated with post-term pregnancy have led to opposing views on the most effective form of care....*

*...Semantic problems also contribute to the confusion. The words 'post-term', 'prolonged', 'postdates' and 'post mature' are all used as synonyms, but are laden with different evaluative overtones (p.234).*

As noted above, prolonged pregnancy is defined by the WHO as greater than 42 weeks pregnant or is synonymous with the label **post term** (FIGO, 1980; Versi et al., 1995; WHO, 1977, cited in Cooke, 1997). This may appear to be hair-splitting. Does a five day difference matter? Five days is in fact quite a lengthy period during which potentially many useful physical changes, necessary for labour to begin, could be underway. This applies particularly to first time mothers.

**The term post mature is used loosely and interchangeably with the above terms. I believe this adds to the confusion, causes concern, and can be misleading for both woman and caregiver.**

The terms are used interchangeably in scholarly texts and by healthcare researchers, so it is no wonder that health professionals feel able to use them loosely and erroneously. Inevitably there is day-to-day ambiguity which is potentially confusing to the woman. One practitioner's use of the word "overdue" could indicate a chronological state; another practitioner referring to the same woman may interpret that she is already at higher risk. Do we continue in practice to confuse by being ambiguous, or use pedantry e.g. "you are overdue but not yet overdue *and* at risk", or do we invent another term? What is important is that we make our meanings clear to the women that we work with and that we help them to appreciate that there are different interpretations for terms such as 'post dates' and 'overdue'.

Perhaps the preceding discussion has done little to reduce the confusion, but my aim has been to underscore the power that a label has. It can lead to decisions about whether to induce labour. We are all advantaged if we clarify our understandings and adopt precise definitions of terms relating to post dates pregnancy.

### Sequelae of induction of labour

The need for women to have a basic understanding of the process that initiates the spontaneous onset of labour and some sense of the meaning of a label of "post dates pregnancy" is critical to any decisions regarding induction of labour (IOL) and whether or not to request IOL. Regardless of the increased confidence in accurately assessing the maturity of the fetus (Davies, 2002, p.8), there remain risks associated with IOL for prolonged pregnancy. These are clearly reflected by the care taken to monitor closely, both mother and baby, should an induction be in progress. Hazards of induction include:

- unexpected prematurity
- neonatal hyperbilirubinemia
- ruptured uterus
- fetal compromise (inadequate placental blood flow) and death
- increased operative delivery and episiotomy
- caesarean section
- haemorrhage
- infection
- increased use of pain medication (cascade of intervention)

(Alfievic & Walkinshaw, 1994; Boyd & Sims, 1988, cited in Almstrom, Granstrom & Ekman, 1995; Bramadat, 1990, cited in Bramadat, 1994; Cole, Howie & MacNaughton, 1975, cited in Bramadat, 1994; Wood, 2004; Yudkin, Frumar, Anderson & Turnbull, 1979, cited in Bramadat, 1994) However, Enkin et al. (2000), in their latest

summary of the better quality studies, found active induction of labour had no effect on the use of opiate or epidural analgesia.

Precipitate labour can happen when the readiness of the uterus to labour is *underestimated* with over conservative assessment of the ripeness of the woman's cervix on digital examination or misjudgement of the strength of the currently occurring contractions.<sup>2</sup> The amount of prostaglandins administered is then excessive or, in retrospect, the woman is found to be more sensitive to artificially delivered prostaglandins than was anticipated. Sometimes this coincides with the often routine rupturing of the membranes. The cumulative effect of these interventions is a tumultuous labour resulting in a shocked baby and mother. The precipitate onset of this type of labour, or the intensity of these contractions, coupled with a natural anxiety magnified by the situation, often leads to increased demand for epidural pain relief, and increased diagnosis of possible fetal distress (Wood, 2004).

Does this increased epidural rate lead to more apparent fetal distress and thereby increased rate of caesarean section? Some research disagrees (Cucco, Osborne & Cibils, 1989; Dyson et al, 1987; Enkin et al., 2000; Hannah, Hannah, Hellmann, Hewson, Milner & Willan, 1992; Robson, Pridmore & Dodd, 1997; Suresh & Stanley, 2002) and some agrees (Parry et al., 1998; Saunders & Paterson, 1991; Soliman & Burrows, 1993; Yeast, Jones & Poskin 1999). Others have found no effect either way (Crowley, 2001; Enkin et al., 2000; Sue-A-Quan, Hannah, Cohen & Liston, 1999).

Lacking full sensation, women with epidural anaesthesia cannot always push effectively and this can lead to increased need for instrumental delivery. This almost always requires an episiotomy to be cut (Fraser et al., 2003). It is not easy to demonstrate clearly a relationship between epidural, synthetic oxytocin (SO) (or prostaglandin) initiated contractions and the development of fetal distress, because of the factor of possible post maturity which classically declares itself by poor fetal response to contractions induced or spontaneous. To examine such a relationship it would be necessary to study considerable numbers of clearly defined groups. The ethical implications may completely preclude such a project today. There

remain concerns about hyperbilirubinaemia; an association that was first cited in Cole, Howie, and MacNaughton cited in Bramadat, 1994 and an effect on breast-feeding (Rajan, 1994).

The range of sequelae also need to include 'failed induction'. This means no method at all was successful in initiating the onset of active labour, leading to an inevitable caesarean section birth, which continues to be associated with higher morbidity and mortality (Bulger, Howden-Chapman, & Stone, 1998; Wood, 2004).

Whilst not a comprehensive review of sequelae, the purpose of this section is to highlight that action in response to the definition 'post dates pregnancy' can lead to a range of sequelae. These can occur even with our current understanding of cervical assessment, the properties of prostaglandins, and assessment of gestation age.

### Conclusion

This paper expands further on the issue and challenges of a pregnancy being "overdue". It is one of the more common points of contact between midwife and obstetrician and a situation that calls upon the midwife to inform and advocate for women when decisions are required to be made

because a pregnancy has been defined as 'post dates'. Such decisions need to arise from balanced knowledge about:

- the mechanism for the spontaneous onset of labour
- defined meaning and associated risks of 'post dates' pregnancy
- risks and benefits of IOL.

In the continuing absence of reliable identification of the truly *post mature*, at-risk, fetus, we can have no expectation of reasserting faith confidently in the normality of all post dates pregnancies. Midwives daily field the pressure to follow risk-averse practice in the current medico-legal atmosphere, and contemporary public expectations of "quick-fix" solutions (which, to some, is what IOL seems to offer).

However, as this article proposes, we do have *some* information. We can trust women with the information. The minimum standard of midwifery practice is to ensure the family is well informed

*continued over...*

# "I'm ready for you, baby, why won't you come?" Further discussion around the issue of post dates pregnancy and the intervention of induction of labour

(NZCOM, 2003). This requires the midwife to critically reflect on available evidence as a basis to inform and support the women with whom she works. The challenge is to share sufficient and relevant information with women and their families, to help them appreciate the complexity and choices of approach to 'post-dates' pregnancy.

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<sup>1</sup> Gibb is a classic example of someone who inadvertently perpetuates the confusion. He heads his chapter 'Prolonged Pregnancy'; within the text of this he explains with care, the specific nature of the 'post-mature' syndrome which clearly does not necessarily relate to gestation, or to being 'post dates'. He comprehensively describes the syndrome, then continues to use the term throughout the chapter to equate to 'prolonged pregnancy'.

<sup>2</sup> Author's personal observation after 22 years experience of IOL

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## Misconceptions: truth, lies, and the unexpected on the journey to motherhood

Written by Naomi Wolf (2001)  
 Chatto & Windus: London

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I recently returned home to New Zealand to live. As I was about to depart from Melbourne, Pru Goward, who was the Australian Federal sex discrimination commissioner at the time, came out with the following advice to aspiring young women in the paid work force. In Goward's opinion women should do the following: "Freeze your eggs in your 20s, when they are the best they will ever be, and then accept you won't have children until you're in your late 30s or early 40s ..." (Jerums, 2001, p. 16). Despite Luce Irigaray's (1993, p. 133) recent observation that; "motherhood is back in fashion ... especially because of artificial methods of fertilization", Goward suggests otherwise. In her view, women are 'voting with their wombs' not to have children. The question immediately raised by Goward's comment is of course precisely 'which women?' To be fair, Goward's statements need to be understood in the context of an interview about the glass ceiling and about (Australian) women working their way up to senior management positions, but the point remains a salient one. For vast numbers of women across the globe, including many in western societies, choosing motherhood and pregnancy for oneself, is simply not an option. Having children and being a mother is, for the most part, understood by many women as an anthropological universal and part and parcel of one's taken-for-granted life course as a female. Certainly this was the view of our own out-going Minister of Women's Affairs, Hon. Laila Harre, in 2002. Then, Harre (2002, p.1) stated quite categorically that "having babies is not a lifestyle choice. It is a perfectly ordinary part of the lives of most women ..."

Reading Naomi Wolf's latest book *Misconceptions: Truth, Lies, and the Unexpected on the Journey to Motherhood* (2001), one could be forgiven for overlooking this somewhat important material social fact. Indeed, Wolf has done precisely what Coward has suggested, albeit conceiving by 'natural' means, and chosen to give birth to her first child in her thirties. Yet despite her choice, Wolf makes clear in this book that the experience of pregnant embodiment, childbirth,

and the institution of motherhood is not to be idealised. Deploying in-depth hermeneutics to discuss medical-obstetric control over pregnancy and childbirth management Wolf explicitly states that the aim of *Misconceptions* is to "explore the hidden truths behind giving birth in the developed world today" (2001, p.1, my emphasis). As such, Wolf attempts to reveal the underlying reality beneath the ideologies of pregnant embodiment and motherhood by drawing on women's personal accounts of their pregnancy and childbirth experiences. At the same time, Wolf uses the ever-present contradictions of reproductive politics as a means to promulgate a personalised version of the birth narrative. By interspersing data from other women's accounts of maternal subjectivity with the authority of her personalised birth story Wolf revives the long standing concern of feminist research to uncover the marginalised experiences and silences of women's voices. Yet unlike the sorts of birth stories sought after in parenting and mothercraft magazines that are designed to reassure the reader about childbirth and parenting, Wolf situates her own far-from-perfect experiences in the context of an analysis of women as medically manipulable objects and in terms of radical scepticism about the realities of equal parenting.

