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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.
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GUEST EDITORIAL

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This year is the centenary of midwifery registration in New Zealand. The Midwives Act 1904 established midwifery registration and the regulation of midwives' practice. It standardised midwifery training and enabled the setting up of a State maternity service through St Helens hospitals.

This centenary will no doubt be commemorated in a number of ways throughout the year. Although I am not a midwife, as an historian I was invited to work in collaboration with midwifery colleagues, Joan Skinner and Judy Stehr, to produce an exhibition which traced the history of New Zealand midwifery over the last century. The obvious place to locate an exhibition of this kind was Archives New Zealand, the repository of all governmental records and therefore the site of centralised archival material on the regulation of the midwifery profession. Our project proposal was accepted by Archives New Zealand and we subsequently joined forces with archivists Alison Hadfield and Carly Hall. The resulting exhibition, *'A Labour of Love: 100 Years of Midwifery Registration in New Zealand'*, was therefore a collaborative venture between Archives New Zealand and the Graduate School of Nursing and Midwifery at Victoria University of Wellington.

The exhibition opened at Archives New Zealand in Mulgrave St, Wellington, on 13 May and will run for one year. The displayed material includes items such as letters, legislation, memoranda, booklets, photographs, film, oral history recordings, cartoons, newspaper articles, licenses, inspection reports, examinations, advertisements and even equipment. The exhibition demonstrates the changes in practice, in professional regulations and relationships, and in the places where midwives have practised over 100 years.

Any event which commemorates the centenary is based on the premise that there is value in casting a gaze back over midwifery's professional past. This yestergazing must be done, though, with a critical eye as much as an appreciative one. It should lead to an understanding which is free from romanticism. Any profession which romanticises its past or allows myths to gain hold without challenge, runs a grave risk of losing its history in a cloud of distorted ideas about the past. Nursing has risked this from time to time. It would be a pity if midwifery did as well.

Let's focus on myth-making for a moment. Any group with a shared culture creates social myths which serve a particular role in sustaining the cultural fabric of that group. As I have written elsewhere,[1] in everyday language 'myth' is often used to denote untruth but in exploring the culture of a group, 'myth' has another meaning. Myths are symbolic statements about the world and our place in it. They may arise in response to difficult situations, as a result of entanglement with reality, or as an effort to inspire or sustain the group. Myths can serve as an explanatory narrative, a blueprint for social structure, a charter for action, or a creative force providing energy for the group.

While the substance of a myth may not be 'true' in a factual sense, or may have only a kernel of fact, the 'truth' of a social myth is gauged by how effective it is in helping the group understand its world and its experiences. One role of an historian is that of myth-revealer, always a risky role as no culture appreciates an outsider (or insider) examining its myths too closely. I have taken on this challenge to present some ideas about the kinds of current midwifery beliefs which might, indeed, be mythical. As with any historical enterprise, however, my interpretation of midwifery's history is exactly that – an interpretation – and equally open to challenge.

Let's look at three beliefs I have heard expressed by current midwives which, based on my archival research in the history of New Zealand midwifery and maternity services, strike me as contemporary social myths. The first relates to the historical practice of midwives, the second to the professional world they worked in and the third to the wider legislative context of that professional practice.

Myth 1

That there was in the past a golden age of midwifery (which should be aspired to again), in which midwives practised with minimal intervention in the birth process. Furthermore, it was only when birthing shifted to hospitals (a trend which was clearly evident by the 1930s) and became medicalised, that the practice of midwives working in these hospitals became equally medicalised and interventionist.

Points to ponder

To investigate this line of argument it is not sufficient to look for historical evidence that shows that midwives practising in hospitals were medicalised and interventionist in their practice. We need to find evidence that midwives who remained practising *outside* of the main hospitals *retained* a non-interventionist mode of practice, if this had existed. Midwives practising in the very small hospitals, which had perhaps two to six beds and maybe only one midwife on at a time, would have had a great deal of control over their daily practice. They would have had the choice of how to practise and could have continued to do so in a non-medicalised, non-interventionist way.

