New Zealand College of Midwives (inc)

JOURNAL

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

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Promote women's health issues as they relate to childbearing women and their families.
Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
Provoke discussion of midwifery issues.

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EDITORIAL COMMENT

By Health Minister Annette King

Happy New Year. This year promises to be busy, particularly with bedding in new legislation providing greater public safety around the delivery of all health services and providing a stronger framework for midwives, along with all health practitioners, to maintain and build competence. The Health Practitioners Competence Assurance Act, passed in September 2003, provides a framework for regulating health practitioners to protect the public where there is a risk of harm from the practice of a profession.

Midwives, as with all health practitioners, work in an area where their practice involves some risk of harm to patients.

In December 2003 the Midwifery Council was established. In September this year the Council will assume responsibility for registering midwives and reviewing and maintaining the ongoing competence for midwives. The Council has already met once this year and I know they have a very busy programme of work for 2004.

I wish them all the best as it is a vital job for both midwives and the public.

It's important that midwives not only be regarded as competent, but that they be able to demonstrate that. This Act gives a valuable mechanism for doing that.

The key thing about the Act is that it provides a framework for ensuring the life-long competence of all health practitioners. Along with midwives, three other responsible authorities were established in December 2003 to join the existing registration bodies. All are working towards September this year when the full provisions of the Act come into force.

The new Midwifery Council will for the first time regulate your profession as a stand-alone authority, and will be concentrating in the first nine months on developing scopes of practice for midwives.

The authority will recognise, accredit and set programmes to ensure ongoing competence of midwives and will also consider applications for annual practising certificates from September 2004. I understand the Council will shortly be consulting with midwives over their scopes of practice.

I am confident the College of Midwives will actively engage with the new Council in that process.

Along with other health professions, midwives will be part of a consistent accountability regime and also have clear guidelines on your demonstrated scope of practice - the area of health care in which you are able to work.

There will also be a change in the way midwives are disciplined. Midwives will face similar processes and procedures to other health practitioners through a single Health Practitioners Disciplinary Tribunal. This consistency of approach will help to build trust in the health system through ensuring a fair and consistent process for disciplinary matters regardless of health profession.

I am confident that midwives appearing before the disciplinary tribunal will be a rare event. That will be helped by the on-going emphasis on building competence, as well as the Health and Disability Commissioner's office approach to resolving complaints with an emphasis on rehabilitation rather than punishment - both approaches I fully support.

I look forward to working with the new Midwifery Council, as will I'm sure the College of Midwives, to make the introduction of this legislation a success. Working together we will achieve our aims of providing safer services and collectively improving our skills.

New Midwifery Council established one hundred years after first midwifery registration in New Zealand

By Sue Bree

President NZCOM and member of the first Midwifery Council

As many of you will now be aware, the inaugural meeting of the Midwifery Council was held in Wellington on 12 February.

Minister of Health, Annette King, appointed the new Council on 16 December 2003 and it consists of eight members. There are two lay members, Sharron Cole and Rea Daellenbach and six midwife members – Mina Timutimu, Hope Tupara, Helen Mary Walker, Thelma Thompson, Sally Pairman and myself. The Council membership provides a good mix of Māori/Pakeha; consumer/practitioner; primary/secondary maternity hospital and independent midwifery practice as well as midwifery education. At our first meeting we all expressed a sense of honour in being associated with this long awaited milestone for our profession. At the same time we feel both excited and slightly daunted at the significant amount of work that is required to operationalise the Health Practitioners Competence Assurance Act on behalf of the public of New Zealand.

Sally Pairman was elected Chair and Sharron Cole Deputy Chair of this first Midwifery Council. Both of these women are well known to us all, having been at the forefront of the development of our profession, as we know it today. A midwife and a consumer member filling these two important positions further reflects our partnership model in all aspects of midwifery governance and practice in New Zealand.

Another major decision made at the inaugural meeting was to contract RBS (Registration Boards Secretariat Ltd) to fulfil the administration functions for the Council. RBS is an independent company that works with the Boards/Councils of eight other health professions. The company is therefore fully cognisant of the operational requirements of the HPCA and has done considerable generic work that will be available to us. RBS will work with us to appoint and employ a Registrar and deputy Registrar for the Midwifery Council. This is also our most economical option, as it must be noted that no formal financial provisions have been made for the establishment of the Midwifery Council. Whilst the Nursing Council has signalled its intention to provide some funding to the Midwifery Council, it is likely that the Annual Practising Certificate fee will need to rise further next year. Annual Practising Certificate fees are the only form of ongoing income available to the Council and the relatively small numbers of midwife practitioners in New Zealand means that economies of scale are limited in meeting the costs of regulation and the disciplinary functions of the new Professional Conduct Committee (to be established by the Midwifery Council) and the new Health Practitioners Disciplinary Tribunal.

The timeframe for our initial work is tight in that the Council is required to be fully functional by September of this year. Our initial priority is to develop the Midwifery Scope of

Rhondda Davies
introduction to this column

I was delighted when Maggie Banks agreed to write the first Midwifery Practice Wisdom column. Her words appeared in the previous issue of the Journal, October, 2003. In this issue I am equally delighted to pass on to you a response to Maggie's thoughts from Sian Burgess, with Sian's kind permission. Following this is Maggie's reply.

In her reply, Maggie has reiterated our vision for the column. Apart from encouraging further responses from you regarding Maggie's topic and Sian's concerns, I urge you to consider contributing 300 to 500 words of a story from your *own* practice, which illustrates perfectly for you a frequently made observation that influences your practice in some area of midwifery. This midwifery-wisdom-based practice approach may not necessarily have been *scientifically* researched as yet, but has proven to *you* to be a trustworthy "way through" because of confirmation again and again though your observations and experience. Send any comments to Rhondda.d@clear.net.nz.

Practice and registration requirements including competencies for registration as a midwife in New Zealand. We are fortunate that we have a starting place with the World Health Organisation/International Confederation of Midwives Scope of Practice of a Midwife as amended by NZCOM for the New Zealand context. We also have existing qualifications and competencies for registration as established by the Nursing Council. However, this is an opportunity to review these requirements and make sure that in this new regulatory era, the parameters and standards of midwifery practice and competence reflect the expectations of both the public and the profession. As consultation is a time-honoured method of midwifery decision-making, we will be seeking guidance from you on specific issues and urge you to respond. Having waited 100 years for a Midwifery Council in New Zealand we do want to get it right!!

Sian Burgess, Midwife
Comment on reading Maggie's words

It was wonderful to see the huge breastfeeding component in the latest issue..... congratulations. I must however admit to a sense of unease with regard to Maggies's Practice Wisdom Article. Having recently attended the first of her midwifery intensives I find her to be charismatic and a real inspiration to midwifery knowledge. The article appears very credible but I am concerned about the potential medico-legal aspects of midwives now not listening to the fetal heart (FH) in labour on the basis of this article.

Midwives have listened and interpreted the baby's heartbeats in labour for a long time and Maggie is correct in stating that there is no evidence to support the recommended intervals for intermittent auscultation. The article asserts that, in certain situations, it is possible to replace 'listening' with observation of the baby's movements in labour. This seems to me to be a giant leap. We do not understand the significance of fetal movements in labour and I doubt whether it is 'wise' to replace listening to the heart with the presence of movements as the only determinant of the baby's well being in labour. In her overriding concern not to disturb physiological birth she states that the invasion of the "birthing head" may be more intrusive than the audible sound of heart tones or the reassurance that the midwife can hear the heartbeat. By the same count not listening to the heart beat can lay us open to charges of negligence for not following commonly accepted midwifery practice. As a result of Maggie's article and workshop I will observe and record fetal movements in labour and use the information as an adjunct to assessing the baby's wellbeing.

Women engage midwifery care for a wide variety of reasons and care in labour is one of them. Within the New Zealand College of Midwives Handbook for Practice, p.28 Second decision point in labour *"assess baby's well-being, including heart rate"*. Section 88 notes *"regular monitoring of the progress of the woman and baby"*. Whilst neither is prescriptive, there is a requirement that we perform certain services and I believe listening to the baby's heart beat to be one of them. Challenging the significance of routine midwifery procedures is useful and necessary, but I will continue to listen to the baby's heart beat in labour and listen after contractions and at times use a doppler, until there is good data to support not doing so.

References

Ministry of Health. (2002). Maternity services notice pursuant to Section 88 of the New Zealand and Public Health and Disability Act 2000. Wellington: Ministry of Health.

NZCOM. (2002). Midwives' handbook for practice. Christchurch, NZ: NZCOM.

Maggie Banks, Midwife
Encouragement to Sian to publish the letter and reply to her comments

Hi there. The Practice Wisdom section of the Journal is all about observation, reflection and a forum to describe midwifery practice as it occurs. I was asked for *"a short story relating to your practice which confirms for you a clear example of pure midwifery knowledge which may strike a cord in others. Or perhaps an exemplar, perhaps just a frequently made observation which has shaped your practice but would not be found 'written up' in the journals (yet!)."* For me that is about describing midwifery knowing, hence my contribution. Your own response to now observe baby's in-labour movements is exactly what the column is about and I hope other midwives do the same. And as long as midwives contribute their observations, we will start to build up that knowledge. Thanks. I constantly hear of midwives embracing all sorts of interventions but the rationale is not whether it benefits the woman or baby but rather how it protects the midwife. You should send your letter - as is - to the Journal, specifically to Rhondda Davies, as debate is essential to explore and add depth to a very real issue for midwives - how practice can be shaped by medico-legal implications. This sort of debate really indicates we are coming of age as midwives in New Zealand and are prepared to address the hard questions. As I am sure you would expect (!) I will certainly participate in the debate.

The cultural capital of midwifery: unique foundations for self-employment

Patrick Firkin RPN, BA (Hons)
Labour Market Dynamics Research Programme, Massey University

Although he is not a midwife, Patrick has worked for many years in the health sector, principally as a registered nurse within the mental health field. Currently he does occasional research for the Labour Market Dynamics Research Programme (LMD) at Massey University. However, most of his time is devoted to studying towards a PhD in sociology.

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Abstract

This paper begins by conceptualising midwifery's philosophy, and the practices underpinned by it, as the cultural capital of midwifery. It is then argued that such capital, both in nature and degree, serves as a unique and substantial foundation, not only for professional practice, but also for self-employment. This is achieved through the particular and various ways that it links consumers and professionals, and in the distinctive approach to care that it informs within the larger maternity market. Importantly, it is also acknowledged that the cultural capital of midwifery exists within a dynamic context of tension and change.

Introduction

As part of a larger project examining the changing dynamics of New Zealand labour markets, a number of case studies were undertaken with various groups.[1] One of these explored the experiences of caseloading midwives, particularly those in self-employment. While the case studies were primarily intended as a form of labour market analysis, as often happens, new insights and understandings also arise in relation to the groups taking part in the research. This was the case with the midwifery study and one aspect of the findings that relates as much to that professional group as to the wider examination of labour market dynamics is reported on here.

In brief, the midwifery case study (Firkin, 2003a) examined caseloading midwifery by interviewing ten midwives from the greater Auckland area on their experiences of working this way. While four of the group were working for various organisations as employee caseloading midwives, the majority were self-employed. Although most of this latter group did not see themselves, first and foremost, as business people or self-employed, this is one way that they can be viewed.[2] Consequently, as part of the analysis a model of entrepreneurial activity, known as entrepreneurial capital (Firkin, 2001b; 2003b), was employed.[3] This model aims to expose the multifaceted nature of entrepreneurial activity by highlighting the range of resources that entrepreneurs possess or acquire, and then employ in starting and running a business. These resources can be seen to belong to one of five forms of capital delineated in the model. These are human, social, economic, physical and cultural capital. It is the contention of this paper that within the context of midwifery the profession's philosophical foundations can be conceptualised as the cultural capital of midwifery. Cultural capital in this form, it will then be argued, intrinsically provides, by nature and degree, a distinct and substantive foundation for self-employment in midwifery.

In order to make this argument, which I believe offers midwives an alternative perspective on their independent forms of practice, I will begin by outlining the model of entrepreneurial capital. Following this, the concept of cultural capital as used in the model is developed. From there it is shown how midwifery's philosophy and practice can be conceived of as the cultural capital of midwifery within the context of the model of entrepreneurial capital. Finally, I discuss some of the tensions that pervade the cultural capital of midwifery as it is drawn on by midwives and consumers, and consider the implications of these tensions.

The model of entrepreneurial capital

The concept of entrepreneurial capital has been developed more extensively elsewhere (Firkin, 2001b; 2003b) as a resource-based approach to exploring aspects of the entrepreneurial process. It rests, first and foremost, on a very broad conceptualisation of entrepreneurship that, following Reynolds (1991), portrays entrepreneurship as a continuum of activities ranging from self-employment to the creation of substantial organisations. As was recognised by some of the midwives who were interviewed, self-employed caseloading midwifery clearly falls within this continuum. That said, many of them pointed out that although caseloading midwifery can be a form of self-employment, and thus has to be approached in business terms, this is not necessarily the primary way it is understood by midwives.

"I think there are obviously some midwives who see themselves as operating a business. They clearly identify with being self-employed and this is the childbirth business that they do. I don't think most midwives see themselves as that. They see themselves as self-employed, they want to be professional, but … the business side of it … someone else can sort of do that" (cited in Firkin, 2003a, p. 25).

I was keen to honour such a sentiment and my intention in applying the model was not to reduce the many rich dimensions of midwifery practice to a strictly business or economic perspective. Indeed, one factor behind the development of the model was to expose the multifaceted nature of entrepreneurial activity and to counter an all too frequent concentration on financial or business aspects.

As has already been briefly noted, the model of entrepreneurial capital generates an analysis of entrepreneurial activity by identifying all the resources that an entrepreneur may possess or acquire and then employ in the entrepreneurial process. These are classified under different forms of capital – human, social, cultural, economic and physical. Each form of capital is broadly defined so as to encompass a wide range and number of resources. In order to explain in detail the model of entrepreneurial capital I want to ground the discussion within the midwifery context.

Like any entrepreneur, the midwife thus identifies and develops their entrepreneurial capital according to what is needed

Any midwife considering self-employment will possess a range of resources, and the mix for each person will vary. This is their total capital. However, not every aspect of that total capital will be appropriate or necessary for becoming a self-employed midwife. Similarly, the nature of the specific opportunity, say in terms of the practice or collective the midwife is going to be part of, will have different resource configurations and thus make different demands on the midwife. The midwife's entrepreneurial capital is, therefore, made up of the components of their total capital that have some worth – defined as entrepreneurial value – in relation to the specific context and venture. Like any entrepreneur, the midwife thus identifies and develops their entrepreneurial capital according to what is needed, by extracting entrepreneurial value from their existing total capital and accessing that which is outstanding. They can also convert some of their existing resources into

others that are useful for being self-employed. This must be seen as a dynamic process since resource needs can change across time in relation to the lifecycle of the enterprise, the people involved, as well as internal and external circumstances.