One of the plusses of Wolf's analysis is her attribution of agency to maternal subjectivity. Adrienne Rich's work aside, the attribution of agency to maternal subjects is often sorely lacking in early second wave feminist analysis, which seemed happy to consign the physiologically maternal body to brutish immanence and bodily function (see de Beauvoir, 1997). Nevertheless, while many women would no doubt agree with Wolf's demystification of sentimentalised and naturalising discourses surrounding motherhood practices, Wolf's own birth story and the accounts she draws on are highly generalised. The generalisations that follow from Wolf's appeal to experience form the crux of my reservations about the book.

First, Wolf's conception of women's identity prior to pregnancy, childbirth and parenting is premised on a notion of a "solitary selfhood" (2001, p. 6) and motherhood is set up in terms of a loss of this identity. While this conception of self-hood may hold true for privileged western women who have had jobs in the paid work-force, and who

have achieved a sense of themselves as persons separate from their families, it doesn't hold true for all women. Many women throughout the world are already constituted and inscribed as selves-in-relation to numerous others, either marked as such by traditional cultures or by relatively immobile class or gender positioning. In these cases, mothering is not perceived in terms of loss as such, but as a gain and expansion of self into a new kinship world. Mothering represents a socialised extension or maturation of self and responsibility that is grounded in a duty-based ethic. Hence for many women, the rite of passage to motherhood, often initiated through marriage, is viewed pragmatically as a way to leave the parental home and achieve a new status with the family, and attain relative independence.

The second problem with *Misconceptions* relates to Wolf's characterisation of childbirth management practices and women's lack of autonomy in relation to these. It is here that I find the specificities of Wolf's perspective too blinkered to account for the diversity of childbirth experiences, even in Anglo-speaking countries. While personalised writing can be a very effective political tool for feminist analysis, Wolf writes as if she is unaware of the limits of her perspective.

Although she rightly wants to challenge hegemonic cultural norms about birth and mothering, her voice is that of a highly educated, professional Western woman whose own maternal identity is informed by dominant North American discourses and practices that continue to structure and characterise birth as a medical-surgical event. As a middle-class Pakeha woman, who has given birth in both Australia (at a hospital birthing centre) and New Zealand (with independent midwives as primary carers), I have trouble identifying with Wolf's perspective. My reasons are two-fold.

My first objection is that the way in which Wolf constructs maternal subjectivity and defines birthing rests on a conception of medical and obstetric control as constraining women from achieving agency and self-determination in the act of giving birth. While we should acknowledge that technologically assisted management of labour can create relatively docile maternal subjects, pregnant and child-birthing women are not exempt from max-

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imising the benefits of monitoring and observing practices and technologies. New technologies and associated practices can enable women to produce new subjectivities through the process of pregnancy and during childbirth. Deborah Lupton (1999, pp. 89-90) makes this point clear when she discusses the ways in which pregnant women police their own bodies, positioning themselves “in a web of surveillance, monitoring, measurement and expert advice that requires constant work ... seeking out knowledge about risks to her foetus, acting according to that knowledge.” How else would Wolf know that Arlene Eisenberg’s pregnancy bible ‘*What To Expect When You Are Expecting*’, “is the intellectual equivalent of an epidural”? (2001, p. 3) - she read it. And let’s be candid: academic women, maternal feminists or otherwise, are not above reading popular literature, including self-help texts. Regardless of our own complicity in the new normalising practices and techniques of contemporary reproductive politics, the important question, as Wolf rightly points out, is who defines what women’s needs are in relation to maternity services and management, and how are these needs satisfied (see Rothman, 2000, p. 67). But Wolf is mistaken in her belief that if women are given the opportunity to articulate their own needs within the birth encounter, then those needs will be adequately represented. Related to this is Wolf’s assumption that these needs are transparent to the maternal subject and known from the outset of the pregnancy: an especially tall order for the labouring *primigravida*. The lived reality, as Iris Marion Young (1990) insightfully argued, is that the pregnant woman experiences radical phenomenal changes to her body during the course of pregnancy, and changes to her self-identity in relation to bodily events can often mean changing one’s mind about a whole host of initial choices. This is one reason why formal written birth plans are essentially ‘sunny day’ scenarios.

Another concern has already been identified as common to Wolf’s work in general. In short, this is Wolf’s tendency to eke general theory out of particularised experience. With specific reference to ‘*Misconceptions*’, Wolf fails to contextualise her account of pregnancy and childbirth management practices and thus to account for what are structural and organisational differences between international maternity services. A quick comparison of

some of these international differences reveals the highly specific nature of Wolf’s narrative.

In contrast to Wolf’s depiction of maternity care and childbirth as mechanically-manipulated and male-attended, figures from a recently published Aotearoa New Zealand ‘*Report On The Results Of The NCWNZ Maternity Service Survey 2001*’ (2002) show that 86% of women in this survey chose as their Lead Maternity Carer an Independent Midwife. This can be compared with Health Funding Authority (2000) figures showing 71% of women choosing a midwife as their Lead Maternity Carer (see Pairman, 2002, p. 15). In addition,

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the ‘*NCWNZ Maternity Services Survey*’ Report also indicates that 95% of women felt that they were included in the decision-making regarding themselves or their baby’s care during labour and delivery. Whilst the sample indicated that Maori and Pacific Island women were under-represented in the data, Pakeha women who responded to the questionnaire appeared to show a high level of satisfaction with current maternity services in Aotearoa New Zealand. Certainly one reason for the overwhelming choice of a midwife as a lead maternity carer for women in Aotearoa New Zealand is due to the 1990 ‘*Amendment to the Nurses Act 1977*’, which gave midwives the legal right to practise without supervision of doctors. However, this does not alter the fact that, at least in theory, much New Zealand childbirth management aims to follow a relatively holistic, non-interventionist model (Guilliland & Pairman, 1995). In the Australian context, Kerreen Reiger has noted that “while Australia still lags behind Canada and New Zealand, health policy has been moving towards support for midwifery care in childbirth” (Reiger, 2000, p. 53). In contrast, and in response to dialogue between Reiger, Karen Lane, and Barbara Katz Rothman in the ‘*Annual Review of Health Social Sciences*’, Rothman (2000, p. 65) states that the United States has no such “recognizable policy at all”.

I am not saying that childbirth management is non-problematic in New Zealand or Australia, because it is not. But, if the context Rothman describes is in fact the one out of which Wolf writes, then it is difficult to support Wolf’s claim to speak for so many women “in the developed world” (2001, p.1). From a scholarly point of view one can only read Wolf’s elision of the finer points of

substantive research here with reserve. The kind of work meticulously undertaken on maternity care issues by feminist scholars and researchers such as Kerreen Reiger, Diane Gosden, and Carolyn Noble in Australia and Sally Pairman, Elizabeth Tully, and others in New Zealand is completely lost in the media hype of Wolf’s globalising brand of feminism and that should be construed as a deficit for the reader. One might surmise that this is why ‘*Misconceptions*’ can be found in the Self-help section of our local bookstores and that such a text doesn’t really warrant academic comment.<sup>1</sup> However, when such a well-known feminist – ostensibly a leading figure of the so-called third wave<sup>2</sup> - writes a book that has the potential to influence the perception of so many women about the sorts of services that are in fact currently available to them, I believe criticism is in order.

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<sup>1</sup> Angus & Robertson in Australia lists *Misconceptions* in the Self-Help section of their bookstores.

<sup>2</sup> See ‘Dialogue’ section, *Feminist Review*, No. 64, 2000, p. 113.

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## Maternal request for an elective caesarean section

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### Abstract

The number of women requesting to have their child born by caesarean section when there are no medical indications for them to do so is increasing. This qualitative study identifies the themes that emerged in interviews with five primigravidae who requested that their baby be born by elective caesarean section. The overriding influence identified by the women was the representation of normal vaginal birth as hazardous, both for themselves and for their babies. The women perceived caesarean section as the best means of maintaining control over the birthing process, ensuring the birth of a normal, healthy child and reducing harm to themselves. While some of the women asserted their right to choose to give birth by caesarean section, they felt guilty about their decision.

### Introduction

Recently there have been suggestions that women's requests for an elective caesarean section (ECS) in an uncomplicated pregnancy may be responsible for a significant proportion of the rising caesarean rate (Bulger, Howden-Chapman & Stone, 1998; Jackson & Irvine, 1998). Requesting an ECS for an uncomplicated pregnancy has become an increasing trend in the western world (Paterson-Brown, 1998). Women today are more aware of their rights to choose and to be involved in childbirth decisions and are increasingly exercising these rights. A review of the literature related to maternal request for an ECS reveals an abundance of papers covering the topics from medical journals to the tabloid press. However, this growing body of literature concerned with the escalating

caesarean rate does not contain studies which involve the women's decision-making on why they elect to give birth by ECS. Thus the aim of this study was to explore and identify the reasons women chose to give birth by ECS in the absence of any medical reason. In this paper we provide an overview of the research process and present the themes which emerged from the interviews with five primigravidae women who chose to have ECS.