The evidence, however, shows the opposite, when taking as one indicator their active use of pain relief medication during the birth process. For example, a 1948 survey of all hospitals, which included small private hospitals and maternity homes where midwives worked, showed that although they were not permitted to use chloroform without a doctor present, they were routinely using a range of analgesic drugs, including Pethidine, Chloral and Bromide, and Nembutal. Only one midwife, who ran a two-bed private maternity home in Auckland, did not give pain-relieving drugs.[2] It might be suggested that this widespread use of analgesic drugs is just evidence that medicalisation had spread beyond the large hospitals, infiltrating the small private maternity homes. The real issue, though, is that even in these places, where midwives could choose how to practise, there is no evidence of a golden age of non-interventionist midwifery and clear evidence of the opposite.

Even earlier evidence comes from the St Helens hospitals which, from 1905, provided a State maternity service to working-class women which was delivered almost exclusively by midwives. Each St Helens hospital had a medical superintendent but this doctor was only called in when birth complications were anticipated. These hospitals were championed by the government as places which achieved better health outcomes (e.g. fewer forceps deliveries, lower puerperal sepsis rates and fewer maternal deaths) than other hospitals, whether large or small, private or public, where doctors were more directly involved in the birth process. Midwives today should be proud of the achievements of these midwives in the past. However, as my research with Dr Maralyn Foureur is showing, even in these hospitals midwives were intervening in a range of ways to manage the birth process and puerperium, such as administering lotions, sedatives, douches and a variety of treatments for insufficient milk supply.[3]

Myth 2

That in the medicalisation of childbirth which accompanied the shift to birthing in larger hospitals, midwives became professionally subservient to doctors.

Points to ponder

A significant part of the government's hospital-based maternity service was sited in the St Helens hospitals. By 1920 these hospitals were established in Wellington, Auckland, Christchurch, Dunedin, Gisborne, Wanganui and Invercargill. As mentioned earlier, the maternity service in these hospitals was provided almost exclusively by midwives.

The key point here is that even in State-run St Helens hospitals, under the watchful eye of a government department where doctors held power, for several decades midwives provided this daily management and delivery of a very important maternity service. It would be hard to argue for midwifery subservience to medical power in these St Helens hospitals which were such a significant part of the State maternity service in the first decades of the twentieth century.

Midwives in private practice in these same early decades had times of troubled professional relationships with doctors. These conflicts, however, do not show evidence of midwifery subservience to medical domination. Quite the opposite. If midwives were not able to solve problems directly, they took appropriate action by requesting support from the government department able to intervene.

In 1916, for example, an Auckland midwife reported to Amelia Bagley, the government Inspector of Midwives, that doctors told her they were 'determined to put a stop to midwives taking cases without medical men being engaged also', and that Auckland doctors were 'going to refuse to attend if called in emergency to a midwife's assistance'. Amelia Bagley immediately sent a memorandum to the Auckland District Health Officer. She described the situation in very clear terms and cleverly challenged him to think about the need for doctors to have collegial relations with trained midwives, compared with their current support for unqualified women, especially as this support connived at breaches of the Midwives Act which endangered the lives of women.[4] Hardly subservience.

Myth 3

That legislation enacted in the early years of the twentieth century prohibited Māori women from breast-feeding their babies, a situation of particular concern to midwives today who support women to breastfeed their babies and promote breastfeeding as the optimum method of infant feeding.

Points to ponder

The legislation usually referred to in discussions of this amongst current midwives (and others) is the Native Health Act 1908. There is no such Act. Nor is there any Act by that name, or any similar name, in the decades on either side of that year. Nor was breastfeeding by Māori women suppressed through any other Act, such as the Tohunga Suppression Act 1907. Other historians have also searched for legislation affecting breastfeeding in this way, but it has never surfaced.[5] In fact, Māori women were actively encouraged to breastfeed and this was incorporated in health policy, particularly by Māori Health Officers like Maui Pomare and Peter Buck, and other members of the Department of Health.[6] The Department also had a consistent policy of encouraging all women to breastfeed and reported success rates in this, in its Annual Reports.[7]

Any profession which romanticises its past or allows myths to gain hold without challenge, runs a grave risk of losing its history in a cloud of distorted ideas about the past. Nursing has risked this from time to time. It would be a pity if midwifery did as well.