While the preceding discussion has presented the model of entrepreneurial capital from the perspective of the entrepreneur,[4] it can be viewed and employed in other ways. For instance, a particular form of self-employment such as midwifery can be analysed in terms of entrepreneurial capital to provide a profile or configuration of the capital requirements for it.[5] Although there may be some non-negotiable demands in any such profile (such as professional qualifications in the case of midwifery), a resource configuration need not be viewed in a prescriptive sense since the very point made by individual analyses is that people undertake similar forms of self employment in different ways and with differing resources.

Before moving on to the main focus of this article, which is an examination of the role of cultural capital in relation to self-employment among midwives, I want to end this short overview of the model of entrepreneurial capital with a brief outline of what each of the other forms of capital encompasses within the model of entrepreneurial capital. Following Shanahan and Tuma (1994, p. 746), human capital is seen as *"a compendium of all the traits and abilities that make human beings economically productive in a society"* and includes both innate and acquired characteristics. Thus, it includes but goes beyond education and training which, together with work experience and skills, are the usual, but limited, factors considered in relation to human capital. Very broadly, social capital can be seen as the ability to secure resources or benefits as a result of people's membership in social networks or other social structures (Portes, 1998; 2000a; 2000b). It has both a familial (Firkin, 2001a) and more general dimension. The former considers how those within a family contribute to entrepreneurial activity undertaken by a family member. The latter is seen in the ways that networks of varying type and makeup are important, both personally and professionally. The financial demands associated with engaging in self-employment are considered under financial capital. Physical capital is made up of the *"tangible assets necessary for the operation of the business"* (Greene & Brown, 1997, p. 164) or, in other words, facilities and equipment.

Cultural capital

The understanding of cultural capital used here comes originally from the work of Bourdieu (1986). He identifies cultural capital as having three dimensions. One of these, which encompasses qualifications, can be incorporated into human capital. A second dimension concerns *"cultural goods (pictures, books, dictionaries, instruments machines etc)"* (Bourdieu, 1986, p. 243). These have a material character and can thus be owned simply by utilising economic capital. However, for their intrinsic or symbolic value to be realised, presupposes the embodied state of cultural capital. This comprises *"long lasting dispositions of the mind and body"* (Bourdieu, 1986, p. 243-244). Harker (1990, p. 34), identifies some of these as *"the body of knowledge, the tacit understandings, the style of self-presentation, language usage, values etc"* that are shared among groups.

It is the contention of this paper that within the context of midwifery the profession's philosophical foundations can be conceptualised as the cultural capital of midwifery. Cultural capital in this form, it will then be argued, intrinsically provides, by nature and degree, a distinct and substantive foundation for self-employment in midwifery.

From this starting point, de Bruin (1999) opens up the idea of cultural capital further. Whereas Bourdieu emphasises its class nature, de Bruin pays attention to the notion of ethnicity and argues that although people from outside the dominant culture are often at a disadvantage, they still possess embodied cultural capital that is shared with others because of common ethnicity. Rather than focusing solely on how a lack of dominant cultural capital disadvantages groups, de Bruin highlights how the cultural capital shared within groups can, under certain conditions, provide positive resources and the basis for opportunity. Cultural capital can thus be seen to have the potential to be utilised in an entrepreneurial sense to provide goods and services in particular ways and forms that are preferred and valued by groups. Aldrich and Waldinger (1990, p. 112), expand the possibilities that de Bruin opens up by arguing that the term 'ethnic' can be used to describe any collective whose *"members have some awareness of group membership and a common origin and culture, or that others think of them as having these attributes"*.

The cultural capital of midwifery

In developing the idea of the cultural capital of midwifery I want to firstly establish how midwifery constitutes an ethnic group within Aldrich and Waldinger's (1990) terms. The emergence of contemporary caseloading midwifery is the result of the efforts of consumers and midwives who fought for the legislative changes that finally occurred in 1990. The desire for change represents their common origin that is now transformed into a desire to maintain and advance what has been achieved. As such, midwifery is a collective comprising both practitioners and consumers who shared, and continue to share, a sense of belonging arising from their commitments to a specific culture. The development of caseloading midwifery in this context has a clear gender dimension and can be alternatively understood as a *"female professional project"*, as Witz (1990, p. 679) describes it.[6]

The culture shared by consumers and practitioners represents the drawing together of distinctive values, beliefs, attitudes, skills, practices and knowledge. As such, it entails a particular disposition to, and perspective on, childbirth that views normal pregnancy and childbirth as healthy processes and seeks to help women give birth naturally, safely and confidently (NZCOM, 2002a). Amongst its philosophical tenets are those of women-centred care, partnership and continuity of care. The interconnections between these various threads are made explicit by the New Zealand College of Midwives: *"the partnership relationship of the midwife and the woman is the foundation for women-centred midwifery care"* (NZCOM, 2002a) and *"midwifery care takes place in partnership with women. Continuity of midwifery care enhances and protects the normal process of childbirth"* (NZCOM, 2002b). Such philosophical orientations underpin and guide how midwifery care is practised. Collectively, these orientations to maternity care, and the practices and experiences that result, make up what I call here, the cultural capital of midwifery. This capital is shared by client and practitioner. That is, the cultural capital of midwifery provides the essential connection between consumer and midwife in two ways. Firstly, it defines the care that many women seek and that caseloading midwives offer. Secondly, and following from this, it frames the care that a client receives and that the midwife provides such that it is embodied in the woman's birth experience and the midwife's practice. As one midwife so eloquently put the latter: *"the skills of the midwife are in herself, in her eyes, her hands, her ears, her knowledge"* (cited in Firkin, 2003a, p.73).

Indeed, as will now be considered, the self-employment of midwives is predicated on the shared

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The cultural capital of midwifery: unique foundations for self-employment

nature of this capital. Like any business, midwifery needs customers that want to take up the services/products they provide and must position itself relative to others in that marketplace. The cultural capital of midwifery plays important functions in an entrepreneurial sense in relation to these issues. One critical function is as the key linkage between consumer and practitioner. A second concerns how the cultural capital of midwifery differentiates midwives from others within the maternity care market. I shall deal with each of these in turn.

Following Shanahan and Tuma (1994, p. 746), human capital is seen as "a compendium of all the traits and abilities that make human beings economically productive in a society" and includes both innate and acquired characteristics.

While the philosophy of midwifery as a whole underpins how care is provided and practised, it is in the model of partnership, as articulated by midwifery, that the linkage between consumer and practitioner is constructed such that it offers a unique mechanism to maintain and grow entrepreneurial value. This is worth examining in a little more detail, beginning with an exploration of what is meant by partnership. As has been noted, partnership has been a fundamental feature of the re-emergence of midwifery. It can be seen to operate on various inter-related levels, most obviously at the personal/practice level and at the political/organisational level. Since "*women's participation has given midwives a public, legal and socially sanctioned mandate for practice*" (Guilliland & Pairman, 1995, p. 19) midwives, for their part, have acted to develop a profession in such a way that "*all of its organisational, regulatory, disciplinary, and educational functions are defined and implemented in partnership with women*" (Guilliland & Pairman, 1995, p. 20). Thus, alongside the partnerships that individual pregnant women develop with their midwives, consumers are active partners in the policy processes and decision making systems which steer, develop and oversee midwifery as a profession. Their involvement in the review process is an example of how this can be played out. Partnership, as an ongoing and reflexive process, evolves alongside and as part of the practice of midwifery. That is, women as consumers shape the notion of partnership which is, itself, part of the approach to midwifery care that they are also contemporaneously shaping. The particular approach to partnership adopted by midwifery stands in stark contrast to "*the usual expert distancing practices of most professions*" (Guilliland & Pairman, 1995, p. 20).

The special character of this function of the cultural capital of midwifery is that the provision of midwifery care is continually renegotiated by both parties with each intimately and necessarily involved in the ongoing process. This has important implications for the relationship between client and midwife which is vastly different, on a number of levels, from that of a customer and business in many other areas of commercial activity. For instance, since any business would clearly fail if demand disappeared, it must consequently have some connections to its market and be getting feedback in order to modify its product/service according to demand. However, this is usually by distant and infrequent market research mechanisms or crude demand feedback. In the case of midwifery, the notion of partnership directly involves consumers in the 'production' and 'marketing' processes, as it were, thereby shaping the service to their needs and demands whether at the level of policy and organisation, or during the intimate moments of birth.

The second significant function that the cultural capital of midwifery plays in enhancing entrepreneurial value is by differentiating midwifery-based maternity care from other styles, most notably the medical model. This has occurred because consumers and midwives sharing the cultural capital of midwifery have opened up the possibility, facilitated by legislative changes, for a 'niche' market. The philosophical tenet of continuity of care illustrates this differentiation. While all maternity-care professionals might claim to provide such continuity, consumers being cared for by other professionals may "*still enter a hospital for the birth not knowing the midwife who will be her primary caregiver during labour. In some instances, especially when labour lasts longer than one 8-hour shift, more than one midwife might be in attendance*" (Fleming, 1996, pp. 353-354). By contrast, caseloading midwifery remains committed to an interpretation of 'continuity' that involves one Lead Maternity Carer (LMC) having "*responsibility for all modules of care*" (NZCOM, 2002c) and directly and continuously providing that care.

The cultural capital of midwifery thus provides the basis for the establishment and maintenance of a specific market within the wider maternity care marketplace. The comments from this midwife sum up the role that the shared cultural capital of midwifery plays in this regard.

There is a sense out there in the community of who we are, so women self-select in some ways to come here. So that gives us a huge advantage that we'll tend to be working with women who are aligned to the way that you want to provide care. So for women who say want to have an obstetrician, want to have an epidural as soon as they want to go into labour, want to formula feed their babies, they would be unlikely to be attracted to come here, just by the nature of the environment really. And so it means that because there is an enormous amount of satisfaction of doing this job and doing it well, you want to work with people you can partner (cited in Firkin, 2003a, pp. 35-36).

Much of this has also become true of caseloading midwives within institutions since consumer demand has forced a revision of the standard ways of working even within such settings.

The role of cultural capital of midwifery stands in stark contrast to other groups of self-employed people where cultural capital, as defined in this model, is less apparent and often less important. Other research utilising the model with self-employed people in trades, for instance, showed this to be the case (Firkin, 2001b; 2003b). Thus, for example, becoming or engaging a self-employed electrician may involve far less consideration of cultural capital than is the case for becoming or engaging a midwife. This is likely to be a reflection of the particular business activity with cultural capital being more important in health care and other personal services than in the trades and other such businesses.

Some tensions in the cultural capital of midwifery

Having made the argument for the importance of the cultural capital of midwifery to the entrepreneurial dimensions of midwifery, I want to now consider some of the tensions that pervade it. The first concerns the occasional moral panics that erupt around midwifery. As one of the midwives who was interviewed put it:

There have been periods or times when there has been a lot of really negative media about midwives … Midwives are dangerous, look at what it says here in the paper, you know. Midwives are drowning babies, that was last week. …its awful stuff to say (cited in Firkin, 2003a, p. 19).

The result of these panics is, as the same midwife observes, "*a fallout, so that women will then think well I can't possibly have this dangerous person look after me*" (cited in Firkin, 2003a, p.19). A further threat of this sort can be found in the various forms of resistance from the medical profession to caseloading midwifery practice. Although, as some of the interviewees noted, relations at the level of individual practitioners can be sound, there are still issues at the group level.

A second issue concerns the rise in the numbers of women opting for a midwife as their LMC since midwives have been permitted to practice independently. The proportion making this choice is currently around 70 percent (NZCOM, 2002d). However, such growth should not simply be seen as an outcome of the cultural capital of midwifery for two reasons. Firstly, following midwives being allowed to practice independently the number of GPs performing deliveries has dropped considerably (National Health Committee, 1999). This means that there are fewer choices in the maternity care market. Some of those interviewed confirmed this in recounting stories of women having extreme difficulties finding a LMC. Secondly, as was noted by some of the midwives who were interviewed, outside of those individuals and groups involved in the push for legislative change and others who have subsequently shared a birthing experience with a caseloading midwife, there are still many people in the wider community who do not have a true appreciation of what midwives do, how they work, and what their philosophical disposition is.[7] Anecdotally, my own experiences among family and friends supports this view. This should not be seen as running entirely counter to the earlier quote which argued that there was a greater awareness among women of what midwifery is all about. Rather, it reflects an evolving marketplace where the majority of care is increasingly being provided by midwives. While this is creating a growing awareness among consumers, it has not yet reached all the population. Summing up a positive view of this are the comments of one midwife:

I think that the community very much as a whole is beginning to see us more as who we are, the independent practitioners that we are, the autonomy that we have, the fantastic job that we do and that we are providing for what women want (cited in Firkin, 2003a, p. 19).

The important part of this statement for my purposes is the proviso within it that perceptions and understandings about what midwifery believes and practices are "*beginning*" to be taken up by the wider community.

The final issue I want to discuss stems from the fact that a philosophy becomes actualised in a range of ways through people interpreting and practicing it. Some examples may serve to clarify and illustrate what I mean. For instance, while midwives interpret the concept of continuity of care differently from other maternity care providers, as was evident from the interviews this particular philosophical disposition still allows midwives to provide continuity of care in a range of ways.

As another example, the issue of partnership can also be seen as a broad tenet of midwifery philosophy that is understood and practised in different ways. It can also be contested in some respects. For instance, a few of the interviewees spoke of a desire among some midwives to no longer have consumers as part of their review process. Other dimensions of the debate on partnership can be found in the literature as is evident in the following exchange drawn from this journal. Skinner (1999) argues that although she feels that partnership at the group level has been, and continues to be, productive, she has not found it to be a particularly useful approach at the practice level. Midwifery, for Skinner, is a relationship, not a partnership. She argues that the model of partnership articulated by midwifery may be better seen as a form of individual contractualism. As well, although midwifery may be a feminist praxis, Skinner believes that the model of partnership is not. In response, Benn (1999) suggests that the partnership model should be viewed as an ideal type. Importantly, she contends that it is how the process of partnership is understood and practised that is the key and not what it is called. A further element of Benn's (1999) argument is that partnership is ongoing and evolutionary. As evidence of that evolution, Pairman (1999), one of the authors of the original model (see Guilliland & Pairman, 1995), revisits and updates it as a result of research she has undertaken. Finally, not unlike Benn's contribution but from a consumer's perspective, Daellenbach (1999) characterises partnership as a process and contends that there is not one true meaning for it and, therefore, not just one way for it to be 'done'.