### Literature

Throughout the literature there are many explanations given as to why women are choosing ECS. Some authors argue that an ECS is a safer birthing option for women than vaginal birth (e.g. Kirby, Hanlon-Lundberg, 1999; Paterson-Brown, 1998; Young, 1999). Greene (2002) suggests that an ECS causes less stress and saves women from an unplanned, 'sloppy' and inconvenient labour.

Hillan (2000) proposes that ECS has become the 'trendy' choice of delivery for certain groups of women. For example, Bastin (1999) observes that Central and South America have the highest ECS rate in the western world. He believes that the ECS has become a fashion statement and now culturally accepted as a normal means of giving birth by white, wealthy, middle and upper class women. Newspapers, magazines, film and television are major sources of information about pregnancy and childbirth for many women. Most of this media implies natural vaginal birth is painful, uncontrollable and a dangerous process (Beech, 2000; Dimond, 1999; Kitzinger, 2001). These authors suggest that these media are encouraging women that an ECS is a safe and easy option.

Women's desire to avoid pelvic floor damage is another reason given for the increase in ECS (Amu, Rajenfran & Bolaji, 1998; Bates, 1998; Duff, 2000; Idama & Lindow, 1999). Many women, according to Harer (2000) and Sultan & Stanton (1996), favour ECS because they fear childbirth and worry about the risks of developing urinary or faecal incontinence or losing vaginal muscle tone, which in turn could interfere with sexual satisfaction.

Two groups of women commonly associated with high ECS rates are the increasing number

of women aged 35 and over who choose to delay having their first child (e.g. Rosenthal & Paterson-Brown, 1998; Usha Kiran & Jayawichrama, 2002) and women who have a commitment to their careers. It is argued that the latter group value the ability to schedule their birthing date, especially when childcare and employment issues need to be pre-arranged (Kirby & Hanlon-Lundberg, 1999) and also as a means of their maintaining control over the childbirth process (Duff, 2000).

*Although the women believed in their rationale for choosing an ECS, they were uncomfortable about their decision, aware that their choice might be controversial and not wholly supported by society in general.*

While there is a growing body of literature concerned with the escalating ECS rate, much of the popular literature is superficial and unsubstantiated (Beech, 2000; Idama & Lindow, 1999; Robinson, 1998). Very

few studies have involved women's voices. In order to give these women 'a voice' this study invited five primigravidae women who had requested an ECS without medical indication to participate in this small study.

### Research design

This study received ethical approval from the local Ministry of Health Ethics Committee, as well as approval from the District Health Board (DHB), and the DHB's Maori Research Review Committee.

The qualitative method of interpretive description was selected for this study, as described by Thorne, Kirkham and MacDonald (1997). This method was selected because it allows for in-depth examination of human experiences and its realities.

Purposive sampling was used for recruitment because it is an appropriate way to select participants who can describe the lived experience of a particular phenomenon (LoBiondo-Wood & Haber, 1994). Nursing staff working in a pre-admission clinic invited women whose surgical booking forms noted caesarean section by "maternal request" over a two month period. Dianne then contacted the women who had expressed interest in participating to confirm their interest and then sent them information about the study. From this process five women were recruited. All were of European descent and middle class. They had professional occupations and held tertiary qualifications. The interviews were semi-structured.

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tured and face-to-face. Pseudonyms were used to protect identity. Permission was gained to tape the conversations.

The semi-structured interviews were opened by asking the women: "Can you tell me why you chose to have an ECS for the birth of your baby?" An interview guide was used to ensure that the following aspects: influencing factors; the information that they received regarding caesarean sections; their views on issues regarding choice of ECS and future births by ECS, were discussed. The audiotapes were transcribed and the transcripts then mailed back to the women to verify their contents.

Inductive data analysis was used with the data being compared continuously as the interviews progressed. Patterns in the participant's scripts were quickly identified and two overarching themes emerged: the negative construction of normal vaginal birth, and the decision to choose to give birth by ECS. Each overarching theme was further divided into sub themes. The negative construction of vaginal birth was constituted by the sub themes "vaginal birth as hazardous" and "safety of the unborn child" and the decision to choose ECS by the sub themes "feelings of guilt" and "the right to choose". These sub themes are presented and discussed in the pages that follow.

### Findings

#### Vaginal Birth as Hazardous

The notion that vaginal birth is hazardous and unpredictable came through in the women's stories. One important means by which the women had acquired this perception was from the stories reported to them of friends' and family member's unsuccessful experiences of normal vaginal birth. Two of the women had based their view on their observations as health professionals. Every woman in this study related stories from friends, sisters and mothers about difficult vaginal births and how the natural birth process could potentially damage their bodies.

*I had five girlfriends who all went through labour and I was disgusted, absolutely disgusted in the way it was handled. These were doctors throughout New Zealand ... in this day and age someone should not have to go through 20 hours labour and then be torn left, right and centre ... we are in the year 2002, so there is no need to go through all that [pain of labour and delivery]. What these girls had to go through afterwards with all the drama and depression was just disgusting. (Julia)*

*My sister had a prolapse [of the uterus] and later had to have a hysterectomy because of difficult births. My sister was only 27 & 30 when she gave birth; so she really wasn't an elderly primip. I was reading a lot*

*about older women giving birth ... I was 36 / 37 and as the pregnancy went on I was thinking more and more about a caesarean section. My mother had four babies and all were difficult births. (Anne)*

For Julia and Anne, a significant number of family and friends had experienced lengthy labours which had damaged them physically and emotionally. Anne's family history of difficult birth combines with her age to increase the probability that she will require intervention. For them, vaginal birth as a sole means of giving birth has the capacity to be destructive. Julia also sees it as anti-progressive. She suggests that intervention exists and thus the prolonged labour and consequent trauma experienced by her friends was unnecessary.

Women relating their birth stories to one another are not uncommon. Most women remember their experiences of childbirth vividly and will probably talk about them with relatives and friends for years to come (Simkin, 1991). Birth stories are valued by other women and do indeed have an influence on them (Weston, 2001). While sharing birth stories can be empowering for some women, negative stories can have the opposite effect and leave women with fear and misunderstanding (Simkin, 1991). Mothers who convey a negative view of childbirth do influence their daughters. Uddenberg (1974, cited in Ryding 1993, p. 284) called this "a transmission of reproductive maladaptation from mother to daughters".

All the stories recounted by the women portrayed vaginal birth as a process that can be destructive to mother's bodies, minds and/or babies. The women's recollections of such experiences exemplify how the negative experience of others can strongly influence women's ideas on birth, and their decision to request an ECS.

There was a strong sense of apprehension that their bodies would be damaged with the natural birthing process. They had greater faith that a caesarean section and modern technology would avoid complications of vaginal birth and keep their pelvic floor intact.

*They call it natural birth, but I can't see anything natural about pushing a baby through that narrow space. I knew labour would knock me for a six if I had to go through a difficult birth. And who knows what I would end up with afterwards? I see a lot of things like anterior and posterior repairs 30 years down the track. There are a lot of things in nature that are not natural. (Anne)*

Anne argues that vaginal birth is unnatural in the way it defies the fit and logic of things. She challenges the assumption that the course of nature is

beneficial. Rather it is inherently damaging. She perceives that the baby's head is bigger than the mother's vaginal opening, and thus the force exerted on the pelvic muscles and tissues is essentially injurious to and exhausting for the mother.

Anne's position as a health professional has both produced and reinforced her view of normal vaginal birth. She attributes older women's need for pelvic floor surgery to earlier vaginal births. None of the five women considered vaginal birth to be the desirable way to give birth. As exemplified by Anne they viewed it as a process that is detrimental to women's bodies, both in the short and long term. By choosing a ECS, these women believed they would prevent the harmful aspects associated with natural birth. There was also a belief that an ECS would eliminate any damage to the baby.

#### Safety of the unborn child

Four out of the five women were convinced that an ECS was the safest route for the birth of the baby.

*The most important thing for me was the welfare of my baby and I felt that a caesarean section was the safest way we could guarantee that our child was going to be born without any problems. I didn't want the baby's entrance into the world to be traumatic. It was controlled and safe. A baby is the most precious asset you can have. (Julia)*

Safety concerns for the baby were paramount for most of the women interviewed. Like Julia, several of the women referred to their baby as "precious", an "asset" in which they have a huge emotional investment. Therefore their baby needed to be safeguarded from the danger of vaginal birth.

*A neighbour's baby had the cord wrapped around his neck during birth and was born with intellectual and physical disabilities. We have seen these parents struggle; I would have hated that to happen to us. You do hear horror stories [about vaginal birth] and I guess that was in the back of my mind. (Elizabeth)*

Elizabeth reflects Floyd's (1981) finding that women voice concern about their own babies if they have been previously exposed to a handicapped child. According to Floyd, some women actively pursue technology in an effort to ensure the baby's safety. Julia and Elizabeth believed that birth by ECS assured their babies' safety.

This reflects a universal message that an ECS is safe and guarantees a perfect baby (Marieskind, 1989; Weaver, 2000). However, there is ample literature that babies sectioned before 39 weeks are at risk for transient tachypnoea, respiratory

distress and iatrogenic prematurity (Duff, 2000; Sabine, 2000). Anne was the only participant who acknowledged this complication.

Although the women believed in their rationale for choosing an ECS, they were uncomfortable about their decision, aware that their choice might be controversial and not wholly supported by society in general.

### Feelings of Guilt

Up until recently the rhetoric regarding women's right to choose contributed to the sense that an ECS was an acceptable method of giving birth. The interviews occurred during a period when maternal request for ECS was a hotly contested topic in the New Zealand media with such headlines as "Keep Surgery Out Of Birth" (Catherall, 2002) and "The Designer Caesarean Under Fire" (Claridge, 2001). Consequently, most of the women interviewed spoke of feelings of guilt associated with their choice.