Sadly, this myth has already become embedded as fact in teaching material, academic theses, research reports and published articles, even within this journal. I hope that Lis Ellison-Loschmann's correspondence to this journal, challenging the historical errors conveyed by a participant in the research reported in an article,[8] has been heeded by all researchers, educators and midwives. She made the same points that I and others have continually made in numerous attempts to reveal the fictitious nature of this claim. For me, it illustrates the endurance of myths which serve some purpose to a group, even in the face of repeated expositions of their lack of historical basis. The questions remaining are what purpose do these three myths serve, and to whose advantage?

My reason for wanting to stimulate some discussion around these myths is to reinforce the importance of understanding the complexities in history and the need to delve under the easily accepted 'surface' presentations of the past. We need to resist each sweeping generalisation about the past. We therefore need to look for research which offers a finely-grained analysis and reasoned interpretation of specific aspects of professional history, at specific times and places. We need to avoid partisan histories, those with a professional agenda as subtext, and welcome all careful, well researched histories which inform midwives' understanding of their professional past. We need to be mindful of myths and understand their place in our professional cultures. I will leave it to midwives to consider why these myths might have arisen, the purposes they might serve and the reasons for their persistence.

What else does a knowledge of history, based on sound research, offer us? It can tell of the resilience of midwives in the face of professional struggles, their persistence and determination in providing a safe, effective and acceptable maternity service for women, and their creativity in offering backblocks families a service that met their particular needs in an innovative way. It shows us the way midwives have provided a diverse range of services in homes and hospitals. It identifies those areas where midwives played a significant part in world-leading New Zealand initiatives, for example in the involvement of St Helens midwives in the dramatic reduction in maternal deaths from puerperal sepsis from the late 1920s. And, more recently, history can show us midwives' strength in political action, joining with women to gain choice in childbirth.

History can be used to shape current policy. A sound historical knowledge can give midwives a stronger place to stand professionally, arguing for change or advocating to retain current practice and services. Sound knowledge, however, depends on squarely facing the possibility that current beliefs might be mythical. It requires a willingness to examine the dearly-held tenets of midwifery faith, an understanding of how knowledge is constructed, a determined critique, and careful research.

Historical research can also be used to celebrate achievement. This year is significant for the midwifery profession. It marks a century of the professionalisation of midwifery practice. It will see the transfer of registration and regulation to the profession's own, separate, statutory body. It

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Guest Editorial

is a year to celebrate. I have enjoyed the chance to be part of these celebrations and to contribute to the profession's commemoration of 100 years of midwifery registration in New Zealand. I look forward to ongoing debates about midwifery history.

Wood, P. (2004). Guest editorial. New Zealand College of Midwives Journal, 31, 4-6.

1 Pamela J. Wood, Nursing's 'place in the sun': Interpreting a New Zealand continuing education policy as myth, in *Myth, Mystery and Metaphor*, Proceedings of the 4th National Nursing Education Conference, Melbourne, November 1990, pp.57-61.

2 Memorandum from A. W. S. Thompson, Medical Officer of Health, Auckland District Health Office, to Director-General of Health, Wellington, November 1948, 'Pain Relief in Maternity Hospitals', held at Archives New Zealand, H1 Box 64 (111).

3 See for example Pamela J. Wood and Maralyn Foureur, Exploring the maternity archive of the Wellington St Helens Hospital, New Zealand, 1907-1922: An historian and midwife collaborate, in B. Mortimer and S. McGann, eds., *New Directions in the History of Nursing*, Routledge Research, London, forthcoming 2004; Pamela J. Wood and Maralyn Foureur, A Depleted, dirty and dangerous terrain: Women's bodies as fertile but foetid in the St Helens maternity hospitals, New Zealand, 1905-1930, paper presented at the Women's History Conference, Aberdeen, September 2003.

4 Memorandum from Amelia Bagley, Inspector of Midwives, to Auckland District Health Officer, 26 August 1916, held at Archives New Zealand, H1, 1 Midwifery/ Nursing Registration.

5 For example, Derek Dow, personal communication, July–August 2002.

6 See for example Derek Dow, *Maori Health and Government Policy 1840-1940*, Victoria University Press, Wellington, 1999, pp.197-8.