> *In the case of midwifery, the notion of partnership directly involves consumers in the 'production' and 'marketing' processes, as it were, thereby shaping the service to their needs and demands whether at the level of policy and organisation, or during the intimate moments of birth*

Conclusion

I want to draw this discussion to a close by firstly considering what the above issues mean in terms of the entrepreneurial value of the cultural capital of midwifery. Moral panics and concerted resistance can be seen as threats to the integrity and utility of the cultural capital of midwifery since, instead of being viewed as viable and positive alternatives, the philosophies and practices that constitute midwifery are questioned and discounted. This will undoubtedly be reduced as more women and their families are cared for by midwives and there is a more general increase in the community's knowledge and understanding of midwifery. Such changes will also contribute to the second area of concern since they will allow the decision to be cared for by a midwife to be based on an informed choice and not just a lack of options. Responses of this nature to these contextual tensions will not only attend to the particular issues but will, I suggest, have the additional benefit of enhancing the entrepreneurial value of the cultural capital of midwifery. Finally, illustrating the dynamic nature of midwifery philosophy through a discussion of differing perspectives on partnership was not meant to suggest that debate and change be stifled. Rather, the point was to signal that the interpretation and implementation of a philosophy can have an impact on the entrepreneurial value of it since consumers will ultimately evaluate the outcomes.

In summary, the argument of this paper has been that midwifery's philosophy, and the manner of practice that it informs, constitutes the cultural capital of midwifery within the model of entrepreneurial capital. Along with the process by which it has been developed, the content of midwifery's philosophy – both in nature and degree – serves as a unique and substantial foundation, not just for professional practice but also for self-employment. In doing so it represents significant entrepreneurial value in the particular and various ways that it links consumers and professionals and in the distinctive approach to care that it establishes within the larger maternity market. That value is not fixed however, since it exists within a dynamic context of tension and change.

Endnotes

[1] This project is funded by the Foundation for Science, Research and Technology and is being undertaken by a multi-disciplinary team of researchers from Massey University as part of the Labour Market Dynamics Research Programme (LMD). The research involving midwifery was part of a phase dedicated to exploring the growth of non-standard work in the contemporary New Zealand labour market. For more information on the programme as a whole, this particular phase, and future initiatives, plus access to the LMD's various reports see http://lmd.massey.ac.nz. Research undertaken by the LMD has received ethical approval from the Massey University Human

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The cultural capital of midwifery: unique foundations for self-employment

Ethics Committee and is conducted according to the Code of Ethics of the Sociological Association of Aotearoa New Zealand (SAANZ).

[2] In this respect self-employed midwives resemble contractors, an emerging and growing category of non-standard workers that broadly lies in the realm of self-employment. That said, the case study also highlighted some important differences between the two groups.

[3] Though I specifically focused on self-employed caseloading midwives many of the experiences of employee caseloading midwives in some areas of their practice are similar enough to be considered as part of the analysis. For instance, while each group have very different income sources, both rely on similar degrees of family understanding and support to help them cope with on-call work. As a consequence, I chose to draw on the experiences of employee caseloading midwives where appropriate to augment the discussion.

[4] Some examples of this approach, which examine individuals and their entrepreneurial activities can be found in the earlier work on the model (see Firkin, 2001b; 2003b).

[5] What was particularly interesting about the model for midwifery was the clear priority given to human, social and cultural capital, over economic and physical resources. While this is very clear in the original report (Firkin, 2003a) it is far less apparent here given the necessary re-working of the presentation to suit the focus of the paper.

[6] In the original report (Firkin, 2003a) I outlined in greater detail the nature of the process whereby midwives gained the legal right to practice independently. Within that discussion gender was signalled as a significant factor both in relation to the specific process and in terms of the larger socio-political context. Not acknowledged in that report was the useful approach provided by Witz (1990) regarding female professional projects. That is, in this case, how women responded to the efforts of the medical profession to exercise control over the practice of midwifery through a struggle to establish an independent realm of practise, or profession, over which they exercised control. I am grateful to the anonymous reviewer who alerted me to Witz's work.

[7] By using the idea of "sharing in a birth experience" I am trying to capture a range of people from mothers and fathers, who directly share in that experience, to other family and friends, who may share in it quite closely or at more of a distance. Either way, even this latter group can still gain some sense of the philosophy that guides midwives in their care and practice through such a "sharing".

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Editorial Board comment

We continue to celebrate the interest that articles in the Journal hold for an international readership.

Our congratulations to **Lesley Dixon** on the request from the MIDIRS Digest to reprint her article from the NZCOM Journal Oct 2003, in their next issue.

And to **Sally Pairman**, whose article on midwifery practice, in an earlier NZCOM Journal, is being translated into Norwegian to include in a midwifery journal.

Please keep writing about research and practice and sending us articles.

Creating a 'safe' place for birth: an empirically grounded theory

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Abstract

This paper asks what effect birth space has on women's birth experience and outcome. Theorises how midwives can provide an holistically safe birth place. Reporting unpublished aspects of qualitative feminist research comparing the midwifery model with medical model care on women's sense of self in childbirth it builds on the model of 'midwifery partnership'. The paper illustrates how medical control imposes a predetermined concept of safe birth environment whereas in the midwifery model an 'holistically safe' space is jointly constructed by midwife and woman. This model enables the woman to feel in control of her birth space, respond intuitively and facilitate her potential for a safe, natural birth.

Introduction

'Safety' for birth is identified as a primary concern for women, midwives and doctors but what 'safety' means and how it is best achieved is contested. Many people believe that a delivery suite provides the only really safe space for birth. This empirically grounded, theoretical paper explores the question "what effect does the birth space (environment) have on women's birth experience and outcome?" We define the labour/birth 'space' or 'environment' as encompassing the woman's physical surroundings, the people who are with her, and everything that happens or is done to her in that space (Fowles, 1998; Green, Coupland & Kitzinger, 1990).

This paper builds upon the New Zealand model of 'midwifery partnership' to provide theory that can be used to guide and support specific midwifery practices associated with providing the safest birth environment possible. We report upon previously unpublished aspects of an Australian qualitative feminist study using in-depth interviews concerning the effect of midwifery model versus medical model care upon women's sense of self in childbirth (Parratt, 2000, 2002; Parratt & Fahy, 2003). Analysis involved creating core stories of the medical and the midwifery experiences of these women. This paper is based on the analysis of these stories from which we have theorised some detailed explanations of how the birthing environment can have positive and negative effects upon the woman biologically, psychologically and spiritually.

This empirically grounded, theoretical paper explores the question "what effect does the birth space (environment) have on women's birth experience and outcome?"

Our preliminary theory is that the environment which promotes the safest birth, is one where the woman feels in control of who is present and what attendants may do. This environment enables the woman to let go of her need to be vigilant so that she can turn inward and respond intuitively to her body, facilitating her potential for a natural birth which is the safest birth of all.

Literature Review

Childbirth theorists and activists have argued for a number of years that the birthplace, which is most safe, is linked to the best birth outcomes (Hodnett, 1989; Kitzinger, 1984; Odent, 1984; Payne, 1999; Rothman, 1982; Wagner, 1994). There is support from these authors that maternity care providers should not impose a particular environment on the labouring woman because the woman must feel in control of what happens to her in order to feel safe and feelings of safety are basic to spontaneous birthing (Taylor, 1995). An extensive literature search, however, found no specific studies that demonstrated the link between providing an holistically safe space for birth with women's experience of birth and the birth outcomes for both woman and baby.

The Shorter Oxford English Dictionary defines 'safety' as a state of being free from danger or potential danger, where 'safe' with regard to an action or procedure means that it is *"guaranteed against failure"* (Trumble & Stevenson, 2002 p.2647). Attempts to 'guarantee against failure' in childbirth have focused on the physical provision of resources in the event of a physiological crisis, this has led to the belief that hospital birth with an obstetrician in attendance is the safest environment for birth. Yet in specific circumstances physical outcomes have been demonstrated to be good or better for women where there are low levels of resources, such as at home and in midwife-led freestanding birth units (Janssen et al., 2002; Olsen & Jewell, 2003; Rooks & Ernst, 1992; Verdam, 2003).

The discipline of obstetrics is based on scientific monitoring and control of the childbearing experience (Wagner, 1994). This statistical approach is indicative of the medicalisation of childbirth where control, predictability, efficiency and calculability are the guiding principles (Bennett, 1997). This approach focuses care on the baby rather than the woman, ignoring and often negating her lived experience, and the holism of mind and body. The woman's opinion of what is safe for her is stifled by obstetrics' consideration of what is safe. When giving birth the woman, as well as the attending midwives, are expected to conform to these scientific principles.

Woman-centred theorists agree that the external imposition of obstetric control undermines the woman's control of her body, her environment and her childbirth experience (Bennett, 1997; Green, Coupland, & Kitzinger, 1990; Wagner, 1994) but those who believe in scientific obstetrics reply 'so what'? The way a standard delivery suite operates assumes that the birthing process is not affected by how a woman feels. There is evidence, however, to the contrary because medical monitoring and intervention in childbirth aimed at making birth safer paradoxically works in the opposite direction and actually increases complications and morbidity (Roberts, Tracy, & Peat, 2000; Wagner, 1994). Women's sense of self may also be diminished by the use of medical intervention (Cox & Smith, 1982; Creedy, Shochet, & Horsfall, 2000; Fisher, Astbury, & Smith, 1997; Garel, Lelong & Kaminska 1987, 1988; Gottlieb & Barrett, 1986; Trowell, 1982, 1986). This psychological morbidity illustrates that, in addition to physical aspects of childbirth, consideration of safety must include the psychological, social and spiritual issues that are important to each woman.

Autonomous midwifery bases its understanding of childbirth in the social paradigm that sees birth as a healthy part of life (Wagner, 1994). A philosophical model was formally described by Guilliland and Pairman (1995) as a 'Midwifery Partnership' between the midwife and the woman. In contrast to the medical model, in the midwifery

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model safety is not imposed on women, rather, the safest possible birth is negotiated individually with each woman. Midwifery is based on the sharing of knowledge and power between the midwife and the woman, so that they both respect what the other has to contribute to the childbirth experience (Guilliland & Pairman, 1995). Along with individual negotiation Guilliland and Pairman (1995) identify the partnership to include the principles of equality, shared responsibility, empowerment, informed choice and consent. The ultimate control always rests with the woman, even, and most particularly, when she is at her most vulnerable in labour. This relationship between the midwife and the woman empowers the woman to enunciate and achieve her goals, which in turn empowers the midwife to be able to advocate on the woman's behalf. The model's underlying premise is that of an independent midwifery profession. Consistent with the partnership model we define autonomous midwifery practice as that which is characterised by continuity of midwife-woman relationship where the focus of the partnership is woman centred.

Guilliland and Pairman's (1995) partnership model is broad, philosophical and ethical in nature and although it is of great assistance to the profession, the model does not give specific details of 'how to' be a midwife in specific situations such as 'how to' provide the safest birth space for a particular woman. Theoretically, the partnership model can be described as dealing with macro concerns for the discipline of midwifery (Chinn & Cramer, 1995). The current paper is concerned with theory grounded in the micro-level interests of midwives (Chinn & Cramer, 1995). The theory described here emerged from analysis of micro-situation of particular births. This new theory links to the broader midwifery partnership model and provides guidance for midwifery clinicians and administrators.

Methodology

The study was guided by the methodology of feminist constructivism. Feminist constructivism shares a philosophical base with the midwifery partnership model, which made it particularly appropriate for this study. We acknowledge our values as feminists and midwives but iterate that openly declaring our standpoint or position is not considered to 'bias' the study, rather it is a strength in feminist research (Fonow & Cook, 1991; Stanley & Wise, 1993; Guilliland & Pairman, 1995; Harding, 1986; Parratt, 2000; Parratt & Fahy, 2003).

The basic philosophical features of feminist methodology include that the research be conducted by women, for women with the aim of enhancing women's lives. Women who provided their stories for this study were considered to be research participants who were co-creating the knowledge that was generated from the study (Reinharz, 1992; Stanley & Wise, 1993; Kushner & Morrow, 2003). This is in contrast to more traditional research where women would be considered to be 'subjects' upon whom research is done by the presumed expert –the researcher (Fonow & Cook, 1991; Harding, 1986; Parratt, 2000; Parratt & Fahy, 2003; Stanley & Wise, 1993). Constructivism is a philosophical paradigm, which is related to, but different from, interpretivism in that constructivist researchers jointly construct knowledge with participants (Emden, 1998a; Stanley & Wise, 1993; Fahy & Harrison, 2000).

The participants are aware of feeling safe at home, and they connect this feeling to the way they give birth:
"I was able to have the birth that I did because I felt so safe in that environment."
(Tanya)

Methods

The study was conducted within an Australian regional city. Maternal and Child Health nurses assisted in recruiting participants and invitations to participate were also issued to previous clients of the first author's midwifery practice. A total of six women who were considered 'low risk' at the beginning of labour, agreed to participate. Three of the participants had homebirths experiencing continuity of care in partnership with a midwife. The remaining three participants had the fragmented care of medically managed childbirth in hospital.

Once ethical approval was gained, in-depth interviews involved women relating their story of childbirth and answering probing questions about how they felt about themselves during this experience. The methods for data collection and analysis followed those described by Emden, (1998b); Polkinghorne, (1988) and Stivers, (1993). This meant the participants' own words were used to create core stories of condensed experiences. What was included in these core stories and what it meant was negotiated with the woman (Emden, 1998a).

Analysis began with identifying recurrent themes (Holloway, 1997). Consistent with what was proposed by Strauss and Corbin (1994) and feminist, empirically grounded theory generation (Kushner & Morrow, 2003) further theorising involved descriptive conceptualisation of these themes. The result was the creation of a tentative theoretical explanation of the relationships between the outer birthing environment, the woman's inner experience and the actual events of the labour and birth. In this paper excerpts of data are provided to support the theoretical propositions, which are made.