*Every now and then I felt a twinge of guilt when I told people I was having an elective caesarean. I felt perhaps I should have had a normal delivery ... because I am a woman and it is the normal thing to do. But then I thought, why go through all of that if it's not necessary. It is a bit of a dilemma. (Anne)*

*People think you should go through 20 hours of pain and labour and have the baby naturally, and you feel you are taking the easy option out. (Elizabeth)*

Anne and Elizabeth's feelings of guilt were provoked by other people's beliefs that vaginal birth is the "normal" way of giving birth. The process of labour, which involves the expenditure of time and energy, is an expectation of motherhood. It is part of being a woman and women inherently have the capacity to endure it. Such beliefs troubled and contradicted those held by Anne and Elizabeth. What is interesting is how again normal vaginal birth is depicted as long, and painful, and can be circumvented by the use of technology. For some women ECS is seen as an equal and alternative means of giving birth. It is one of the birthing options available to women.

Three of the women identified antenatal classes as the context that evoked their feelings of guilt. They found that there was very little information regarding ECS provided in these classes and when it was mentioned there were negative connotations attached to it. For example,

*They [the midwives] were very anti caesarean sections. I didn't let them know we were planning a caesarean section. (Elizabeth)*

*We found the [ante-natal classes] a waste of time, we only went once. The midwife asked us not to share with anyone else that we were having a caesarean section, she said the rest of the class would want one. (Julia)*

At ante-natal classes Julia and Elizabeth were both indirectly and directly silenced. They subsequently kept their choice of ECS hidden. Therefore any opportunity to articulate their concerns and anxieties about pregnancy and childbirth was lost. Another participant, Rosemary believed that an ECS was a legitimate choice, and was angry that she allowed the midwives to make her feel uncomfortable about her decision. The three women viewed the antenatal classes as biased towards normal vaginal birth and against ECS. None of them returned to the antenatal classes.

### The Right to Choose

Controversy surrounds the issue of choice in regards to ECS in the absence of medical indication (Leitch & Walker, 1998). With the growth of feminism there has been a valuing of women and their experiences, ideas and needs (Draper, 1997). This is especially true where women's health is concerned. In New Zealand the Code of Health and Disability service consumer rights, 1996 and the earlier "The Inquiry into the Treatment of Cervical Cancer at National Women's Hospital" (1988) assert women's right to choose how one gives birth (Douche, 2001). The women interviewed here perceived that they had a right to choose ECS. For example,

*The media is saying people are waiting for life saving operations, but hey, I've worked for 20 years and paid taxes. I think it's a personal choice but I feel I'm entitled to make my own choice [about having a caesarean section]. (Rosemary)*

Rosemary legitimates her entitlement on her having paid taxes over a considerable number of years. In this way she has earned her entitlement to ECS as an elective operation. Her right is equal to that of other Zealand citizens who also require surgery. However, the Ministry of Health does not support ECS as a choice. This is made evident in the Crown funding agreements that are made with DHBs and which stipulate that the Crown will not pay for ECSs that have no clinical indications (Campbell, N., personal communication, July, 7, 2005).

### Discussion and conclusion

We wish to acknowledge that the small size of this study limits the generalisations that can be made from the findings. It has also meant that important issues pertaining to this topic, such as the rhetoric of choice have not been critically addressed.

The overarching influence on the women's decision to ask for an ECS was their negative view of normal vaginal birth as uncontrollable and potentially hazardous, physically and psychologically,

*The findings of this study tentatively suggest that women's decision to request an ECS are influenced by the social construction of natural birth as a potentially harmful process.*

to themselves and their babies. Castro (1999) proposes that the liberal use of medical technology during pregnancy fuels such ideas that birth is hazardous and conveys that women are not capable of giving birth without technology. Contributing to these understandings is the relationship between scientific knowledge and medicine, which has lulled the public into thinking that increased use of technology will ensure the safe delivery of babies (Papps & Olssen, 1997).

The findings of this study tentatively suggest that women's decisions to request an ECS are influenced by the social construction of natural birth as a potentially harmful process. The women gained their understanding of birth from friends, family and work. From such sources, they constructed normal vaginal birth as an unpredictable, lengthy and potentially dangerous event for mothers and babies alike. In complete contrast, the women represented ECS as a procedure that was controlled, safe and which ensured the wellbeing of the baby and of themselves. Yet, present knowledge would suggest that in the absence of medical need, a vaginal birth is safer than undergoing ECS. There is a dearth of reliable information on the mortality and relative short and long-term morbidity of caesarean section when compared with vaginal birth (Bewley & Walkinshaw, 1999; McCandlish, 1998; Stirrat, 1998). The authors believe that current evidence seems to suggest that vaginal delivery is generally safer for the mother. ECS is still major surgery and carries all the risks associated with surgery and anaesthesia (Hillan, 2000). Short term risks include, haemorrhage, infection, paralytic ileus, pulmonary embolism and Mendelson's syndrome (Wagner, 2000). The prevalence of hysterectomy due to haemorrhage after caesarean section is ten times greater than a vaginal delivery, and the risk of maternal death is increased up to 16-fold (Amu, Rajendran & Oblati, 1998). There are many studies that have shown that continuity of midwifery care in preg-

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## Maternal request for an elective caesarean section

nancy and childbirth lowers caesarean section rates (Johanson, Newburn & Macfarlane, 2002; Leitch & Walker, 1998; Schimmel, Schimmel & DeJoseph, 1997; Wagner, 2000).

This study has raised the possibility that antenatal classes are not safe places for women to voice their concerns about natural vaginal birth. The women in this study were very aware of the bias against ECS, and subsequently felt guilty and silenced about their decision. We would like to suggest that the issue of discussing ECS during antenatal classes does present a problem to childbirth educators and midwives. Firstly, classes are problematic because of their on mass, public nature. They bring together a number of women who do not necessarily share the same understandings of pregnancy and birth. Secondly, if the educators position themselves in the natural birth discourse, which constructs childbirth as a holistic process and whose success is dependent on the state of the woman's mind as well as her body (Payne, 2002; Surtees, 2003), then the voicing of natural birth as dangerous is problematic. Bringing into the open negative attitudes and beliefs about natural birth could influence the women present, and hinder their potential to birth naturally. Therefore the idea that an elective ECS is a more desirable means of birth needs to be kept silent.

However, antenatal classes are a valuable way of informing and supporting women through a major event in their lives. ECS is a procedure that does need more discussion antenatally, but drawing on these women's experiences, it needs to be addressed in a non-judgmental and non-confrontational way. These women also need to be provided with full and accurate information. Special classes for women planning an ECS or individual sessions with a counsellor or a psychologist may prove valuable to allay these women's fears.

Women's stories are important for their potential to assist midwives to understand why some women choose to give birth by ECS. Before we judge these women we should be prepared to listen to their stories and realise they have major concerns about birthing vaginally. There is a place for midwives to explore and challenge the assumptions and understandings around vaginal birth in an effort to put some of the negative stories to rest. This needs to occur both at an individual and societal level. For example during the antenatal care period, time could be given to allow a woman (and her partner) to articulate their fears. Midwives' use of therapeutic communication skills would facilitate the expression and exploration of such concerns.

More accurate information about ECS needs to be conveyed from groups such as midwives, childbirth educators, lactation consultants and birth activists. This can be achieved by inviting

childbearing women, consumers, and consumer groups, such as Parent Centre, to lectures and conferences.

Finally, more research concerning the risks and benefits of an ECS versus natural birth is needed. No one study has looked at medical outcomes as well as psychological, social, and economic implications. More investigation and research into women's decision-making may be valuable in helping them make alternate choices.

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## reflections

Our actions, reactions and the choices we make in midwifery are influenced by our personal and professional ideas, beliefs and values. These are not always stated clearly nor immediately evident to us but are implicit in the things we do, the reactions we have and the choices we make. Sometimes it is not until we are asked to identify these values and beliefs that we think about them and try to articulate what they are.

Our professional practice context highlights the importance of reflective practice and using practice as a basis for continual learning and development in midwifery. This may be achieved by reflecting on particular practice scenarios that have inspired, unsettled, disturbed or stimulated us to think more profoundly about our midwifery practice. An important starting point in reflective practice can be the articulation of a philosophical framework for practice. This just means setting out our ideas, values and beliefs about midwifery and the things that are important to us.

This is what Postgraduate Midwifery students were asked to do in a paper at Otago Polytechnic that focuses on reflective practice in midwifery. In addition to a short written piece they also had the option to depict aspects of their framework in another creative form. In this issue of the journal Deb Pittam, Tina Murdock and Jennie Crawshaw have generously agreed to share their creative work with you.

The Standards Review process is important for midwives in New Zealand as it supports and stimulates midwives to reflect on their practice. Margaret Falconer-McGlashan's Standards Review panel suggested that she write a small piece for the journal and this resulted in her letter to Sarah. It is published here with the consent of Sarah and her mother.

I suspect that there are many wonderfully creative midwives amongst us and it would be great if we could create more opportunities to share this creativity. If you would like to share something with other midwives by publishing in the journal then please contact the Editorial Board

*Deborah Davis*



## The incoming tide at Waionu

*Tina Murdock*

The flow of the tide with its constant rhythms of time and progress coming in and out on our shores. Watching the sea from my home always reminds me of the natural flow of nature and how vulnerable it is to the interference of man.

This is a constant reminder to me on how vulnerable the process of normal birth is and how as a midwife I ought not to interfere with the process without just cause.

## Life is a journey

*Jennie Crawshaw*

The harakeke (flax) is home grown and nurtured, then prepared according to tikanga learnt from wise Ngati kahungunu wahine; representing attending to my physical, emotional, and spiritual wellbeing.