7 Wood and Foureur, 2004.

8 Lis Ellison-Loschmann, letter to the editor, *New Zealand College of Midwives Journal*, 25, October 2001, p.38.

P R A C T I C E W I S D O M

Rhondda Davies

Introduction

I am delighted to introduce the following contribution to the Midwifery Wisdom Column. At first reading it may seem to extend beyond the original brief the Board composed in Journal 27, October 2002. So much of what we "know" and incorporate into our practice is shaped by personal beliefs and values. When these find resonance with comments and stories shared by another midwife, there is a sense of relief and validation or vindication. At other times comments from colleagues oblige us to review automatic and habitual behaviours. These encounters constitute the vital shaping of how we practice.

Sarah Wickham (2001,P.26) writes, "Research is only one of the forms of evidence available to women and midwives. Indeed, other forms or evidence may better serve to answer questions which are outside the boundaries of research …" She illustrated this as a series of bubbles in a diagram. Each bubble containing evidence sources which she labelled "Experience, Intuition, Practice, Insight, Physiology, Research, Women, Spirituality, History, Reflection and Philosophy".

The following contribution from Kate is, I believe, aligned with the sources of "Reflection, Philosophy, Experience, Insight, Practice and Women". Kate feels passionately about her topic. It is something she is conscious of on a daily basis. How more basic to good wise (sage [femme]) midwifery practice than using le mot juste?

What do you think? Send any comments or your own view of practice wisdom to Rhondda.d@clear.net.nz.

Kate Alice

Kate recently left her role as Charge Midwife, Queen Mary Maternity Centre, Dunedin, to complete her MPhil and to refresh her homebirth skills. Prior to that she worked in a variety of settings both in hospital and in the community. Currently she works part time as Research Assistant for the "Iodine in Breast Milk" study at the Department of Nutrition, Otago University.

Hey… mind your language! (Ou gardez votre mots!)

"Pizzas are delivered. Strong women give birth."

A plea to make to my sister midwives and although you have probably heard it before, I ask you to be patient. I realise that you are sensitive to politically correct means of talking to your colleague midwives and medical staff. I know that you will never ask a woman to *"hop(s) up on to the bed, after having popped into the loo to do a little wee"* (Leap, 1992, p. 60). I am certain that you would never speak of 'allowing' this or 'permitting' that and 'management' is what the facility leaders do, isn't it?

Ask yourself, as you read this piece (it is short)… whose language are you talking, who are you seeking to influence. Because words are never, ever 'only words'. They form our thoughts, make our experiences and, moreover, express our allegiances, so be very, very careful. In the days of radical feminism, there was a phrase—speaking 'the language of the oppressors'. In attempting to communicate with the patriarchal hierarchy, the only words women could use were those **of** the hierarchy itself and in so doing we participated in our own oppression. The validity of this radical viewpoint may be questioned but we **must** consider the language we use when communicating with our sister midwives, our medical colleagues and the women we serve. Medical terms are regarded as a sort of objective and neutral norm when in fact they are part of a language that is privileged and definitely not accessible to all. If *Medicine* is designated a language as French is, for example, then perhaps midwives are skilled bilingualists, speaking *Medicine* to their medical colleagues then translating it into a form that will be comprehensible to the woman. I am not for a moment suggesting that the woman cannot understand *Medicine* but like a person in a foreign land, the nuances of the conversation may escape her. Not only that, *Medicine* may feel itself to be universal in the place the woman is in—the hospital—is it 'while in our country, speak our language'?

So—this is my plea. When we say to the woman that we will insert gel into the posterior fornix of her vagina to induce labour could we also bring ourselves to say 'I am going to put this drug inside your fanny (or yoni or whatever the woman familiarly calls herself) to terminate your pregnancy'? No? Why? Isn't that what we are doing? Or does *induce* sound nicer, friendlier and kinder and vagina more 'professional'? If the last sentence rings too true… whose language are we speaking?

Could I also add that *Academia* and *Politspeak* are out there too. The most fascinating thing is that, like any foreign language, the longer you converse in it—*Medicine, Academia* or *Politspeak*— the more familiar it becomes. That's fine if you wish to understand the people and the culture but the wise woman/midwife never forgets her heritage. So remember, sisters, it's not called your *Mothertongue* for nothing.