Methodological Rigour

The quality and depth of data and how it is treated are the most important elements determining the 'rigour' of qualitative research. We argue that this study meets the criteria of *"credibility"* (believability) *"auditability"* (of data), and *"confirmability"* (by participants) and *"fittingness"* which are widely accepted standards for judging the rigour of qualitative studies (Roberts & Taylor, 2002, p.380). The way this study was conducted is consistent with Morse and Singleton (2001) who state that the internal validity of a study is dependent upon the 'fittingness' of the research question, philosophical assumptions, research methods and analytical procedures. Morse and Singleton argue that the external validity of the results of a study *"is demonstrated by assessing pragmatic fit"* (2001, p. 844). This means that the results of one qualitative study are applicable to another setting or context (Morse & Singleton 2001, p.844; Roberts & Taylor, 2002, p.380). These authors support the notion that a smaller, less abstract study, such as the one described here, has a greater likelihood of being transferable to other similar settings (p. 844). They argue that when a new theory does fit another context it will be *"more obvious, the information that is transferred will be more concrete, and the process of application eased"* Morse & Singleton (2001, p. 844). We argue that our study and results meet these criteria for rigour and thus our theoretical formulations can be applied in similar and related contexts.

Notwithstanding the above, we recognise a limitation that theorising in this paper is derived from an exploratory pilot study and therefore readers need to be cautious about transferring our theory to another context. There is no previous research that has attempted to theorise the link between the birthing environment, the woman's inner experience and the events of birthing. Given that this is an aspect of midwifery practice that is of central importance to what happens to both women and midwives in the context of birthing our early theorising should be useful in creating debate and continuing the development of midwifery practice theory.

Results

A thematic analysis of the pilot study of women's sense of self during childbirth results was provided elsewhere (Parratt, 2000; Parratt & Fahy, 2003). The results that were used to ground the theory of creating a safe space for birth are presented in bold type, in participants' own words. Our interpretations, where they are needed, appear in nor-

mal type to link direct quotes from the women. The words of women experiencing midwifery-led homebirths are presented first followed by those of the women having medically-led birth. These extracts originate from the women's narratives about their sense of self during childbirth (Parratt, 2000). To preserve their anonymity the women in this research are referred to using pseudonyms.

Women experiencing a midwifery partnership

Some participants chose homebirth following visits to hospital and they compare their feelings at these visits to their experience at home. The participants are aware of feeling safe at home, and they connect this feeling to the way they give birth:
"I was able to have the birth that I did because I felt so safe in that environment." (Tanya)

"The birthing unit … was completely sterile to me … you couldn't be yourself …For me to be able to give birth, the biggest things were being somewhere I felt comfortable, being with people that I trusted and feeling really safe." (Tanya)

"I felt like I needed peace and quiet and I needed people who were going to be supportive and not ignore the fact that I was in labour." (Anne)

"The people who were there helped in their calmness and relaxation … They were focused on each moment and were flexible to what I was doing rather than what might happen." (Jane)

As the literature suggests, feelings of control in the birth environment and trust in those present are important for women to be able to act spontaneously during labour and birth:
"I felt disempowered the minute I walked into the hospital just like I had no control … they knew best … I felt like I was constantly being defensive. I didn't have confidence that I could let go and trust the people around me. I felt like I had to constantly be aware of what people were doing … I … felt like they were going to come in and force me to do things I didn't want to do…" (Tanya)

"… being in my own environment, … I could really do what I wanted … what I needed to do, … not having to think or worry about where I was or where anyone else was … in hospital it might have been very different ... I might not have felt so in-control." (Jane)

"I try not to be in control of my surroundings, letting go of what I can't control … I retreat so much into myself." (Anne)

The women need to feel safe enough so they can release their mental control through an altered conscious state and respond in whatever instinctual bodily way feels right to them:

"… getting out of my head allowed me to go more with my instinct … to not think … as it went on it got more intense and I just got more into my body and blocked out around me, I lost my sense of time." (Jane)

This need for a feeling of safety is because women feel vulnerable when their conscious state changes and they respond spontaneously:
"I was completely unaware of what was going on around me … I was completely inwardly focused, not deliberately focusing - it was just I had no choice ... It's like returning to my animal self or a very primal self; it's really exposing too." (Tanya)

Women experiencing medical model birthing

Women planning hospital birth recognise that home feels safe but having the reassurance of a hospital-based health professional is also important:
"We were hoping that we could stay at home as long as possible because I felt safe here, I was … a bit scared of going to the hospital ... but there was the security of having someone, like a midwife, a doctor to say yes this is going all right." (Marg)

Manipulation and lack of respect for the perspective of the labouring woman does not promote a feeling of safety:
"The Registrar said 'a lot of women get too far and then they can't have any drugs and they regret it'. This scared me … so I thought maybe I better, what if I can't handle it?" (Marg)

"I had the pethidine because they suggested it more than me wanting to have it. It didn't take the pain away … I got to a stage where if they said do this I'd just do it." (Faye)

"I didn't have much say when I was in labour, the doctors would come in and say '… this is the way it's going to happen'… I had to agree, because I knew it could have been my baby's life in my hands and it's not worth messing with." (Louise)

The attitude and behaviour of non-professional labour attendants are important to an environment that feels safe:
"What helped me was my sister-in-law and mum talking to me the whole time, trying to keep me calm, saying comforting and reassuring things." (Faye)

Maintaining an altered conscious state and being spontaneous in labour is sometimes possible in the hospital environment, but can it can be difficult to maintain:
"She opened … the door of the room and just had a curtain across. I could hear people going past, talking … It was so distracting and really took me out of what we were doing. I became really self conscious of making any noise and of being myself." (Marg)

Self conscious behaviour limits the woman's ability to release mental and physical control, which may be directly linked to medical interventions:
"Instead of trying to push I was trying to fight it … I was still trying to stay in control instead of just letting it go. I was scared I was going to lose it and I wouldn't be in control, I tensed up quite a bit … When they realized that he wasn't going to come out that's when they got the vacuum." (Faye)

In the most unconducive medical environment a focus on the baby's safety becomes paramount as if it were really possible to consider the baby's safety separate from the woman's holistic safety:
"They were coming in and out with equipment ... I was still trying to push Rachel out, it was a horrible atmosphere, not what I wanted … I had a spinal tap … I'd been through so much, I was exhausted and scared; I just wanted it over and my baby to be all right." (Marg)

Discussion

This paper captures some of the unique aspects of midwifery practice in a homebirth setting and compares them with those aspects of obstetrically-controlled maternity care that happen for most low risk women in Australian hospitals. The study shows how this medicalised approach makes it very difficult to provide an holistically safe birthing space. It is clear from the study that women need to feel free to adjust their labour space according to their own personal needs. When the midwife enabled the women to feel empowered the women retained a feeling of control over the environment. In contrast, the medical management, usually argued to be the safest way to birth, was shown in experiences of the participants who had a medical model birth to actually work against creating a 'safe' space. The medical intrusions created fear and uncertainty that undermined the basic conditions of a safe, natural birth.

By contrast, the midwifery partnership model of practice in a homebirth setting was shown to empower both the midwife and the woman to create an individualised holistically safe birth space. The autonomous midwife who had formed a relationship with the woman over a period of time had become familiar with, and was able to respect, the woman's particular situation, thus she provided true woman centred care. In the midwifery model experiences a consideration of what is 'safe' was negotiated by both the woman and the midwife thus the concept of an 'holistically safe' space was jointly constructed. This concept of negotiation of a jointly constructed understanding of 'safety' is founded upon two people who feel equally free to con-

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tribute and to disagree with each other in ways that are conducive to the long term harmony of the partnership (Guilliland & Pairman, 1995).

In concluding we theorise that an holistically safe birth space must 'feel' safe to the woman. The concept of 'safety' incorporates both physical and psycho-social-spiritual safety that cannot be imposed on a woman. For the women in this study, all of whom were 'low risk', a 'safe' space was one that was private and peaceful. The actual, or even potential, event where strangers (unknown doctors and midwives) can enter the woman's space without the woman's invitation is sufficient reason for the woman to use energy to stay vigilant and 'in control'. When a 'safe' space is achieved it enables the woman to find an internal focus (England & Horowitz, 1998; Gaskin, 1990; Odent, 1984). When the woman can let go of mind control she naturally enters gradually deepening levels of altered consciousness. In this state the hormonal cascade necessary for effective labouring is optimised. The production of endorphins is also optimal in this state which assists her endurance of labour and further letting go of inhibitions which ultimately leads to spontaneous birthing (Grof, 1988; Odent, 1984, 1992; Parratt, 2002; Taylor, 1995).

Compared with the women who birthed in medically dominated hospital environments the women labouring in such a 'safe' environment were able to behave spontaneously. This spontaneous behaviour appears to be contingent upon a 'safe' environment being created but this can only happen if the midwife can assure the woman that her wishes about the environment can be met. Thus the midwife acts on behalf of the woman to control the environment so the woman can feel 'safe' enough to be able to 'let go' and be 'out of control'. With this approach to giving birth the woman reaches inside herself for strength because she knows that she is the one who has to labour and birth. A woman's sense of safety is also dependent upon the knowledge that other people and resources will be available to help her through the process if needed. An holistically safe place is one where the woman is utterly confident that her bodily or emotional integrity will not be violated during her time of great vulnerability.

The study implies that it is easier to create such an holistically safe environment in a home situation than in a hospital. The creation of holistically safe birth environments is much harder in hospitals because hospitals normally impose hierarchical control and medical protocols on both midwives and women. We believe that depending upon the particular hospital, the level of the midwife's professional autonomy and the level of 'partnership' between the woman and the midwife, an holistically 'safe' space for birth can be achieved, and that this could be in a hospital birth centre and on occasions even in a hospital delivery suite.

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The importance of ethical review in midwifery research

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Introduction

Many midwives have a desire to understand more about pregnancy, childbirth and the social context in which these occur. This may be partly driven by aspirations to understand more or improve their own practice and the experience for women and their families. There is also a move within health care to base practice on firm foundations of knowledge rather than on unsupported belief, theory or anecdote (Sackett, Richardson, Rosenberg & Haynes, 1998). All of these factors have meant that many health care providers, such as midwives, are involved in research. However, whenever people are part of a research study there is always the potential that harm could arise. This short article explores why ethics committees review research and some key areas of ethical concern.

Ethical review of research involving human participants

We know from history that research participants have not always fared well and concern for their welfare has, at times, been lacking (Beecher, 1966; Paul, 1988). There has been recognition worldwide that safeguards are required to ensure that the welfare of research participants is protected. In New Zealand a formal process of ethical review for any research involving human participants is carried out by research ethics committees established regionally throughout New Zealand.

It may be thought that the review process is sometimes an unnecessary step in research. For example, it may be argued that since midwives have the best interests of their clients at heart, and aim for good outcomes, it is not necessary for anyone to make judgements about the ethical status of their research. In particular, it may be argued that midwifery practice is generally particularly sensitive to the needs and wants of women and their families by being firmly based upon a partnership model of practice.

However, midwives also undertake research because of their own interests – to publish, obtain degrees, and advance their own profession. But the real issue here is not so much mixed motivation as the fullest possible protection of potential and actual research participants. It is widely agreed that this requires all proposed studies to be assessed by research ethics committees who have no vested interests in the research (World Medical Association, 2000). This is viewed as an element of good clinical practice and the duty of a health carer rather than merely complying with external demands.

Ensuring the wellbeing of research participants: Consent

The first responsibility of these committees is to ensure the wellbeing of participants. And the primary means by which this wellbeing is ensured is through participant consent. Ethical review aims to ensure that in so far as possible no research participant will ever be the subject of research without his or her full, informed and continuing agreement. Ways of achieving consent include information sheets describing the intended research written in such a way as to be readily understood by someone new to the area of study. Participants also need to be given time to think about participation, and the option to withdraw without penalty, which means that there will be no reduction in the level or quality of care provided if they decide not to take part.

For example, it may be argued that since midwives have the best interests of their clients at heart, and aim for good outcomes, it is not necessary for anyone to make judgements about the ethical status of their research.

But even with all this in place, consent can be subtly compromised, for example in the actual circumstances in which it may be sought. A particular problem in midwifery-based research might be the occasions where the prospective participants are the clients of the researcher. The enthusiasm of the researcher-midwife for the research or the gratitude of a woman for what the midwife has done, or is doing for her, may make it difficult for the woman to refuse a request to participate in research. Overcoming these problems requires careful consideration of **how** women are approached and **who** makes that approach.

Ensuring the well being of participants: Harms and benefits

However, a concern with consent cannot be enough to ensure that the proposed research is ethical. Ethical review of healthcare research is commonly concerned not only with whether proper consent procedures are in place, but also with whether or not the risks of taking part in research are acceptable. This issue precedes the concern with consent and places some onus on the researcher to make sure that the planned research is minimally harmful **before** consent is requested.

Here it may be argued that midwifery research is unlikely to be harmful. In particular, it may be suggested that most midwifery research is likely to involve the woman as an informant where she is asked to take part in an interview or questionnaire. Surely, it may be imagined, the risks of such forms of research are low when compared to being in the trial of a new drug for example. But harm can come from all sorts of unexpected sources, including from questioning and interviewing. **What** is asked, and **how** it is asked, are issues which are of ethical interest.

In addition, some research, while it may not actually produce harm, is incapable of producing benefits, for example because the design of the study is inadequate. Research that cannot meet its own aims is pointless and if the research proceeded then any risk or even inconvenience to the participants would be unacceptable. This is not to say, however, that all research will have easily defined aims. For example, some research is exploratory, seeking areas in which further research might be undertaken.

Ensuring the wellbeing of participants: Confidentiality

It is common for ethics committees to demand that those who participate in research have their identities protected in any published (that is publicly available) form of the research – unless they have agreed to being identified. Because much research undertaken by midwives may involve telling their experiences the maintenance of confidentiality takes on increased importance. A story, whether it is one of a number or simply reported as a single anecdote, can reveal the identity of its subject even if some obvious identifying details are changed.

When does clinical practice need review?

Generally, any research activity will need to go through a review procedure. However, there are times when clinical activities in health care could

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do with assessment and proper research. In any clinical practice, such as midwifery, there is constant innovation. Midwives will become aware of new techniques and may see situations where they can try some of these, believing that they may be just what the woman needs or that some adaptation of them may be right in the particular circumstances. This kind of evolving innovative practice is common but raises some ethical questions. Is this practice effective in the situation where it is used? Can it cause harm? These questions cannot be addressed without proper research. However it is difficult to pinpoint exactly when innovative practice requires research. Midwives, as with all health care professionals, need to be alert to when a developing practice requires research to validate its use before it becomes a new and accepted practice.