The plait at the bottom of the rourou (basket) reflects the woman, the client, it is the central point, the heart, what everything else springs from.



The pounamu (greenstone) is the baby, the taonga, (treasure), with the whanau, family, support people reaching around supporting and holding.

The paua are also taonga, and represent the people who are there for the woman, believing in her and supporting her. The care I provide places value on the people who surround the woman.

The large thick plait at the top of the rourou represents the making of a safe place for the woman to birth, a protection and upholding of the choices that she makes.

The many little imperfections, and the koru and the swirl of harakeke at the end indicates that life is a journey, and you never know what is around the corner. The journey isn't about good or bad, success or failure, it's what is learnt and appreciated, and contemplated along the way.

## With her

Her person, her life experience, her family, her herstory is where she has been.

She matures as she gains knowledge and she marvels at the physical and emotional changes which shape her as a mother.

... *The midwife is with her.*

She chooses an environment appropriate for her and her family within which to birth.

... *The midwife is with her.*

The physiological process of labour and birth, progress unimpeded by influences unnecessary for her.

... *The midwife is with her.*

When she needs and accepts that medical care is required, she remains fully informed and empowered.

... *The midwife is with her.*

Her needs and those of her child remain fluid throughout this life process, encouraging flexible, creative care (NZCOM, 2002).

... *The midwife is with her.*

The political environment impacts on provision of her care requiring midwifery involvement at all levels.

In this the woman is protected.

... *The midwife is with her.*

Accountability of the midwife is to the profession, the woman and to herself allowing the woman to make choices within a culturally safe supportive environment.

... *The midwife is with her.*

She is who she is, she grows her unborn baby, she learns, she matures, she experiences pain, she births, she nurses, she nurtures, she is a woman, she is a mother.

... *The midwife is with her.*

The relationship ends, she is a mother, independent, empowered with the knowledge only motherhood brings, she has her family, her child.

The midwife now is a part of her herstory.

... *With her.*

*Deb Pittam*

## Dear Sarah

*Margaret Falconer McGlashan NZRCOM, MW*

*Independent Midwife*

*Margaret practices rurally with home and Helensville Maternity Unit deliveries. She and her husband live on a farmlet in the beautiful Makarua Valley, where she has raised her four children. She has one grandchild who was born at her home last April.*

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22 April 2005

Dear Sarah

Congratulations on your 21st birthday.

It is a milestone for me too as it is 21 years since my first homebirth. Your Mum a very shy girl of 17 asked me to be her midwife as she wanted to have her baby at home. She had found a doctor that was willing to come out to your country home, but it was too far for one of the few homebirth midwives to come. I scolded her and told her how dangerous it was to have a baby out of hospital. I asked her if this doctor was a hippy or an ex-missionary. She said he did look a bit like Billy Graham. My negativity went on throughout the pregnancy. I decided that I would be the martyr and come along as she wasn't going to budge midwife or no midwife.

It was 14 years since I had done my 6 months midwifery training at St Helens in Mt Albert. I hadn't enjoyed it and my general nursing days held my affection. I had since given birth to your four cousins and had concentrated on being a mum.

The big day arrived. Your mum rang to say she was having contractions, so with apprehension I set off for the farmlet, an hour away. The doctor arrived just before me. I will always remember the look of relief on his face as he faced me, expecting a bossy midwife after all the things I'd been saying. I am sure he saw the expression of relief on my face when I saw, he just looked normal too.

Your mum was in the latent phase of labour and didn't have you until 30 hours later! During this time she and your dad took the doctor for a tour by your river and across the farmlet, your mum was in shorts and had her gumboots on. Later the doctor made a game up of Othello using a piece of polystyrene and 3 cent pieces. It kept us amused

for hours. At teatime he insisted on cooking the dinner and marinated the steaks in grapefruit juice off the tree outside. Meantime your mum laboured on so very courageously.

It was now deep into the night and she settled into the room so meticulously prepared weeks before hand. I had followed the instructions of the Maggie Myles Textbook that I had studied during my midwifery training. The bedding was all washed in savlon, the walls scrubbed and I had forbidden your dad from painting or sanding the house.

It was deep into the night when your mum wanted to push. The doctor had been so patiently attending her rubbing her back and giving her fluids between sparring with his so-called midwife. He did a check and found that you were lying in a posterior position and weren't ready to be born. He had anticipated you were and had put his last pair of sterile gloves and gown on. He had carefully set out his sterile instruments I had been to the local maternity hospital weeks before and had obtained a mucus extractor.

We were exhausted and were all dozing off around her when your dad came in with a box of chocolates and offered them to us. What a funny sight it must of been, doctor all gloved up, hands in the air, trying to stay sterile. Your mum says I made her climb up high on top of five mattresses! I was obviously trying to create a theatre bed.

How she must of silently suffered as she pushed you out in a persistent posterior position. (Something that took her then naive midwife many years to appreciate). You were a beautiful baby!!

What a life changing experience that was for me. As you know I have had the privilege of being your mum's midwife 14 times thus far and look forward to the 15th this year. Over the 21 years I have learnt so much about how wonderful nature is. At the local Birthing Unit (The first in the country, and of which I had the privilege of influencing as a homebirth type unit) I have sat along with my labouring mums through many a long night learning patience and the wonder of nature in childbirth. The power of water, both soothing while bathing and the importance of being well hydrated in labour. Quietness, so women can go into their own space, allowing the mums to go to sleep and have the energy for the next powerful contraction during transition.

Good seating, positioning techniques in the last weeks of pregnancy. A good wholesome diet,

exercise, a good mindset. All basic things yet so important for a good outcome.

Your little sister who has a complex heart defect needing two operations of open heart surgery was born safely at home and didn't go to hospital until she was 8 months old. The gentle birth and the wonderful parenting she had, I am sure played a part in this. One lady had a prolapsed cord and we travelled an hour through peak hour traffic for an emergency caesarean. This baby had 9 /10 appgars.

On another day I attended a lady in premature labour who had a baby at 27 weeks gestation weighing 890g. The doctor went with the baby wrapped in tinfoil in the helicopter and the mum and I followed in the ambulance unsure of what the outcome would be. We were greeted by the paediatrician, full of praise for the good condition the baby was in when he had arrived. He is now a healthy boy. That same afternoon I attended the delivery of my largest baby, 5400gms, another normal homebirth.

I have attended hundreds of births mainly at home and at the Birthing Unit, which is now a maternity unit. So many more wonderful experiences; I have had babies born outside, in caravans, in places with no power or running water. I have had the privilege of attending the births of all the children in the family such as yours.

In all of this I am thankful for the wonder of birth and how the majority of women have the ability of delivering normally, if they only have the mindset to do so. It reminds of King David's 139th Psalm, of how fearfully and wonderfully we are made.

Thanks to your brave little mum and a dedicated, kind and patient Doctor Don Dalziel, that set me out on such an incredible journey.

May God continue to bless you precious Sarah.

Much love

Aunty Marg

*Postscripts:*

- Sarah and her mother gave permission to Margaret for this letter to be published.
- Sarah and her husband are due to have a baby in December and have asked Margaret to be their midwife.
- Margaret attended Sarah's mother who gave birth to her fifteenth child on August 4 2005.

## Mum's the word

By Nicola Mutch

After spending eighteen months "obsessively" pouring her views on of parenthood into her computer, North Auckland mum Kathy Fray – without high hopes – submitted her work to New Zealand's leading literary agent.



"I'd been told they receive a thousand unsolicited manuscripts each year, and only accept about a dozen – but I needed to tick them off my list."

Within hours, the phone had rung. They loved it. Random House Publishing completed the deal, and Kathy Fray's long-wished-for contribution to New Zealand's parenting literature was achieved.

"I was annoyed at the pious mother-craft bibles out there – always concentrating on the baby with little focus on the mother. I wanted to finally tell some truths," says Fray of her book, *Oh Baby... Birth, Babies and Motherhood Uncensored*.

The mother of three, all of whom were under five for a while, says she was also motivated to write a book after "reflecting on how many informed consent decisions I'd had to make during my pregnancies and births, and how hard it was to get sound, unbiased, middle-of-the-road advice.

"When I would investigate these topics, the "pro" stance would be very righteous, while the "anti" stance was often very propaganda-like. I knew it was impossible to write a book that every expert would agree with, but that was its point. I saw a huge gap in the market for information that didn't have an agenda attached to it."

Fray's book certainly refers to expert opinion – with information gleaned, checked and critiqued by a range of pregnancy, infant, maternity and holistic specialists – but it is communicated through the voice of a pretty down-to-earth mum. She describes her work as "a girlfriend's guide".

The distinction's important, she says. Because among Fray's gripes about "expert" opinion is the mantle the authors quickly assume, whereby they appear to have they right to "expound the perfect way to do things. I've witnessed so many friends with high levels of guilt, trying to be the perfect parent. As a society, we are so good at making our mothers feel guilt."

Fray recounts standing in a swimming-pool changing room overhearing two mothers talking: "I've switched my baby to formula," said one. 'Soy, I hope,' responded her friend. 'Oh yes,' came the reply. And I'm thinking, 'Oh God, what have I missed now!'"

Fray – who is now studying to be a midwife – says

it was imperative she wrote this book before embarking on her new career. "I didn't want it to be from the perspective of an expert, it needed to be told from the point of view of a mother.

"What I wanted to tell women is that it's not about being the perfect mother. It's about being a good-enough mother. There are lots of ways of doing things 'right'. And it's OK to get it wrong sometimes."

Consequently, *Oh Baby* reads like a long, loving chat with a wise aunty of the community – one who's totally in love with babies and in awe of all women. She is insightful, blunt, compassionate, self-deprecating, affectionate, funny.