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An evaluation of the midwifery services at a New Zealand community maternity unit (birth centre)

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Abstract

A comprehensive evaluation was undertaken in 2002/2003 of the midwifery services in a New Zealand community maternity unit. A range of stakeholder perspectives included interviews with midwives and women, and analysis of birth outcomes statistics from 1203 women and their infants (1999-2001 inclusive). The important midwifery management and decision-making skills needed for working autonomously and successfully are recognised.

Introduction

This paper outlines the key findings from a comprehensive evaluation undertaken in 2002/2003 of the midwifery services in a midwifery-led community maternity unit or birthing centre (titled "Unit" in this paper). Senior district health board management requested data on which to base policy decisions, and midwives were keen to have evidence that would illumine the practice and skills of midwives working in this community context.

Background and setting

Medicalisation of maternity services

In the 1950s a movement towards regionalisation in health service organisation led to closures of small units. Between 1970-1985, 33 rural maternity units were closed (Papps & Olssen, 1997). Many of these were the only hospitals in their community. There was a view that these small hospitals, where annual birth numbers were often less than 100, were unsafe and that larger hospitals could provide more technologically advanced care (Donley, 1986; Rosenblatt, Reinken & Shoemack, 1984). In the larger hospitals women found that they often did not know their caregivers and missed contact with their local general practitioners and midwives. Rosenblatt et al. (1985) produced a report that found little to suggest that small New Zealand community hospitals were, in fact, unsafe. However, this report was embargoed from public release as it did not sit well with the Health Department's ideology of the day (Donley, 1986). In 2004, approximately 38 community maternity units remain in New Zealand, and many face an uncertain future.

The social and political trend that occurred in New Zealand has been prevalent in many other countries. Women have not only witnessed the closure of their small local maternity units but have also found it increasingly difficult to obtain a home birth (Campbell, MacFarlane, Hempsell & Hatchard, 1999). Some health professionals and consumers have challenged this trend, and questioned whether large hospitals are actually the most appropriate place of birth for all women (Papps & Olssen, 1997). In particular, concern has been expressed that a 'medical model' of care, dominant in large hospitals, actually increases the risk of intervention for otherwise normal women (Papps & Olssen, 1997).

The influence of place of birth and carer on birth outcomes

Researchers internationally have considered safety, cost-efficiency and efficacy of small hospitals with varying results and, according to Campbell (1997), with some contention. A medical research statistician, Tew (1990), found that over a number of years (1958-1970) the analysis and interpretation of published UK statistics data was deliberately misinterpreted to favour births in large hospitals. There have been a number of studies examining the effects of place of birth on birth outcomes and maternal satisfaction (Hodnett, 2002; Hundley et al., 1995; Rowley, Hensley, Brinsmead & Wlodarczyk, 1995; Waldenstrom, 1998; Waldenstrom & Nilsson, 1997). Where the context and the caregivers support 'normal' birth there is less likelihood of interventions associated with less optimal clinical outcomes (Campbell et al., 1999; Page, 2000, 2001, 2003). Page (2000) notes, for example, that women offered continuity of carer are more satisfied with their care, have less likelihood of receiving epidural anaesthesia or episiotomy and show some evidence of increased confidence and preparedness for the birth and care of the baby. Kirkham (2003, p.260) describes "*the enabling culture*" of birth centres to provide *"choice, control and continuity"* for women.

New Zealand studies

Donley (1986) believed that the small units, such as the one in this study, have been a threat to medical control of obstetrics, yet, there are limited studies that have investigated the safety of small community units in New Zealand (Conroy, 2000). Wagner (1994) reviewed care provided in small community hospitals and confirmed the findings of Rosenblatt et al. (1985) that New Zealand women are safe and better placed in 'low tech' units. A retrospective descriptive study by Conroy (2000), comparing birth outcomes statistics for low-risk women at two small community maternity units supported the safety of these units.