Conclusion

Midwifery, in common with all areas of health care, is seeking to establish a research base from which to practice. The aim of research is to improve knowledge and understanding of good practice. Research involving people automatically raises ethical issues, and there is international agreement that a process of ethical review centred on certain key issues is essential. These include consent, confidentiality and an evaluation of harms and benefits. In the midwifery context there are some specific subtle issues which arise in relation to both these and to the question 'What counts as, and or needs, research?'

Suggested reading

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NEW ZEALAND RESEARCH

Lactating, feminists and breastfeeding advocacy: some complexities

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Abstract

Although it is widely recognised that breastfeeding has significant health benefits for infants and mothers, and breastfeeding advocates work hard to promote this message, breast-feeding rates in Aotearoa New Zealand have been decreasing. Reasons for the decline, say breastfeeding analysts, are multifarious. Sometimes, feminism is wrongly blamed as partly contributing to this decline. The following paper addresses this problematic belief and some of the unacknowledged assumptions surrounding it, as well as foregrounding the growing recognition, amongst feminist scholars, of the importance of breastfeeding as a subject of feminist analysis and debate.

World Breastfeeding Week (2003) is now over, and the risqué *Women's Health Action* image of actor Michael Hurst nursing an infant in the workplace is no longer the topic of teatime conversation. Breastfeeding advocates, however, are still hard at work trying to sell breastfeeding to a population of women and men who seem, sadly, to have lost the precious art of supporting it. From time to time, feminism is wrongly blamed as partly contributing to the decline in breastfeeding rates. This assumption is one I intend to critique in the course of the following discussion, for its failure to fully comprehend what feminism is and what it entails. Nevertheless, it is fair to say that in the popular imagination, breastfeeding and feminism are often thought to be antithetical. The common sense assumption, 'out there', is that breastfeeding and feminism form an uneasy, if not hostile, alliance. Certainly this sentiment is one I have heard reiterated numerous times when interviewing women for qualitative research on breastfeeding in Aoteaora New Zealand. In recent work I have undertaken, as well as on-going research on the ethics of cross-nursing[1] (Shaw, forthcoming 2004), I often hear women express concerns regarding the supposed conflict between feminism as a political and social movement and motherhood as an ideology and set of everyday practices. These women frequently lament that motherhood is socially under-valued, and at the same time, opine that this is perhaps the fault, or one of the consequences, of the feminist movement. While my research does not directly investigate the intersection between women's perceptions of feminist discourse and support for breastfeeding - or the lack thereof - the relation demands recognition as a significant topic for feminist analysis.

Tiina Vares' (1992) exploratory discussion of these issues, in regard to her own experiences of motherhood and feminism as a breastfeeding woman, places these complexities squarely on the feminist agenda. Writing in 1992, Vares, who describes herself as a feminist, notes the lack of an appropriate feminist discourse through which to articulate her experiences of breastfeeding after the birth of her first child. Nevertheless, as Vares states in her essay, she was;

"drawn to a cultural feminism which embraced and celebrated the embodied aspects of womanhood, particularly breastfeeding. This was in contrast to my previous critical view of biological essentialism. I also saw a tension over, even a hostility towards, mothering in many feminist writings at a time when I was looking for a means to locate my new experiences and explore the ways in which our feminisms inform our breastfeeding practices" (1992, p.25).

It is this antipathy - perceived or otherwise - between feminist discourses and infant feeding practices, and the contradictory tensions each appears to embody, that this paper addresses.

Like Vares - though less critically - many of the women involved in my research expressed reservations about the extent to which their embodied maternal experiences seemed to fit what they understood as feminist accounts of those experiences. In most cases, their views were volunteered without any prompting. When I asked one woman in my cross-nursing study why she thought the traditional role of 'mother' was currently more under-valued than it once may have been, her considered response was revealing. In fact, she replied that she genuinely 'didn't know'. She then went on to say:

"I don't know if I believe that it is because feminists have been fighting to free us from that role and whether it comes from the pressure put on from the feminists … or if in fact it's an economic thing that

suits everybody if you get women out there working…" While this statement is worth unpacking for what it says about the complex and contradictory nature of the social relations women experience in the waged labour market, this particular interviewee's observations are also revealing for what they say about the perceived relation between feminism and motherhood. Although my interviewee suggests multiple ways of reading the shifting historical relations between motherhood and social life, prevailing popular views about feminism tend to flatten these kinds of open-ended interpretations by lending credence to the belief that maternity and lactation are marginal topics for feminist analysis. The perception of an unbridgeable gap between feminism and maternities couldn't be more wrong, however, and this is well demonstrated by even a cursory glance at contemporary breastfeeding literature (e.g. see Bartlett, 2002; Blum, 1999; Hausman, 2003). The sorts of investments cultural publics have in perpetuating contrived antipathies like those set up between feminism and maternity are intriguing nonetheless. How is it, for instance, that this perceived alienation between the nether-realms of motherhood and maternity on the one hand, and feminist theory and politics on the other, occurs, and how it is 'allowed' or able to persist in the public imagination?

One partial answer to this question stems from a number of false generalisations that circulate in the popular imagination about what feminism is and exactly what it entails. As Caroline Ramazanoglu and Janet Holland (2002, p.6) note in their book on feminist methodology *"the feminism that developed in the last 30 years or so still attracts criticism for its supposedly powerful consensus, and its tyranny in imposing hatred of men and denying fun and femininity"*. Contrary to public opinion, however, feminism covers a plurality of theoretical perspectives and a range of politics and practices. The existence of a broad range of feminist voices means that there is often considerable disagreement between different feminist projects over issues to do with epistemology, ontology, and politics. Ascribing anti-maternalist beliefs holusbolus to feminism as a supposedly unified body of thought and political practice thus arises from the failure of its critics to recognise the diversity of feminist perspectives, as well as the failure to recognise the discursive, historical, and contextual origins of these perspectives.

Predictably, too, the more publicly visible 'feminism' as a homogeneous ideology becomes, the less likely theorists and practitioners who describe themselves as 'feminist', are inclined to identify with it (see Kavka, 2001). Notwithstanding this crucial point, popular media are notorious for their promotion of high profile versions of feminist discourse and for spotlighting particular intellectuals as spokespersons for the movement as a whole (note Germaine Greer's positioning as feminist icon in the Australian media). This practice reinforces dominant and paradigmatic images of what feminism is as far as the general public is concerned. One feature of this purported consensus that is frequently identified as characterising the spectre of public feminism is the focus on equality or sameness with men. This emphasis often comes at the expense of identifying or recognising 'difference' or differences between men and women, and within groups of women.

From time to time, feminism is wrongly blamed as partly contributing to the decline in breastfeeding rates.

Since the late 1980s, feminist discourses have been self-consciously framed by controversies and discussions that pivot around what has come to be known as the equality-difference or sameness-difference debates (see Evans, 1995). In these debates, issues that centre on equality emphasise women's identity and sameness with men and their inclusion into the political order, whereas issues about difference tend to focus on women's unique characteristics, special qualities, and the valorisation of these differences in politics and social life. Historically, these two axes or markers of feminist politics and scholarship have been positioned as dichotomous (Pateman, 1992, p.17).

Although it is incorrect to cast feminism as fundamentally equality-focused, opposed to sexual difference, and/or anti-maternalist, it is true that variants of dominant second wave feminism took a decisive stand against pronatalism and against cultures that lent weight to pronatalist ideologies. Many western feminists, at the time, worked very hard to decouple what it meant to be a woman from the supposed biological imperative to reproduce the species, and sought to promote the idea that being a woman, and a human being, was about more than being a mother. Obviously there was good reason to rail against prescriptive mandates such as compulsory motherhood, just as many commentators today (see Murphy, 1999) rail against the contemporary injunction that women must breastfeed at all costs. However, just because second wave feminism opposed social roles and stereotypes that rigidly affixed womanhood to motherhood, doesn't mean that it opposes motherhood in its entirety. Feminism *per se*, as I have suggested, is not anti-maternal. In fact, in some versions of feminism, and not just conservative ones, quite the opposite is true. While maternalist identity politics can be traced back to early debates in liberal-conservative white feminism about women, citizenship, and enfranchisement (see Reiger, 1999), pro-maternalist themes are also present in more contemporary versions of feminist scholarship. In variants of cultural feminism, as well as difference and corporeal feminisms,[2] mothering and the maternal are often valorised and highly praised. The qualities deriving from mothering care, moreover, are seen by these feminists as contributing to the social, psychic, and moral good.[3]

Tiina Vares's (1992) essay is evidence of the move to rethink maternities along the lines of 'difference'; so too is Alison Bartlett's (2002) work on the possibilities of reconceptualising breastfeeding through the lens of corporeal feminism. In these discourses, maternity isn't axiomatically wedded to every normative aspect of the maternal matrix (e.g. heterosexuality). However, as Vares indicates, cultural feminisms often readily fuse into anti-feminist politics that rest on biological arguments about the essential natures of men and women (see Evans, 1995, chapters 6 & 7). It is this pro-maternalist essentialism that is held by many commentators to be profoundly anti-feminist (see Reiger, 1999).

In debates over breastfeeding, the voices of pro-maternalism and anti-maternalism pivot around two models that appear to be at odds with one another. These discourses are often played out against the background of the so-called equality-difference schism. Where breastfeeding is concerned, this is often articulated in terms of the breast-versus-bottle feeding controversy, with liberal feminisms emphasising the 'bottle' side of the debate (see Evans, 1995, chapter 4). One of the more prevalent myths underpinning these particular debates, is the assumption that feminism promotes bottle feeding above breastfeeding because it enables women to return to waged work more easily after childbirth and participate in the public domain as equals with men. However, as Bernice Hausman (2003, p.5) notes, this approach to infant feeding is based on a *"non-productive"* either/or dualism that fails to address *"breastfeeding as a real choice for women"* without compromising their *"participation in civil society"*. Since one of

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Lactating, feminists and breastfeeding advocacy: some complexities

the primary aims of feminism is to promote, support, and protect women's rights to good health and to emotional, psychological, and social well-being, support for bottle feeding, and formula feeding in particular, is always qualified. Certainly there may be good reasons to substitute the breast with the bottle – so that one's partner, nanny, extended family, whanau member, or friend can help in the care-taking process - but one of the aims of contemporary feminisms with regard to infant feeding is to enable women to breastfeed or express breast milk at work in comfortable, stress-free, and supportive environments. Support for breastfeeding-friendly workplaces, as a policy aim, needs must underpin this commitment.[4]

Given the complex and contradictory issues that the equality-difference debates raise in terms of the politics of infant feeding, it is not surprising that feminist theoreticians and practitioners alike have felt considerable ambivalence, as breastfeeding scholar Linda Blum (1999, p.6) states, in terms of which of these signifiers to emphasise. Carole Pateman's deconstruction of equality 'versus' difference discourse in her discussion of the complexities of the politics of motherhood illuminates Blum's point. Pateman remarks, *"that only women have the capacity to become pregnant, give birth and suckle their infants is the mark of 'difference' par excellence"* (1992, p.18). Yet motherhood simultaneously exists as a central mechanism of women's inclusion into the political order. According to Pateman, herein lies the paradox. Women's political standing and their inclusion as citizens rests on the very same capacities and attributes that form the basis of their exclusion. This paradox is graphically illustrated by the public breastfeeding act of Kirstie Marshall in the Australian Houses of Parliament in February of 2003. On this occasion, Marshall, a Victoria State Labor MP and elected political representative, was removed from the parliamentary chamber during proceedings of the Legislative Assembly for attempting to breastfeed her 11 day old baby.[5]

While Marshall's breastfeeding act and ejection from parliament highlight her contradictory positioning as a political subject, they also bring a couple of perennial issues in feminist scholarship and methodology to bear on the infant feeding debates. The first has to do with how we are to define and represent female subjects and whether or not our subjectivities have bodily roots (Braidotti, 1992). The second problematic pertains to how these subjective locations affect the ways we see and represent our material and social realities. For scholars and researchers, this age-old methodological issue is directly connected to the question of whether it is ever possible to achieve 'scientific' value-freedom from personal interest, and impartiality from one's lived experiences. Naturally, many feminists would argue that we don't leave our bodies at home, for example, when we step onto the parliamentary steps. They would also emphasise that women's bodies have the capacity to demonstrate this in no uncertain terms, as Marshall's breastfeeding act amply shows. For feminists generally speaking, knowledge is always already embodied. It is thus inextricably linked to the reflexive self of the researcher in such a way that makes thinking and knowing, to a lesser or greater extent, situated and partial. This means that it is essentially impossible to claim complete analytical detachment from the object of one's analysis, or to claim disembodied neutrality from investment in one's research. This situatedness of knowledge is why many feminist scholars argue that all research is biographical in some way or another. On a personal note, I cannot deny that, since becoming a mother myself, my own interest in maternities and in breastfeeding has increased exponentially.

Many of these feminist mothers are proud of their lactational prowess and use their personal breastfeeding experiences in their research as a means to stimulate discussion and debate about infant feeding in general

(e.g. Bartlett, 2000, 2002; Giles, 2003a; Vares, 1992)

There is, however, a corollary to these points about knowledgeably embodied subjects. While I would want to argue, along with Rosi Bradiotti (1992, p.83), that *"thinking is a bodily, not a mental process"*, listening to what our bodies have to say doesn't foreclose the issue on questions of ethics or justice. In other words, although knowledge is grounded in one's experience, there can never be any direct, transparent correlation between experience and material reality, since experience itself is always mediated by language and discursive and political constructs. Acknowledging this entails recognising that using one's experience as a source of knowledge has discursive and existential limitations. Theory can, for instance, help inform one's experiences, and, vice versa, the sorts of experiences one has of a particular situation or event – or does not have, for that matter - will shape the kinds of theorising one chooses to use in interpreting material realities.

Feminist scholars writing in the field of breastfeeding frequently make the sorts of connections between ideas, experience, and material social life (see Ramazanoglu & Holland, 2002), I have alluded to. It is often the case that their work is grounded in biographical insights. Virtually all the feminists in my field (social sciences and cultural studies), whose work I draw on, and who write about breastfeeding in scholarly journals and texts are mothers and advocates of breastfeeding. Hausman, whose book *Mother's Milk: Breastfeeding Controversies in Contemporary America*, was published recently in 2003, concurs with this observation. Hausman says, *"[most] of the academic women I know have breastfed their children, and this is precisely the cohort producing feminist theories about the body and critiques of the medical management of childbirth"* (2003, p.192). Many of these feminist mothers are proud of their lactational prowess and use their personal breastfeeding experiences in their research as a means to stimulate discussion and debate about infant feeding in general (e.g. Bartlett, 2000, 2002; Giles, 2003a; Vares, 1992). The narrative experiences of these scholars provide them with the requisite springboard from which to mobilise introspective and self-reflexive interpretations of the ethics, politics, and even erotics, of breastfeeding practices. The accounts of these scholars, in addition, are often critical of objectivist and medico-scientific discussions of infant feeding that focus solely on biology and physiology, because they pay insufficient attention to the lived experiences of the lactating woman in the mother/infant breastfeeding dyad.