"I had to be careful with the humorous aspect though," she comments. "I didn't want to overdo it. It's easy to look back on your early days of parenting and laugh, but you don't always feel like laughing when you're in the trenches."

But while she claims to offer "middle-of-the road" parenting advice, Fray admits it's hard to hard to remain completely free of bias.

"Where I do have a strong philosophy, I am upfront that it is a pet peeve subject," she explains. The topics she says she holds particular views include are the importance of holistic medical approaches and avoiding feeding young babies starch. And sleep. Indeed Fray's book features perhaps the most hard-line chapter on sleep I've ever read (this is the let-them-cry-from-new-born end of the spectrum).

"I am tough on sleep," admits Fray. "Something to do with having three kids under five, I suspect. But it's also to do with valuing women, and their right to sleep, and their baby's need for sleep. The insidious fall-out for parents who are sleep-deprived is dreadful. It's a price that doesn't have to always be paid as dearly as it is."

Now, Fray says she's ready to take on the next chapter of her life, joining the ranks of birth experts. She already wonders what she'll think of her book once she's a practising midwife, but feels encouraged by the positive feedback she has received from the profession – "I've even had midwifery fan mail," she beams – as well as the tremendous support she has received from AUT's School of Midwifery. She's convinced the profession is her calling.

"Having three children has ignited in me a passion about the empowerment of the almighty woman," she says, explaining her decision to study for a midwifery degree. "The sacredness of the moment of birth is such a special moment in a woman's life. And people don't tend to let you be involved in it unless you're a midwife!"



## Informed Choice in Maternity Care (2004)

Mavis Kirkham (Ed.)  
 Palgrave MacMillan Publishers  
 ISBN 0-333-99843-X

Reviewer:  
 Catherine Donaldson, Midwife & Independent Midwifery Educator, Midwifery Education Services Ltd.

In the introduction the editor, Mavis Kirkham, makes the comment this book is *“sad reading”*. Although I have to concur with her remark this book also provides us as midwives with many challenges in practice as it frequently poses the question what is and how does informed consent really occur? In the first chapter tellingly titled *“Why can’t women just say no? And does it really matter?”* the rather academic use of language is offset by the valid points that author, Nadine Edwards, identifies. She writes about the *“telling not listening culture”* that has evolved in practice within maternity services and how midwives who actually provide informed choices can become ostracised and subject to horizontal violence from both midwifery and medical colleagues especially in a dominant medicalised environment. These themes are referred to in other parts of the book and continue in chapter two with reference to Valerie Levy’s research concerned

with how midwives use protective steering to facilitate informed choice in childbirth by making stereotypical personalised judgements of women. Levy identifies midwives as being gatekeepers who protect women by either giving too much or too little information; often this is caused by what she terms *“hierarchies of work”* in maternity services and how this constrains midwives offering advice to enable informed choices due to employment circumstances. The findings from Levy’s research are supported by Mavis Kirkham and Helen Stapleton’s work, with reference to both qualitative and quantitative research methodologies, examined exactly what informed choice is and how it occurs in regards to the use of MIDIRS informed choice leaflets. Issues of power and control being held by medical and midwifery professionals were clearly evident where midwives were observed to be colluding with doctors to reduce choices and steering women rather than enabling. This research also reveals variations in what midwives actually consider informed choice to be. The thorny debate around elective caesarean section on demand for the *“worried well woman”* is explored in-depth by two obstetricians who make ten very salient workable points in conclusion of how this social issue can be tackled.

Throughout the book it is clear that guidelines, policies and procedures are being used as ‘absolute rules’ to justify professional’s actions and behaviour. This is supported by Tricia Anderson’s chapter *“The misleading myth of choice, the continuing oppression of women in childbirth”* where she describes very lucidly how choices are effectively minimised through harassment, un-evidenced based practice and *“shroud waving”* coercive behaviours. Who really holds the power in maternity services? This question is neatly summed up in the final chapter by Kirkham on *“Choice and Bureaucracy”*.

Although much of this book deals with maternity services in the UK it is heartening to see reference being made to work by New Zealand midwives and authors Maggie Banks, Liz Smythe and Marion Hunter. In conclusion I recommend this book be purchased by Midwifery Schools, NZCOM regions and individual practitioners with this message. Don’t be complacent that you are actually providing informed choice but reflect upon this question **‘do you tell and provide information or actually listen?’**

## NEW ZEALAND RESEARCH

### Building a picture of labour: how midwives use vaginal examination during labour

Lesley Dixon RM, BA (Hons) Midwifery Practice, IBCLC

Lesley is currently Charge Midwife at Burwood Birthing Unit in Christchurch. Originally from the UK, Lesley has been in New Zealand for the last six years and has worked as an employed core and self employed independent midwife.

This article is based on a thesis submitted as partial fulfilment for the requirements of the degree of midwifery with Otago Polytechnic.

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#### Abstract

Vaginal examination has been an important part of midwifery practice for many years. However, the invasiveness of the procedure raises concerns regarding an increased risk of infection and the negative perceptions of women. This research is a small, qualitative, descriptive study exploring midwives’ use of vaginal examination during labour

in the New Zealand model of continuity of care. Six midwives working in a Lead Maternity Carer role were interviewed and provided data for thematic analysis. Three themes were identified. These were: the woman’s beliefs and expectations, the midwives’ ability to build a picture of labour, and the influence of the medical culture within the tertiary unit.

#### Introduction

Vaginal examination is a fascinating subject with two distinct elements. There is the practical skill needed to determine cervical dilatation, the descent and the application of the presenting part, as well as the interpretive skill, i.e. the knowledge and experience required to understand the findings. My use of vaginal examination is dependent on the circumstances, and I wondered about the practices of other midwives. I decided to explore this area in more depth as a midwifery two-paper thesis research project. The aim of this research project was to describe the issues that influence midwives in their use of vaginal examination dur-

ing labour within a continuity of care model of midwifery practice.

#### Literature review

Midwives and doctors have used vaginal examination as a diagnostic tool for centuries (Donnison, 1988; Loudon, 1992; Rhodes, 1995; Towler & Bramall, 1986). However, vaginal examination is associated with an increased risk of infection, which, prior to the twentieth century, caused death from puerperal fever (Donnison, 1988; Loudon, 1992; Towler, & Bramall, 1986). During the twentieth century strict regulations around the use of vaginal examination and hygiene were introduced as a means of reducing the risk of puerperal infection. In contemporary society the maternal mortality rate has been reduced due to an improved general health status of women, better hygiene and the use of antibiotics (Donnison 1988). However, vaginal examination continues to carry the risk of introducing infection. Imseis, Trout and Gabbe (1999) found that even under sterile conditions vaginal organisms were introduced into

# Building a picture of labour: how midwives use vaginal examination during labour

the cervical canal, whilst Lewis and Dunnihoo (1995) found that there were increased rates of infection in women who had vaginal examinations after premature rupture of membranes.

## Labour progress and vaginal examination

Many textbooks advocate the use of vaginal examination to assess the degree of opening of the cervix so that labour progress and the time of birth can be estimated (Fraser & Cooper, 2003; Henderson & Jones, 1997; Sweet, 1999; Varney, Kriebs & Geger, 2004). In the 1950s Friedman first described a graph of cervical dilatation in which he argued that the cervix should dilate at one centimetre an hour and that any labours which lasted longer than twelve hours would be outside of the normal range and would require intervention (Murphy-Lawless, 1998). This became known as the Friedman's curve and has subsequently become a standard for normal progress of labour (Albers, 2001; Varney, Kriebs & Geger, 2004). Prolonged labour was thought to increase the risk of mortality or morbidity for both mother and baby (Studd, 1973). Albers' (2001) research studied nine midwifery birthing sites in the United States of America, which had put in place care measures to keep birth normal such as social support, non-pharmacological methods of pain relief, activity and position change. She was able to produce descriptive statistics collected over a year from a sample size of 2,511 women. Her results indicated a slower progress of labour and she argues for a cervical dilatation rate of 0.3cm -0.5cm per hour for labouring women who have had healthy pregnancies. Increased morbidity was not found in the longest labours. She concluded that a slower labour is not necessarily associated with untoward outcomes for the mother or the baby (Albers, 2001).

The frequency of vaginal examination is often dependent on the health professional and the institution (Albers, 2001). Textbooks variously advocate frequencies of 3 hourly, 4 hourly, 6 hourly or at the midwives' discretion (Fraser & Cooper, 2003; Henderson & Jones, 1997; Sweet, 1999; Varney, Kriebs & Geger, 2004). This variation reveals a lack of agreement about the optimal timing for such examinations in labour (Enkin, Marc, Keirse & Chalmers, 1989).

## Accuracy of vaginal examination

Vaginal examination is an imprecise measure of progress especially when undertaken by different examiners (Munro & Spiby, 2000). Tufnell, Johnson, Bryce and Lilford (1989) demonstrated in their research that there were both over and under-estimation of the cervical measurement by obstetricians and midwives. A cervical simulator was used to measure accuracy with overall accuracy

exactly right in just 48% of cases. Tufnell et al. (1989) suggest that the more than 50% inaccuracy could lead to increased interventions because decisions to augment labour or perform a caesarean section are influenced by cervical assessment.

## Negative aspects of the vaginal examination

There are few procedures that can cause as much distress and embarrassment for women and yet there is little recognition of the pain and emotional distress that can be caused by repeated, regular, vaginal examinations during labour. Menage (1996) found that, out of a self-selected sample of 500 women, 100 gave a history of an obstetric or gynaecological procedure which included vaginal examinations, that they found was distressing or terrifying. These women described feelings of powerlessness during the procedures, felt that they had been given inadequate information, had experienced physical pain and had found an unsympathetic attitude on the part of the examiner. Nine of the women had a past history of sexual abuse or rape in addition to the obstetric or gynaecological trauma.