Phenomenological studies of women's actual breastfeeding experiences aim to rectify the over-emphasis of infant feeding discussions from the perspective of the disciplines of biology and medicine and to document breastfeeding practices from the perspectives of women themselves (e.g. see essays in Beasley & Trlin, 1998; Ryan, 1998; Schmied & Lupton, 2001). Some scholars, however, advocate a complete cultural and psychic reconceptualisation of the meaning of breastfeeding and lactation in women's lives (see Giles, 2003a). In a presentation at the recent *2003 Conference of the International Lactation Consultant Association* in Sydney, Fiona Giles (2003b, p.595) called upon Lactation Consultants and other health professionals to think about the pleasures of breastfeeding for women, and to remind women of its many potential (and unspoken) joys. Giles's perspective wasn't just focused on the nutritional or health benefits to mother and infant, but on the bonding process and on the 'feel good' sensuality of infant feeding itself. Scholars like Giles want to re-connect the lactating and nurturing breast with the sensual, feeling, and erotic breast, not to separate the two. Such a move is radical – though not necessarily compatible with feminist politics - because it aims to rethink breastfeeding differently and 'otherwise', and this, in turn, entails re-valuing the maternal experience itself. It also requires rethinking aspects of the institution of motherhood, which takes us back to Adrienne Rich's (1986) theoretically prescient dis-

tinction between motherhood as a compulsory institution and motherhood as an embodied experience. For Rich, and for others, the value of this distinction is to be found in the contradictions it unearths and in understanding the ways in which women's differential experiences often fail to approximate motherhood either as a codified ideal or as an oppressive social norm. Rich's account is also prescient for the way in which it attempts to *"think through the body"* (1986, p.284), by reconceptualising female subjectivity in terms of situated embodiment. Her writing about women's own lived experience, in addition, immerses us as readers in the particularities of our own bodies. It also enables feminist discourse to move beyond dichotomous discussions of female subjectivity as either equivalent to 'universal' maleness, and thus disembodied, or essentially different from it, and thereby constrained by a static, fleshy materiality.

These kinds of references to embodied experience and to the place of experiential knowledge in recent discussions of infant feeding by feminist scholars raise a number of methodological issues that are integral to on-going debates in contemporary feminist thought. Saying that feminists who write about infant feeding are often academics who have breastfed their own children, does not mean feminists who are not mothers in the traditional sense of the word, are not breastfeeding advocates and have nothing useful to contribute to the subject.[6] I am not suggesting that experiential knowledge is analytically imperative for thinking about a particular subject, nor am I suggesting that it gives one license or special privilege to discuss it.[7] Sometimes the contrary is the case. Certainly, I believe it is an empiricist folly to suppose that before experience there is nothing, or that there is no knowledge before concrete experience. Our experience is not a window to the realness or truth of our lives. Rather, experiential narratives offer insights into the production of those truths as meaningful realities.

Both the work and comments of New Zealand economist, Marilyn Waring (1999), illustrate my point. At the beginning of a presentation of her work on the economics of breastfeeding to the *Australian Lactation Consultants' Association* in Melbourne, 2000, Waring made the remark that she *"has never been a nursing mother"*. She added:

> *"I was interested to see that in my academic department of public policy, this was viewed as a reason I should not be here: as if not breastfeeding undermined any capacity I might have for economic analysis in the area"* (Waring, 2000, p.44).

There are certainly some under-theorised assumptions embedded in such a claim, as well as an implicit (masculinist?) double standard on the part of Waring's colleagues. Are Waring's workmates suggesting that when female academics talk about women's issues they are incapable of satisfactorily doing so – or shouldn't do so - unless they can draw from their own lived experiences? If this is the case, then the privileged signifier in terms of knowledge and truth here is what Diana Fuss (1989, p.113) refers to as *"the authority of experience"*. This raises the question, however, as to whether Waring's colleagues believe the appeal to experience should hold for all political analysis, or merely for analysis that involves women or women's issues. If the latter, then why should research by women, on women, be any different to other kinds of research that demands putative impartially from its subject matter? If we have no right to speak about a topic unless we have had first hand experience of it, then what does that say for the *"traditional vision of the knowing subject as universal, neutral and consequently gender free"* (Braidotti, 1992, p.182)?

The point to be made here is that the so-called 'absence' of experiential knowledge in Waring's case in no way detracts from the insights and importance of her work. We can't de-authorise Waring's right to speak seriously about infant feeding on this occasion simply because she had never suckled an infant. Indeed, Waring's macro perspective, which is based on structural economic analysis, draws attention to the fact that there are explanatory limits to individualised and personal accounts of the mother-infant breastfeeding dyad, and we should be wary not to over-emphasise or sentimentalise the relational aspects of these narratives. What Waring shows us is that breastfeeding is not just a 'gift' of nourishment that a mother bequeaths to her infant, but also work that women do; work that is currently treated as invisible, unpaid women's labour.

The vast disciplinary and discursive differences between the scholars I have referred to in this short discussion should leave the reader in no doubt of the breadth of analysis that contemporary feminism is engaged in where breastfeeding research is concerned. If there is a single point to my commentary, it is simply to state that breastfeeding, like motherhood, is not incompatible with feminist consciousness. Concomitantly, it should be acknowledged that feminism offers a variety of reflexive frameworks for thinking about the realities of women's and men's lives. And some of these discursive frameworks – corporeal feminisms for example - are useful in helping to frame women's embodied experiences of breastfeeding.

Endnotes

[1] In my research on cross-nursing, I talk to women about their infant feeding experiences with their own and other people's children. While I prefer to deploy the notion of cross-nursing in my work, it needs to be noted that some women prefer to use the concept of wet-nursing to that of cross-nursing. Various reasons are usually given for this. One is directly related to the word-association between 'cross-nursing' and 'cross-dressing', which some women feel uncomfortable with.

[2] Corporeal feminism refers to feminist research and analysis that emphasises the concrete specificity of bodies. It pays particular attention to embodied differences between sexed subjects. See Grosz (1994) for an early discussion of this body of work.

[3] See Collins (1990), Kristeva (1987), and Ruddick (1989) for a range of perspectives that all affirm motherhood or maternity, albeit in different ways.

[4] Judith Galtry's (1997) work brings to light some of the central issues in these debates (see also Galtry & Annandale, 2003).

[5] See New Zealand Herald, February 28, 2003: B3.

[6] There are numerous ways to 'mother'. Not of all these are attached to bio-genetic parenthood, nor are they necessarily sex-specific.

[7] See Fuss (1989) and Scott (1990) for extended discussions of these issues.

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Waterbirth protocols: five North Island hospitals in New Zealand

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Abstract

This article reviews protocols for waterbirth obtained from five North Island hospitals in New Zealand. Evaluation indicates varying practices. The findings are compared with available literature in order to develop suggestions for practice.

Introduction

In view of the headlines "*Doubts over waterbirths*" (New Zealand Herald 9/8/02) it seemed a timely opportunity, as I was planning the final project for my Masters in Midwifery, to conduct a review of North Island hospitals' waterbirth/immersion in water protocols. The newspaper article questioned waterbirth safety after four newborn babies were said to have nearly drowned. This paper compares and evaluates five hospital protocols in relation to the existing literature on waterbirth safety and suggestions are made for strengthening the protocols.

All North Island Women's Health Managers with e-mail addresses on the 'National Women's health managers list' were sent a standard letter, requesting a copy of their local waterbirth protocol. (Editors' comment: interested readers can obtain a copy of this letter from the author). Nine replies were received out of a possible seventeen, enclosing waterbirth guidelines, procedures or protocols, (for the purpose of this paper they will all be referred to as protocols). Of these, eight had identified waterbirth protocols and one did not have a protocol. The stated reason for no protocol, being that the Lead Maternity Carer (LMC) took the responsibility for screening and caring for women during waterbirth. What is readily apparent is that eight out of the nine hospitals do offer waterbirth in a permanent pool. One does not recommend birthing in water, but promotes the pool for its comforting and analgesic effects. Only five protocols were received within the time frame for commencing the review. Due to the time limitation of one university semester to research and complete this study, the review is based on these five protocols.

An outline of the project was proposed to the university tutors and was accepted. Approval from an ethics committee was not required by the university. However, the ethical issue of confidentiality was respected. The maternity hospitals are not named or identified. For the purposes of the tables in the text, hospitals are numbered 1-5 to enable identification of the different protocols.

A thorough literature review was performed using the Cochrane library, CINAHL and Medline to identify literature that would be useful in the critical evaluation process. In addition consensus/good practice statements were obtained from the New Zealand College of Midwives (NZCOM, 2002), Royal College of Midwives (RCM, 2000) and the Royal College Obstetricians and Gynaecologists (RCOG, 2001a) to assist evaluation.

The New Zealand Guidelines Group (2003), describes the purpose of a protocol as assisting consumers and practitioners to provide or choose best practice, by supplying the latest available evidence and recommendations for management of care. Where there is little or no evidence then recommendations should be based on expert opinion grounded in clinical experience and should be identified as such.

Reviewing the protocols

On examination of the protocols, common elements were found and grouped into the following major elements for review:

- explanation of the purpose of the protocol
- knowledge and scope of practice
- screening criteria for waterbirth
- water related issues, including pool entry time, temperature and depth
- pain relief issues
- issues in relation to birth safety, including clinical observations
- issues in relation to management of the third stage of labour
- issues in relation to waterbirth equipment
- health and safety issues, including cleaning policies
- systems for data collection
- reference materials used in the protocols

All the major elements of the protocols are critically examined in the following sections.

Findings

Purpose of the protocol

Three of the five protocols describe their purpose as being to ensure safety for mother, baby and staff. The remaining two do not refer to their purpose. The protocols have marked variances. Three are very detailed and would assist practitioners in staff development and training whilst the other two merely cover basic information on waterbirth.

Knowledge and scope of practice

Appropriate waterbirth knowledge and training of practitioners is promoted by all hospitals. Two hospitals provide waterbirth study sessions as a pre-requisite to waterbirth, whereas another two hospitals suggest that practitioners unfamiliar with waterbirth should have an experienced midwife with them. Additionally one hospital recommends two competent waterbirth practitioners be present or one competent and one learning practitioner, as the minimum standard. Comparison with the Royal College of Midwives (RCM) Position Paper 1a on the use of water in labour and birth (RCM, 2000) indicates that the RCM recommends that appropriate education, training and supervision are necessary. It recognises that some practitioners may lack experience in this area and may be faced with demands to carry out waterbirth even though they may not have had clinical experience in this field. This scenario is possible for New Zealand LMC's who access maternity hospitals. In these circumstances the RCM suggests that the practitioner must research the literature and try to gain knowledge and experience in waterbirth. Furthermore the NZCOM (2002a), in its recommended standards for practice, proposes that the practitioner has the responsibility to refer to another practitioner if she/he has reached her/his limit of expertise or requires supervision. As, for example, might occur during a waterbirth.

Ensuring women are knowledgeable about the use of water during labour is recommended in four protocols, with emphasis on it being an informed choice to enter the pool. The protocols promote an awareness of the need to leave the pool if deviations from normal occur, which is in line with the NZCOM (2002b) consensus statement on waterbirth.

Screening criteria for waterbirth

Four of the five protocols include large sections of contraindications for waterbirth.

Table 1 presents examples of these.

Table 1 Contraindications to pool use

Condition Protocol number	1	2	3	4	5
Epilepsy			X		
Severe anaemia		X			
Grand multiparity					X
Diarrhoea	X	X			X
IUGR	X	X	X		X
Prolonged ruptured membranes	X	X			X
Induction of labour					X
Augmentation of labour	X				X
Continuous fetal monitoring		X	X		X
Large fetus/ risk of shoulder dystocia	X		X		X
Known fetal distress		X			X
Hepatitis B & C / herpes/ maternal pyrexia	X	X			X
Malpresentation	X	X	X		X
Meconium liqor	X	X	X		X
Multiple pregnancy	X		X		X
Post mature › 10 days					X
Previous caesarean section	X	X			X
Severe pre-eclampsia			X		
Pre-eclampsia / BP › 90mmHg diastolic	X	X	X		X
Premature labour ‹ 36 weeks					X
Premature labour ‹ 37 weeks	X	X	X	X	
Pethidine within 4 hours	X	X	X	X	
Antepartum haemorrhage	X		X		
Prolonged second stage	X		X		
Previous third degree tear			X		
Previous postpartum haemorrhage	X		X		
For delivery of placenta			X		
Heavy third stage bleeding / feels faint			X		

The RCOG (2001a) notes that there is little evidence to guide high risk women in the use of water during labour. However, with the issue of safety being uppermost this may be the boundary that these hospitals wish to practice within. Such a comprehensive list of contra-indications that are not supported by evidence, may exclude many women from using water in labour. For example, a woman who has had a previous caesarean section is excluded from water immersion/birthing in one unit but included in another unit. Brown (1998), in her audit of waterbirth, reports that of 10 women who had previous caesarean sections elected for waterbirth, all succeeded in achieving normal deliveries in water. Although this study is limited by the number of cases studied, it does suggest the possibility of safe waterbirth after previous caesarean section.

Appropriate waterbirth knowledge and training of practitioners is promoted by all hospitals.

The literature review did not reveal any research that produced evidence for, or against, the use of water in situations such as being more than ten days post dates, grand multiparity (these women may indeed be more prone to unexpected waterbirth when bathing), induction of labour, or prolonged ruptured membranes (in the absence of signs of infection). One article reported inconclusive evidence on the efficacy of the delivery of the placenta under water (Garland, 2000). However, there are theoretical and anecdotal suggestions that water immersion in labour can produce physiological and psychological benefits that may well help women who are facing barriers to normal birth. These benefits include; decrease of pain, increasing of contractions, reduction in blood pressure, increase in self control and increased diuresis (Garland & Jones, 1997). For women who are categorised at potential risk from waterbirth, perhaps an explanation of the implications and risks of waterbirth might be presented to women antenatally. This would allow them to make an informed choice for the use of water in childbirth rather than be excluded until further research evidence is found.

Water related issues including pool entry time, temperature and depth

In two protocols, the recommended time of entry to the pool is for women to be at least 5 centimetres (cm) dilated. Another protocol states that women should only enter the pool for short periods in early labour. It also adds that uterine action is enhanced if the woman is in established

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Waterbirth protocols: five North Island hospitals in New Zealand

labour. The other two protocols do not have any recommendations in relation to pool entry time. When reviewing the literature there is inconclusive evidence on water and uterine activity enhancement. However, a study by Eriksson, Mattsson and Ladfors (1997), which compared entry to the pool prior to and after reaching 5cm dilatation, concluded that women entering prior to 5 cm had a higher chance of experiencing prolonged labour and requiring oxytocin augmentation.

Variations exist amongst hospital protocols for both water temperature and the time schedules for monitoring this (Table 2). A review of the literature recommends a water temperature of 37degC for delivery (Brown 1998; Charles, 1998). Some authors have noted the theoretical risk of increased fetal cerebral vasodilatation and oxygen requirements if the temperature is too hot (Charles, 1998; Johnson 1996). Also if the baby is born into water that is too cool or not born fully submerged in water it is thought that it could cause the baby to gasp prior to fully surfacing from the water (Rosser, 1994).

None of the literature reviewed revealed evidence for water temperatures in the first stage of labour. Marchant et al. (1996) found national variations in practice recommendations which ranged from 33-40 degC for first stage immersion temperatures.

Table 2 Water Control

Stage of labour	Water temperature deg C	Recording frequency	Protocol 1	2	3	4	5
1	28-35	1 hour	X			X	
1	36-37	1 hour		X			
1	Not › 37	1 hour			X		
1	36-37	1 hour					X
2	36-37	1 hour	X			X	
2	37	1/2 hour		X			
2	Not › 37	1/4 hour			X		
2	36.8 – 37.2	1 hour					X

Johnson (1996) recommends that water immersion temperatures and the area of the maternal body that is immersed in water should be continuously monitored, displayed, and recorded to prevent overheating the mother. This is discussed further in a later section on monitoring of maternal temperature and water depth.

Water depth in all protocols is recommended to be sufficient for the baby to be born fully submerged and for the baby to be brought to the surface, either as soon as possible or within one minute of complete delivery. However, no protocol identifies the need for the water level to be low enough to allow maternal expiration of heat thus avoiding maternal hyperthermia (Forde, Creighton, Batty, Hawdon, Summers-Ma & Ridgway, 1999). These authors recommend having the water level no higher that the level of the breasts when sitting in the pool in order to allow maternal expiration of heat. Furthermore, the RCOG (2001a) recommends the water is not unnecessarily deep to prevent the cord snapping as the baby is brought to the water's surface. However, the RCOG states there is no evidence that increased depth can cause the cord to snap. The complication of cord snapping was unexpectedly found by Gilbert and Tookey (1999) in a surveillance and postal study on waterbirth.

There are marked inconsistencies between hospitals on exclusion criteria for the use of the pool in labour, resulting in women being prohibited from using the pool in some institutions and not in others

Pain relief issues

Four protocols recommend the woman should not enter the pool if it is less than four hours after administration of an opioid analgesic. Garland (2000) suggests this is probably due to the sedative effect which may impact on the woman leaving the pool in an emergency, or lead to her being less aware of her surroundings. Opioids can cross the placenta and cause drowsiness and unresponsiveness in the baby at birth. Interestingly, one protocol allows the use of the pool with fentanyl (intravenous or intramuscular) for analgesia in labour but not pethidine (if less than four hours since administration). Fentanyl is classed as an opioid drug and has similar side effects to morphine and pethidine (British Medical Association` & Royal Pharmaceutical Society of Great Britain, 2000), however it has a shorter duration of action. It would be interesting if this maternity unit audited the use of this drug in waterbirth to identify any effects and outcomes.

Birth safety, including clinical observations

Two protocols state the woman should not be left alone in the water and two protocols advise the woman should have the ability to leave and enter the pool easily. This would be in anticipation of any unexpected complications. Not all protocols identify possible complications or how to deal with them as recommended by the RCOG (2001a). Only one protocol had an evacuation from the bath procedure. However, one suggests the mother stand up for nuchal cord (if there is difficulty delivering the baby). Another suggests the mother squat in the pool for shoulder dystocia and leave the pool if this fails. It is acknowledged that these types of emergencies may be covered in staff training on waterbirth, but emergency procedures laid down in a protocol do remind staff about what is expected.

When I examined the recommended clinical observations for labour I found that three protocols advise observations as is usual for normal labour. Whereas another protocol advises:

- a cardiotocograph (CTG) recording prior to entering the pool
- maternal pulse, temperature (to detect signs of maternal hyperthermia), blood pressure one hourly
- fetal heart recordings 1/4 hourly during a contraction in the pool.

A further protocol advises:

- maternal temperature 2 hourly
- fetal heart recordings 1/2 hourly in the first stage of labour and 1/4 hourly during the second stage.

Brown (1998) in her audit of waterbirth did not find a connection between the time spent in the pool and maternal pyrexia which led her to extend maternal temperature recordings to 2 hourly. However, Charles (1998) recommends monitoring the maternal temperature hourly and if it rises more than one degree above the baseline the mother should leave the pool or the water be cooled, due to the theoretical risk that prolonged maternal hyperthermia may lead to fetal hyperthermia (Johnson, 1996).

The need for a woman with uncomplicated pregnancy and labour to have a CTG prior to entering the pool is not in line with the current evidence, which does not support an admission CTG in low risk pregnancy (RCOG 2001b). Intermittent auscultation of the fetal heart is the present recommendation for uncomplicated labour. The RCOG (2001b) and the American Academy of

Family Physicians (2000) recommend intermittent auscultation for at least 60 seconds every 15 minutes after a contraction in the first stage of labour and every 5 minutes in the second stage.

Vaginal examination is not mentioned in three protocols but two agree that these could be performed in the bath. There are no known dangers with this. However, in some cases there may be some difficulty for the practitioner due to the woman possibly being less accessible than if she were out of the water.

Four protocols indicate *"that if episiotomy is required the woman is asked to leave the pool"*, but one protocol suggests it can be performed while the woman is in water if necessary. In contrast, Garland recommends the woman must leave the pool if episiotomy is required as she argues *"in an emergency an episiotomy may well facilitate delivery but if that is occurring, I would question why the woman is still in the water"* (Garland, 2000, p.110).

In four protocols cord clamping is not recommended until after the birth of the baby's body, preferably after the baby has surfaced. However, one protocol suggests that if the cord is tight around the baby's neck, and it requires clamping and cutting prior to the birth of the body, the mother is asked to stand up from the water. Another protocol suggests clamping, cutting and then bringing the baby to the surface immediately. Garland (2000) does not recommend cutting or clamping of the cord prior to the baby surfacing the water, this is because such babies are at increased risk of experiencing hypoxia. Fetal hypoxia is likely to interfere with the baby's dive reflex by depressing the swallowing response which subsequently may lead the baby to inhale water during waterbirth (Johnson, 1996).

All protocols recognise the increased possibility of delayed respiratory initiation for the waterbirth baby after it surfaces the water when compared to babies born in air. Garland (2000) provides an explanation of this when she discusses and compares stimuli relevant to delayed respirations such as entry into warm water, non-touch birth technique and gravitational pressure differences. A suggestion of gently blowing onto the baby's face to stimulate breathing is made by Brown (1998) should a delay of respiratory initiation occur following the surfacing of a baby born in water.

Issues in relation to management of the third stage of labour

The protocols vary in both third stage management and difficulty of estimation of maternal blood loss (Table 3). The literature and the protocols differ with some allowing the mother to deliver the placenta in the pool (NZCOM, 2002b) and others advising the mother to leave the pool (Forde, et al., 1999; RCOG, 2001a). No conclusive evidence was found against delivering the placenta in the pool. However, theoretical risks associated with the relaxing effects of warm water on uterine muscles were noted, which included retained placenta, water embolism and increased blood loss (RCOG, 2001a).

If the woman chooses active third stage management then two protocols advise giving the oxytocic drug once the mother has left the pool. No reasoning is given for this advice. My guess is this would be to allow the procedure of controlled cord traction and prevent entrapment of the placenta in the cervix.

As the result of an isolated incident, Austin, Bridges, Markiewicz and Abrahamson (1997) raised the issue of newborn polycythaemia due to delayed cord clamping. They hypothesised that this may be due to the warm water preventing the cord to vasoconstrict (as it usually does on contact with air), resulting in too much blood being transferred to the baby. Odent (1998) recommends clamping of the cord 4-5 minutes following delivery to prevent this. These considerations are not reflected in any of the protocols.

Table 3 Third stage management

Hospital number	Comments
1	Advised to deliver out of the pool, theoretical risk of water embolism. Oxytocic withheld until left the pool. Difficult to assess estimated blood loss.
2	Theoretical risk of water embolism but no reported cases. Expect physiological. If active, increased estimated blood loss or difficulty/ delay with the placenta [then] woman to leave pool.
3	Informed decision, physiological in or out of the pool. If active oxytocic to be given when out of the bath. Practitioner assesses maternal condition, if in doubt remove client from bath.
4	Physiological recommended, if prolonged remove from bath/ change position. If active give oxytocic once out of bath.
5	No recommendations

Issues in relation to waterbirth equipment

One protocol does not suggest any equipment requirements but the four other remaining protocols all recommend; a water thermometer, Aqua Doppler, and a sieve to evacuate contaminants from the pool. Two protocols also suggest a torch and mirror whereas and another proposes an electric fan, to help circulate cool air in the room. Garland (2000), also recommends a room thermometer to enable maintenance of the room temperature at 21-22degC in order to aid control of maternal core temperature at 37 degC.

The RCOG (2001a) recommends having a cord clamp on hand in case of cord snapping as previously described. Whilst this comment would alert staff to this risk, it would be reasonable to assume that all units would have delivery equipment, including a cord clamp, readily available in the waterbirthing room.

Health and safety issues, including cleaning policies

Protection against personal injury for staff is acknowledged in three protocols with one recommending that easy access is maintained around the pool and that the *"midwife wears protective clothing"*. The precise nature of such clothing is not identified. This might be gauntlet style gloves as recommended by Garland (2000). Other protocols suggest that staff attend manual handling training and finally note that; *"the midwife must not enter the pool"*. This is surprising because no evidence or suggestions for the midwife to enter the pool are found in the literature. However, these suggestions may be in response to the public, which has been known to pass comment indicating that they assume that the practitioner **does** enter the pool during a waterbirth.

Screening for hepatitis B and C is acknowledged by three hospital protocols, but no protocol mentions human immuno-deficiency virus (HIV). Three protocols (Table 1) do not recommend the use of the pool for women with known hepatitis B or C, but one protocol says this is at the discretion of the practitioner. Garland discusses the risk of HIV and hepatitis in relation to waterbirth and notes; *"infectivity is dependent on the quality and quantity of the virus (direct inoculation or mucosa contact with birth attendant)"* (2000, p.49). This would be difficult to assess in waterbirth so therefore should not be recommended unless the practitioner is aware of the personal risks and how these might be managed.

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Waterbirth protocols: five North Island hospitals in New Zealand

The importance of using clean tap water is recognized by all protocols. Three recommend that no additives, such as aromatherapy oils, are used. Interestingly the RCOG (2001a) recommends considering the use of isotonic water to prevent the theoretical haemodilution effect and possible freshwater drowning (Barry, 1995; Nikodem, 1999). Johnson (1996) provides an explanation of the inhibition of fetal breathing and the initiation of the full diving response by isotonic alkali solution. However, a letter of response to this suggestion by Pearn (1995) does not recommend this practice until results of further experimental research are available.

Four protocols identify pool cleaning procedures varying from the use of Presept 5gm tablets to 'Snow Glow' cleaning solution. One protocol does not comment on cleaning procedures and another protocol suggests swabbing the pool in between use to monitor bacterial infection. Garland (2000) proposes this may be useful when defining/auditing a cleaning policy but does not recommend this in general. However, she does recommend cleaning and drying the pool daily (even if unused) and after individual use. Forde et al. in their waterbirth study, conclude that *"there is no increased risk of bacterial infection to mother and baby"* (1999, p.171). This suggests that routine swabbing could be an unnecessary procedure and expense providing that correct cleaning procedures are followed.

Systems for data collection

Only 2 of the 5 protocols indicate that waterbirth statistics are collected. These include only the births in water and do not include women who use water for immersion in labour and then opt to deliver out of the pool. Additionally, there is no national database of such information. An interview with Robyn Maude (Cassie, 2002) acknowledged this and plans to develop a national database are being made. Data collection on water immersion in labour and delivery, nationally and internationally, would enhance further knowledge, research and practice on this issue.

Reference materials used in the protocols

Two protocols have a reference section. However, citations are not included in the text and therefore these could be more appropriately termed a 'bibliography section'. The remaining three protocols do not refer to any literature or research so it is difficult to ascertain where the information to support the protocol is obtained.

Discussion and recommendations

There are similarities and disparities amongst the five North Island hospital protocols and when compared to the literature review of waterbirth. For example, there are marked inconsistencies between hospitals on exclusion criteria for the use of the pool in labour, resulting in women being prohibited from using the pool in some institutions and not in others. An example of this is women who have had a previous caesarean section. There is limited research that suggests waterbirth may be a factor in the successful normal outcomes of labours which are labelled 'trial of scar' (Brown, 1998). Perhaps hospitals should reconsider their protocols for otherwise uncomplicated women in the light of this.

A lack of reference to research in the protocols and discrepancies between protocols raises questions of: 'Who is formulating the protocols?' and 'What evidence supports the protocols?'. These in turn question the credibility of the protocols. Insufficient up-to-date information could limit informed choices for pool use during labour and birth which could be detrimental to both women and their carers. I recommend that hospitals provide, and reference, the best available evidence to support the protocols. They should also indicate where expert opinion for practice is used if insufficient research evidence is available to support practice.

The need for staff and women to have education about waterbirth is identified well in the protocols. Some are more detailed which, provided they are based on sound evidence, offers better assistance for practitioners, learners and women in waterbirth, especially if faced with an unexpected waterbirth. Emergency scenario evacuation procedures are not covered in all protocols. I would suggest that these be included to remind and assist staff of how to react should complications arise.

The standard of monitoring maternal and fetal wellbeing varies, as does water temperature control and in some cases it is not in line with current evidence. For example, the recommendation of a CTG prior to bath entry is unnecessary for women with uncomplicated labour and births. Additionally the monitoring of the pool temperature in late first and second stage of labour needs more frequent observation than 'hourly' for an imminent birth to ensure the ideal temperature of 37 degC.