## Issues of power

In an ethnographic study from the United States of America, Bergstrom, Roberts, Skillman and Seidel (1992) examined the frequency and use of vaginal examinations during the second stage of labour. They found that vaginal examinations were common procedures in hospital births in the USA. There was a range of between two and seventeen vaginal examinations per woman during the second stage of labour. The stated purposes of the vaginal examinations were to assess maternal bearing-down efforts or to teach the woman how to push correctly. However, Bergstrom et al. (1992) suggest that there is an implicit social message by the manner in which the vaginal examination is performed which communicates the power and authority of the caregiver. There is an inherent philosophy behind this practice, which suggests that the woman's body cannot be trusted to function correctly. With a need to teach the woman where to push showing that she cannot determine this for herself and doing so several times communicates a belief by the examiner that the woman is unable to learn (ibid).

## Alternative methods of determining onset and progress of labour

Midwives have noticed other physical indicators of labour progress. Hobbs (1998) discovered a purple line, which develops along the natal cleft of the buttocks during labour and suggested that watching for this has helped her to identify a woman's progress in labour. Stuart (2000) argues that assessing the descent of the fetus abdominally is an alternative way to assess labour progress. She

suggests that the rate of descent of the presenting part during the active phase should be one centimetre per hour in primigravid women and two centimetres an hour in the multigravid woman (Stuart, 2000). Burvill (2002) used grounded theory research to build a model, which represented the midwifery knowledge about midwifery diagnosis of labour onset. She found that midwives used cues from the women to interpret the labour. She stresses that the stage of labour must be based on observable events and women's experiences, not cervical dilatation alone (Burvill, 2002). Burvill (2002, p. 605) concluded, "labour onset is unique to each individual woman and therefore can not be defined by physiological measurements, time restrictions or other medical criteria alone". The optimal frequency of vaginal examination remains unresolved. Albers (2001) stated that the midwives in her research study performed vaginal examinations periodically, when maternal behaviour or clinical signs indicated the need for one. Monro and Spiby (2000) suggest that as the vaginal examination is an imprecise measure of labour progress it should be carried out by the same examiner each time. Of the research reviewed there is limited reference to the topic from a midwifery perspective. The research to date has been set in models of care that have very little continuity of care from a midwife. Continuity of care from early pregnancy and through labour is the usual practice in the New Zealand setting. By setting this research within a continuity model of care, it is hoped that a greater understanding of the factors that influence midwives could be achieved, along with important insights into midwifery practice and knowledge.

## Research design

A qualitative research design was chosen for this research because it was thought to be the optimum way of achieving an understanding of the influences for doing a vaginal examination as stated by the midwife. Within qualitative research there are different approaches, which help to focus the research. This study has drawn on feminist principles to explore an issue that affects women and midwives; it gives value to the experiences and opinions of midwives. By giving voice to what midwives do within their practice the results of this research raise awareness of practice issues and provide an alternative perspective.

## Method

Participants in the research were six midwives who work as Lead Maternity Carers and provide continuity of care. In depth interviews were used to collect data with analysis ongoing from the first interview. The ethical principles of the research

*continued over...*

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were considered in the research proposal and adhered to, in order to ensure that the research maintained the respect and trust of the participants as well as the midwifery community. Ethics approval was gained from the Otago Polytechnic Ethics Committee.

### Sampling

It was recognised that there are many variables that can impact on decision-making about vaginal examination; however, this research was looking for commonalities despite different backgrounds, size of caseloads, and other differences. A convenience sample of six midwives was taken from a small region of New Zealand. All of these midwives worked as Lead Maternity Carers. In this role the midwife is required to provide care throughout pregnancy, labour and the postpartum period. These midwives work within the Maternity Services Notice, Section 88 of the New Zealand Public Health and Disability Act and can be self employed or employed by a facility (Ministry Of Health, 2003). By looking through the telephone book, I identified all of the midwifery practices in the chosen region. Practices that used the unit in which I worked were excluded due to ethical concerns. This left six practices with a total of eighteen midwives. Six midwives were approached from these practices and asked to participate. All of the midwives who agreed were given pseudonyms. Three midwives had more than 25 years experience as midwives. The other three had a range of experience from eighteen months to three years. Two midwives identified their practice as urban, two as rural and two as a mix of both. They attended births mainly at a primary unit and at the tertiary unit, with two midwives also providing home births.

Data were collected by in-depth, unstructured interviews for the first two participants. Transcription and analysis were ongoing from the first interview. Emerging themes were looked for and explored further in subsequent interviews with the remaining participants by the use of semi-structured interviews. A feminist framework was used to guide analysis, with feedback to the participants to honour their input and validate the thematic analysis.

### The influence of women's expectations and beliefs

The midwives discussed how the women themselves influence their use of vaginal examination. The midwives develop a relationship with each woman during pregnancy. By understanding the woman's beliefs and expectations the midwife is able to provide care that meets the needs of that individual. During the antenatal period the midwives stated that they discussed the use of vaginal

examination for assessment of labour as part of the preparation and care plan.

*"We've usually talked about it beforehand so they'll know that we'll only do an examination if it's indicated or if they particularly want us to do an examination."* Carmen (Urban practice, midwife for 2 and a half years)

There are women who want to have a vaginal examination as a way of finding out what was happening to their body in labour.

*"One of the issues is more often that the woman will ask, 'Can you examine me and see how far on I am?'"* Lucy (Rural/urban practice, midwife for 31 years)

Alternatively, there are some women who would rather not have a vaginal examination at all.

*"Others they'd rather not, so if they'd rather not then you try to hold off, or I try to hold off or not do one at all."* Tracey (Rural practice, midwife for 3 and a half years)

When a woman asks for a vaginal examination the midwife will normally do one immediately. However there were times when the midwife would delay the examination. On these occasions the midwives described how they would try to distract the woman because, by their initial visual assessment, they thought that the woman was not in active labour.

*"I don't think she's that far on but she's really like kind of hoping that she is, I'll keep delaying things in some way.... So that hopefully by the time that we do end up doing one she's dilated (sic) enough that she's OK with that."* Tracey

The midwives discussed how vaginal examination can have a negative impact on the woman's confidence in her ability to labour, particularly if little cervical dilatation has occurred. Using distraction and delaying techniques were seen as strategies to counter the potential for disappointment and demonstrate how midwives may be not only tending to the woman's physical condition but also optimising her emotional response to labour. This suggests that the midwives are using visual clues to distinguish early labour from established labour. The woman's beliefs and expectations have an influence on the midwives' practice. This is an important conclusion of the research as it demonstrates that continuity of care enables and empowers women to influence whether a vaginal examination is undertaken.

### Building a picture of labour

In this theme the midwives discussed how they work with a variety of clues to gain an understanding of a woman's labour. Vaginal examination was a diagnostic tool used by all of the midwives during labour. However, they all stated that they did not use vaginal examination in all cases and it depended on the behaviour of the woman and the speed of the labour.

*"I've conducted births with no vaginal examinations because the woman is in tune with her body and can let you know what's going on even if they're not vocalizing it in that manner..."* Kim

(Urban/rural practice, midwife for 18 months)

When asked how labour was assessed without the use of vaginal examination the midwives described a range of clues. I have categorised them into the following:

- **Contractions** – length, intensity, regularity, time between contractions
- **Woman's psychological state** – how she is feeling, e.g. needing privacy, chatty, happy, concentrating, restless, irritable.
- **Physical signs** – vomiting, show, waters breaking, pressure, grunting, perineal changes
- **Fetal signs** – descent of the presenting part, heart heard lower in abdomen, baby changing position.

This list is gained from the interviews. It is not exhaustive but is an indicator of the range of assessments that the midwives are using to guide their practice.

*"Mainly the woman's behaviour would be my most typical guide - just that process of going from mild contractions, contractions getting stronger but still being quite chatty and happy between contractions to progressing to the point in not being able to participate much in the outside world between contractions, and really head down and concentrating. So that would be my most classic ways (sic) of watching a woman progress through labour. There's also other things like the baby changing position and noticing descent whether that be with hearing the fetal heart most clearly as it come down the abdomen, watching her perineum for changes, ... and just what the woman's saying the changes that she's feeling inside, - the pressure or intensity."*

Carmen

The midwives discussed their reasons for deciding to carry out a vaginal examination on a woman during labour. These were as a preliminary to giving analgesia, if there was fetal distress and to assess the progress of labour, especially when they were unsure, or unable to assess the labour by observation alone.

*"Well it varies a wee bit if... someone say who comes in and is in advanced labour and I've had no concerns about presentation, size of baby and those sorts of things and I know that she's getting close to coming fully then I probably wouldn't do one but I would use my judgement on that. If I had any - you know - concerns at all, then I would do one fairly soon after she was admitted."* Hannah (Urban practice midwife for 34 years)

Often if a vaginal examination was done initially there would be less need for one further on in labour as the midwives were then able to assess by observation alone. They were in essence establishing a baseline and 'tuning in' their assessment skills from that point.

*"When I got there she was probably a good five or so centimetres and several hours later she'd, you*

know, things had stepped up, you could just tell, really moving along, and I thought that based on the first VE that OK so many hours had passed. This was what she was doing now so we really needed to go if we were going to go. Another one I'm thinking of she was probably 4–5 and then about an hour or two later she was really changing and she was a primip and I thought maybe I should just check cause I wasn't sure and yeah, she'd just motored on really fast and it was time to go or stay (laughs).” Tracey

Tracey admits that she will sometimes use another vaginal examination to ensure that she is ‘reading’ the labour correctly. The vaginal examination is being used to confirm the midwife’s ‘gestimate’ of labour progress. I tried to gain an understanding of how often during a labour that vaginal examinations were carried out by these midwives. They discussed using their judgement for each individual woman.