Water depth requires further research. Although the protocols recognise the need for the water to be deep enough for the baby to be born totally submerged, they do not highlight the possible complications of having the water too deep, such as maternal hyperthermia.

When considering areas where there is inconclusive evidence such as management of the third stage of labour and cord clamping, I recommend that women who are considering waterbirth be presented with all available up-to-date information including theoretical risks so they can make a truly informed choice.

The collection of statistics on immersion in water during labour and waterbirth , along with the initiation of a national database on waterbirth will help inform practice. There is also the potential to promote research questions to provide further evidence to support decision-making and choices about the use of water during labour and birth.

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A Marshall factfile: breastfeeding your baby

Author: Heather Welford, 2000
Marshall Publishing, London. ISBN 184028-290-8
Price: approximately $NZ 39.95
Available from local bookshops

Reviewed by: Nicola M. Budding
Midwife, Palmerston North Hospital

Breastfeeding your baby is a book aimed at breastfeeding women rather than health professionals. It provides practical information answering some of the most commonly asked questions about breastfeeding and how it affects women, babies and the family. The text puts significance on breastfeeding both as a learnt and learning experience, as well as a worthwhile experience with no right or wrong way of accomplishing it. Also incorporated in Chapter 3 is how the day-to-day changes challenge and impact on a woman's perception of breastfeeding, herself and her family.

The author, Heather Welford, is a freelance journalist and author who contributes to, and edits, many newspapers and magazines whilst also writing about the subject of pregnancy and childcare. Apart from having three children of her own, she does not appear to have formal credentials in this subject, but this does not discount the validity of information in the book.

The six chapters of the book explore a variety of topics from initially choosing to breastfeed through to solving breastfeeding problems. Plus the final chapter on breastfeeding in special situations includes twins, preterm infants and babies with special needs. The book is colourful with photographs (researched and edited by Elizabeth Loving) rather than graphics punctuating, and giving context to, the written words. Each chapter is indexed in three places (contents page, on the page edges and lastly at the back), which enables directly finding what one is looking for. The book is easy to read since the topics are written in short 2-4 pages sections. It is easy to choose a subject, pick up the book and read what is needed without having to wade through irrelevant and superfluous information to get to the heart of the matter. The book is generalised and non-technical with a large variety of subjects being only briefly covered. Readers, particularly healthcare professionals, who are looking for a physiological understanding of breastfeeding may find this book inadequate for their needs, as would women who needed additional information about a topic.

Because the information in the book is limited, it is important that readers use it as intended; as a guide rather than a professional textbook. Both Helford and the publishers note this at the beginning of the book with a disclaimer which states *"this book is not intended to replace consultation with a doctor or other healthcare professionals"*. No references appear in the book as it seems to be written from a personal perspective, which in itself can be valuable. And there is no supporting literature or resources which might be useful for readers looking to further their knowledge about a particular topic.

Despite some of its limitations, this book contains easy reading information about breastfeeding, which suits a target audience of some women and their families. Although written for the United Kingdom market, it is suitable for use within the New Zealand context.

A Midwife's Handbook

Author: Constance Sinclair, 2002
St. Louis, Missouri, USA: W.B.Saunders
(www.elsevierhealth.com)
ISBN 0-7216-8168-9
Price: approximately $NZ 79.95
Available from local bookshops and Capers bookshop (www.capersbookstore.com.au)

Reviewed by: Sarah Stewart, Midwifery Lecturer

I have to admit to being prejudiced against textbooks from America, because of my fears that they will be highly medicalised. However, I am really impressed by this book, which is well written, evidence-based and underpinned by midwifery philosophy. The book covers normal pregnancy, birth and the puerperium, as well as their complications. There are also chapters on contraception and the menopause. I especially enjoyed the chapter on complementary medicine which gave me an insight into areas such as aromatherapy, Chinese and homeopathic medicine and reflexology. There are also excellent appendices that include nutrition information, laboratory values and fetal skull landmarks. What I particularly like about this book is that it is small and easy to carry around in a bag or glove compartment of the car. It packs in a broad scope of information, which can be easily referred to in a rush. It also highlights midwifery management, which facilitates the decision-making process. I highly recommend this book to midwives and students, especially as the price is very reasonable compared to other textbooks.

HIV in pregnancy and childbirth

Author: Jane Kennedy, (2nd ed.), 2003
London: Books for Midwives
(www.elsevierhealth.com).
ISBN 0-7506-5325-6
Price: approximately $NZ 87
Available from local bookshops and Ace Graphics (www.acegraphics.com.au) and Capers Bookshop (www.capersbookstore.com.au)

Reviewed by: Sarah Stewart, Midwifery Lecturer

HIV in childbirth is a very topical subject at the moment. At the time of writing this review, national guidelines for testing and management were being debated and formatted (www.nhc.govt.nz/publications/AntenatalHIVdiscussiondoc.pdf). I came to this book being fairly uneducated on the subject of HIV and childbirth. I found it quite complicated at times, so appreciated the summaries at the end of chapter. The book is a comprehensive text about HIV, written in the British context. Thus, there are differences such as routine HIV testing in pregnancy in the UK but, not as yet, offered in NZ. This book is a good starting point for increasing knowledge, but it is worth being aware that the management recommended in the book is controversial at times. For example, there is international discussion about breastfeeding and the transmission of the HIV virus. Kennedy recommends that women with HIV do not breastfeed. There are opposing opinions, so it is worth reading further in order to fully understand this complex issue. I would also recommend that midwives shop around for this book, because price differs between various retailers.

TIPS FOR CONFERENCE PRESENTATIONS

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Introduction

In the next couple of years there are plenty of opportunities for midwives to give conference presentations. For instance, the New Zealand College of Midwives (www.midwife.org.nz/index.cfm/Conference2004) has its biennial conference in Wellington during September 2004, and the International Confederation of Midwives (ICM) is holding its next conference in Brisbane, July 2005 (www.midwives2005.com/index.shtml). This article will discuss some issues that midwives must consider when presenting a conference paper.

Writing an abstract

The call for conference abstracts usually goes out nine – twelve months before the conference date. The abstract must:

- summarise what the presentation is all about;
- contain a preview of the paper, and catch the eye of the conference organisers;
- have a title that is short and reflects the subject of the paper, to draw the attention of the reviewers to the abstract (Van Dyke Hayes, 2003);
- contain the purpose, rationale and significance of the full paper, as well as identify the major themes, findings and conclusions;
- be logically organised and persuade the reviewer that the paper should be included in the conference programme.

When writing an abstract, the choice of subject to present should be guided by the conference theme. The presenter ought to:

- stay relevant to the conference theme;
- follow the format required by the conference organisers in the "*Call for abstracts*";
- pay particular attention to details such as font and word limit;
- check for errors such as grammar or spelling (Van Dyke Hayes, 2003);
- contact the conference organisers if further advice about the subject is required.

Preparation

Thorough preparation is the key to a successful presentation.

- Tailor the presentation to meet the needs of the audience.
- What do the audience want to know? What is their current knowledge?
- Are there any sensitive or controversial issues to be aware of?
- Use language that is appropriate for the audience.
- Be familiar with venue – is it a large hall or small intimate room?
- Be familiar with any audio-visual aids, such as computer, slide-projector or microphone.

Structure

Be clear about the purpose of the presentation and the message that is left with the audience (Hadfield-Law, 2001a).

- Spend time developing the conclusion first, remembering that the conclusion is the last thing the audience hears.
- The conclusion should summarize what has been said, provide closure, make a good lasting impression and motivate the audience.
- Set the scene quickly in the introduction because there are only a couple of minutes to catch the audience's attention.
- Use a story, humour, amazing fact or unusual visual aid to grab the audience's interest.
- Find out if there is a customary or traditional manner of greeting the audience.
- Provide name, credentials and contact details.
- Focus on presenting three to five main points in the main body.
- People lose concentration after ten to fifteen minutes, so think about how to keep the attention of the audience.
- Provide references at the end of the presentation, so that people can pursue the subject further if they so desire.

Time management

Commonly, there will be only 15 – 20 minutes to speak, so it is crucial that time is managed time effectively (Hadfield-Law, 2001b).

- Rehearse the presentation, especially if visual aids or PowerPoint special effects are being used.
- Have a strategy prepared in case time runs out, for example what information can be missed out.
- Spend time on the conclusion because that is what the audience will remember.
- Ask the chairperson to indicate when the conclusion needs to be made.
- Do not overrun the time because it is unfair on the person following, and annoys the audience.

Using visual aids

Visual aids can either complement a presentation or be the speaker's nightmare.

- Make sure the visual aids are functioning beforehand.
- Check that equipment such as computers, slide projectors or televisions are available at the conference.
- Check there will be someone available to help deal with technical difficulties.
- Consider compatibility of videos/DVDs and computer software, especially if overseas.
- Have a back-up plan in case the equipment does not work at the conference.

PowerPoint

Increasingly, conference speakers are expected to use PowerPoint. However, one of the problems is that people concentrate on the format and not the content (Tufte, 2003). It is possible to have the most elaborate presentation in the world, but the audience will still become bored if the speaker has nothing to say.

- Use large font, at least size 24/28 so that people can read what is written.
- Do not have a large number of slides, because the audience will find too much information difficult to absorb.
- Keep the presentation simple.
- Make sure there are no spelling mistakes.
- Do not use a large number of animations and sound effects because they can be very annoying to watch, and easily distract the audience. They are also very time-consuming to apply to slides.
- When using pictures or illustrations, use high quality images rather than drawings. Consider copyright issues when downloading images from the Internet.
- Be familiar with how PowerPoint program works, because there may be no one available to help if there are difficulties.
- Run through presentation at the conference as soon as possible, to check that it works.
- Email presentation to the organiser, so it can be checked ahead of the conference.
- Be prepared for the worse case scenario in which the computer crashes, although this is unlikely at a professionally organised conference.

Delivery

The most important thing is to speak to the presentation, and not read from a paper or slides.

- Have notes or cue cards as prompts.
- Rehearse beforehand to be familiar with the content.
- Ask for feedback from friends or colleagues before the presentation.
- Make eye contact with the audience, focusing on friendly faces.
- Do not talk too fast or quietly because people will not be able to hear what is being said.
- Reduce personal mannerisms such as talking with hands, because they are distracting for the audience.
- Be prepared to answer questions from the audience.

Dress and appearance

It is important to make a good visual impression on the audience (Banks, 2003).

- Dress according to the expectations of the audience. Look smart and tidy.
- Wear clothes that inspire personal confidence, and avoid over-heating which can be exacerbated by nerves.
- Wear comfortable shoes.
- Wear lipstick and light make-up, because stage lights can make a person look pale and washed out.

Reducing nerves

Being well prepared, familiar with content and confident with visual aids can greatly reduce nerves.

- Use humour to relax, and catch the attention of the audience.
- Try deep breathing exercises.
- Go to the toilet before the session.
- Keep well hydrated to prevent a dry mouth. Takes sips of water when speaking, but handle the glass carefully so that water is not spilt.
- Keep nervous trembling hands out of sight and avoid doing things such as handling transparencies (Hadfield-Law, 2001b).
- Avoid words that are difficult to pronounce.
- Keep cue cards at waist level. Number them so they can be sorted if dropped. Write on one side only, using lower case.

After the presentation

Do not be afraid to actively seek feedback, to find out what worked and what improvements can be made for next time.

- Reflect on session and document details in professional portfolio, noting where and when presentation was made; size and nature of audience; subject of presentation; what was learnt from the process; what went well and what would be done differently.
- Add details to curriculum vitae.
- Submit presentation as a paper for publication to a professional journal.
- Do not submit the full paper for publication in the conference proceedings, because it cannot be published later in a journal.

Conclusion

The key to giving a successful conference presentation is to be fully prepared, with a thorough knowledge of the material, and being confident with the use of visual aids. Concentrate on expounding three - five key points and do not overload the audience with information. Finally, do not be afraid to give it a go and enjoy the experience.

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LETTERS TO THE EDITOR

Letter from Jennie Crawshaw, Midwife sent to Lesley Dixon with a copy to the Editorial Board, which is reproduced with permission.

I am writing in regard to your article in the latest College of Midwives Journal regarding *"birth in a caul".*

I read your article and would like to tell you a tale, which challenges your explanation of babies not breathing before the waters have broken.

On two occasions during my practice as a midwife I have been present at a birth where the baby has birthed with the membranes remaining completely attached to the placenta. The placenta birthed at the same time as the baby, it is notable that there was a significant haemorrhage at the time of birth.

It is the second birth I want to talk about. I was practicing alone about 1000 kms from a hospital where there was a credible NICU or caesarean section facilities. The woman was about 28-30 weeks gestation and had presented with an antepartum haemorrhage. The fetal heart was strong but it was acknowledged by the family that the baby was probably "too small".

However, as time passed it was clear that she was in labour, and the birth was rapid. The baby/membranes/ placenta birthed in one push and rested between the woman's crossed legs. The baby looked small and I thought it would be kindest to just let it pass away in its warm familiar environment, it looked so peaceful and calm. After about 2-3 minutes the baby started wriggling round, and then it started desperately trying to breathe, sucking the membranes in, like it was in a plastic bag waving its wee hands around endeavouring to make a hole. I made a wee hole for it still thinking it would just die and it literally crawled out of the sac and went looking for its mother.

So there you go, I think that sentence that you wrote "the baby will not initiate respirations until the membranes are ruptured" is incorrect.

The rest of your article, although stating the obvious, I agree with.

In reply to Jennie, Lesley wrote the following.

Thank you for your letter regarding the article in the Midwives Journal in October.

I read of your experiences with interest. I wrote the article to bring an area of interest of mine into focus for midwifery discussion. I feel that this is an area of midwifery that has not been widely discussed and the management of birth in a caul is not described in great detail in midwifery textbooks. Having discussed this topic with other midwives I have found that most have experienced a birth in a caul. As such the management of birth in a caul does need to be considered by the midwifery profession for best practice outcomes.

It was interesting to note that your baby did attempt to breathe with the membranes intact following birth but I feel that this may have been due to the reducing placental surface and reduced gaseous exchange that would have occurred after 2 – 3 minutes. This fetal hypoxaemia would stimulate the baby to commence breathing. I have tried to be clear in my article that the membranes do need to be broken as soon as possible following birth of the shoulders for this very reason.

I would suggest that your experiences shows that there is a need to make sure that the membranes are broken within 1-2 minutes of the birth.

Thank you for your contribution to this debate.