“Prolonged labour I would assess them probably around three hourly so and again that depends a wee bit if I think they're making really good progress then I'm not rigid on that. So if I can see that their contractions are building up and the progress is picking up then say I probably would go like perhaps more four or five hours and then reassess but if I really thought there was no progress I might even cut down to two hours.” Hannah

Vaginal examination was used to get a fuller understanding of the woman’s labour. Often the midwives were aware of a mismatch or an indicator that was not as it should be in a normal labour. It appeared to be quite difficult to articulate how they knew that normal progress was not being made.

“Sort of vaguely I've sort of felt unsure and sort of felt no I am going to at 3 hours check it because I've just sort of felt that maybe things are not progressing .... but I wouldn't have been able to tell you what I thought you know, whether it was maybe her contractions were irregular or something or the pattern of her contractions or the baby. Something was telling me that things weren't just quite right and I don't know.” Hannah.

This type of knowledge can be described as intuitive knowledge, which arises though no logical or rational thought process can be articulated to account for it.

In this theme the midwives are describing midwifery knowledge, which is based on a combination of scientific knowledge, midwifery experiences, intuition and judgement. A picture of labour is being built which is based on various clues much like a jigsaw puzzle. Each part builds the larger picture. A fuller understanding is only achieved at the end when the whole picture can be seen and some of the clues can be fitted in retrospectively.

### The influence of the medical ‘culture’

The midwives that participated in this study looked after women who gave birth at home, in primary

units and in the tertiary unit. They discussed the differences in expectations between their own ways of observing a woman’s progress and that of the midwives and the doctors at the tertiary unit. Within the tertiary unit there was an expectation of frequent vaginal examinations during labour and labour progress was all-important.

“I think I feel more pressure to do a vaginal examination if I'm in at (tertiary unit) because that's the name of the game there.... Progress.”

Tracey

Some of the midwives discussed how in their own practice in a primary setting they liked to use the vaginal examination tool judiciously. However there was an acknowledgement that if subsequently a problem developed, there could be criticism from the staff at the tertiary unit.

“If I'm practising at (primary unit), I would do a vaginal examination for a reason, not as a four hourly routine, but you've got to be really strong. Like if this women went through to (tertiary unit) you know that would be something that you would certainly be questioned about.” Sharon

During the interviews all of the midwives discussed differences in the findings between what they had found during a vaginal examination and what the doctors subsequently found.

“...when we transfer and the registrar has also done an internal I find that they usually feel that the dilatation is less than when I assessed....So I actually kind of feel that like they underestimate my dilatation but for a while I thought I'm not very good at this.” Tracey

For the less experienced midwives there was the fear that their judgment and ability were at fault, whereas the more experienced midwives felt that they were accurate and that it was the doctors who were not. Sometimes there were significant differences in cervical measurement between the obstetrician and midwife. The midwives thought that these differences were a sign that there was a problem, as it appeared to occur during a prolonged labour, a rotation of the baby or following spontaneous rupture of the membranes.

“They might have been 7 centimetres and then they go back to 5 or 6 I really think that must happen now because you can be absolutely sure that they're 7 centimetres but there they are only 5 or 6.” Lucy

“You don't think it's to do with interpretation?” Lesley

“I don't think it could be really because it's very definite, isn't it, if there's less cervix once you get to about 7 you're mainly feeling how much is left, aren't you? Whereas, when you're about five, you're feeling across the cervix, so no, not really. I have examined people later myself and I've noted that they can.” Lucy

Another aspect of the expectation around vaginal examinations, within the tertiary unit, is that they should be undertaken to confirm full dilatation. The midwives in the study discussed their preference to wait and watch, reserving the use of

vaginal examination for if there were no progress with pushing.

“...the woman's got to fully dilated and she's wanting to push and the medical staff still want you to check before allowing her to push, that kind of mentality. I guess my choice would have been to just wait to see what happens and if there was progress that's great and carry on and if there's not then sure then check.” Carmen

In this theme the midwives have discussed the differences in their practice and those of the doctors and midwives in the tertiary unit.

### Discussion

This research took place within a midwifery model in which continuity of care was a key factor. The goal was to explore whether knowing the woman and her family would make a difference to how a midwife provided care during labour.

The first theme suggests that knowing the woman helps to guide the midwife in her use of vaginal examination. The woman’s beliefs and expectations were discussed during the antenatal period along with the preference for or against a vaginal examination when in labour. During labour the midwife negotiates with the woman’s wishes and beliefs as well as using her own judgement and practice knowledge. By working in this way the midwife is operating within a relationship that is based on partnership. Guilliland and Pairman (1995) suggest that continuity of caregiver is fundamental to a partnership relationship because the woman and the midwife have the time to get to know each other and build up a relationship of trust. By understanding the woman’s beliefs the midwife is able to provide care that has been planned with the woman.

The second theme suggests that midwives have formed their own set of beliefs around the use and frequency of vaginal examinations. These beliefs can be described as;

- keeping vaginal examinations to a minimum,
- watching the woman and interpreting the signs that she displays as a way of ‘reading’ the labour,
- being alert to clues that indicate that there may be a problem at which point a vaginal examination is used as a tool to increase the midwife’s knowledge and ability to build a picture of the labour.

The midwives discuss using their judgment on the necessity for a vaginal examination based on each individual woman and each situation. Providing continuity of care enables the midwife to have a better understanding of the woman both prior to labour and during labour itself. Being with the woman from the beginning of labour through to the birth also provides a fuller understanding of the individuality of the labour process. The midwives used vaginal examination more frequently when they needed to gain a fuller understanding of the woman’s labour, when the observed clues

continued...

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and signs were less clear, or a problem was felt to be developing. Articulating the 'why' and 'how' there was an awareness of a concern was difficult for these midwives and can be described as intuitive knowledge. This is often a skill that is acquired with experience (Davis-Floyd & Davis, 1997). Benner (1984) suggested that an expert clinician's knowledge is hard to teach because it is embedded in perceptions rather than the particular elements of procedures. She continues that it is difficult to capture the explicit, formal steps in the mental process that enable an expert clinician to recognise when there is a need for action (Benner, 1984). Midwives work with women during pregnancy and labour as part of their regular work practice. Building expertise in this area is an ongoing process. The midwife is continually adding and adjusting her knowledge and expertise with each new woman and each new labour. All of the participants described using the vaginal examination when they thought it was necessary and were comfortable with their decision-making regarding what prompts them to examine and the frequency of use of the examination.

The third theme identified the medical culture of the tertiary unit and the strong pressure to do vaginal examinations on a regular basis to assess labour progress. The midwives' ability to 'read' a woman's labour and individualise her labour care was undermined. Within the interviews all of the midwives discussed differences in cervical interpretation. In this study the midwife, as the Lead Maternity Carer, was the single examiner during labour until referral to an obstetrician. Despite this they were sometimes thought to be inaccurate in their assessments. At times there were significant differences between the midwife's and obstetrician's assessment of dilatation; the midwives suggested this occurred most commonly following rupture of membranes or rotation of the baby's head. Stables (1999) states that it is the increasing pressure of the presenting part on the cervix that aids dilatation. It is possible that with the loss of this pressure following a change to the fetal position or membrane rupture that there could be a corresponding transitory change to the cervical dilatation. This suggests a variability as well as subjectivity that could be occurring from examination to examination.

At the tertiary unit there was an expectation that the second stage of labour be diagnosed by vaginal examination. Some of the midwives described a 'fear' of appearing unprofessional for 'allowing' women to push when the cervix was not fully dilated. The concern being that by pushing at this time there was a risk of cervical tearing or an increase in oedema to the cervix. Chalk (2004) in her discussion of the second stage suggests that spontaneous maternal pushing efforts may occur before or after full cervical dilatation. In cases where there is malposition such as occipital

posterior presentation there is often a premature urge to push when the cervix is not fully dilated. In these circumstances there may be an increased incidence of trauma or oedema. However, when there is a normal anterior presentation with a head low in the pelvis and the woman has a strong urge to push she should do so even if there is a rim of cervix as there is no research that reports vaginal lacerations or increases in oedema in this situation (Chalk, 2004). This supports the midwifery culture of observing for progress rather than confirming full dilatation with vaginal examination every time.

This research has provided a valuable insight into how six midwives practice in one area of New Zealand. Although it cannot be generalised to anyone outside of the research, the qualitative nature allows in-depth insights and has the potential to produce resonance for other midwives when they are presented with the themes. A greater understanding has been gained into how the continuity of care model affects the working practice of the midwife. Further research is required into the woman's perceptions of the vaginal examination during labour within the New Zealand context of continuity of care.

### Conclusion

The midwives in this research discussed the building of a relationship during the antenatal period when the expectations and beliefs of both parties are explored. The midwives suggested that the nature of their use of vaginal examination during labour was dependent on the individual woman and labour. They stated that they did not do vaginal examination as a routine practice and sometimes did not need to do one at all. They discussed using vaginal examination to establish a baseline, when they needed more information, or at the woman's request. They therefore kept the use of vaginal examination to a minimum and more used their own observational skills to assess progress of labour. Woven throughout this is the knowledge that if they transfer to, or work at, the tertiary unit there will be an expectation that vaginal examination be used to assess labour on a more frequent and routine basis. For these midwives every labour is a negotiation. The key element to this negotiation is the continuity of care because, by knowing the woman well, the midwives are able to fully utilise their knowledge, experience and judgement along with sensitivity towards the woman's beliefs, expectations and wishes regarding assessment of labour.

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Page, L. (Ed.). (2000). *The new midwifery*. London: Churchill Livingstone.

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