The implications of providing intrapartum midwifery care in small community hospitals were explored in a study of Auckland independent self-employed midwives (Hunter, 2000). Her thesis showed that providing intrapartum care in small maternity units required additional midwifery skills such as being:

- confident to provide intrapartum care in a low technology setting
- comfortable using embodied midwifery skills and knowledge to assess a woman and her baby as opposed to using technology
- able to 'let labour be' and not interfere unnecessarily
- confident to avert or manage problems that might arise
- willing to employ other options to manage pain without access to epidurals
- solely responsible for outcomes without access to on-site specialist assistance and

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An evaluation of the midwifery services at a New Zealand community maternity unit (birth centre)

- a midwife who enjoys practising what participants called 'real midwifery'.

A midwifery model or philosophy and a focus on 'keeping birth normal' (Hunter, 2000; Page, 2000, 2001, 2003) underpinned the perspectives brought to this evaluation.

Research aims

The overall aim of the evaluation was to provide information that would support current positive aspects and identify aspects that could be improved or modified in the Unit's midwifery services, in order to contribute towards improvements in women's birth outcomes and experiences.

Research design

The study used a design consistent with evaluation literature and a mixed-methods approach (Greene, 2002) provided a diversity of researcher perspectives.

Ethics

Ethics approval was gained from the Auckland Ethics Committee (ref 2001/266), the AUT Ethics Committee and the National Plunket Ethics Committee. There was considerable planning with key stakeholders prior to the study. Quotations included in this article are presented anonymously.

Setting

The midwifery-led Unit stands alone from other health services within a large metropolitan New Zealand city, providing care for 300 births annually and for women who are transferred postnatally from the base tertiary hospital, located at a distance of twenty minutes road travelling time. Women also transfer from the community to the base hospital for secondary services.

Participants

There was purposive sampling to collect a range of material and viewpoints. Information was gathered from hospital and self-employed midwives, hospital managers, clinical educator, women who had used the Unit within the last year, consumer organisations and health provider representatives. In addition, 'information-rich' participants (Patton, 1990, 1997), such as administration staff, and a student midwife were also invited to participate. Birth outcomes from 1203 women and babies, the total who had used the Unit between 1999-2001 inclusive, were collected and analysed.

Methods

Three midwife researchers and one evaluation researcher collected the data. Data collection methods included: literature review, development of a programme logic to guide the evaluation, face-to-face interviews, focus groups, site visits, document analysis, a patient satisfaction survey (retrospectively analysed by a hospital survey researcher independently from the researchers), and maternal / infant birth outcomes data (collected retrospectively by one of the research midwives). Interviews and focus groups were generally audio-taped (otherwise notes were hand written if this was preferred by participants) and sessions lasted approximately one hour. The Unit midwives preferred face-to-face interviews with a researcher, whereas a number of self-employed midwives and consumers chose focus groups. A semi-structured interview schedule, based on key evaluation questions guided the interviews.

Analysis of the data

Data was analysed against an evaluation framework (Veney & Kaluzny, 1998) using descriptive statistics for birth outcomes, surveys, and economic data. Qualitative approaches were used for document analysis, interviews and focus groups. Qualitative information was analysed using content analysis. Birth outcomes data and survey material were analysed with SPSS software using descriptive statistical methods.

Findings

This article focuses on the interviews with midwives and consumers and reports the main findings from the statistical analysis of the maternal and infant birth outcomes data. These three perspectives illustrate the activities and relationships between midwifery practice, women's experiences and satisfaction with their care, and the maternal and infant birth outcomes recorded in the Unit.

Women's perspectives

Forty-three women were recruited via community organisations and Well Child providers such as Parents Centre, Plunket, La Leche League and local play centres. They were interviewed by an evaluation researcher, who was not a midwife, either face-to-face or in focus groups. Approximately half of these women had given birth and the other half had received postnatal care in the Unit within the previous year. Two-thirds had self-employed lead maternity carers (LMCs) and one-third had hospital-employed midwives as their LMC. Twelve Māori and thirty-one Pakeha/European women participated, with no responses from the small population of Pacific Island women who used the Unit. The comments in the text derive from these interviews.

The value of the Unit

All the women articulated well the value of the Unit for them. They liked that it was close to home and easy for their family and whanau to visit. For many, the long established Unit was part of family history, and it was good for mothers to show their children where they were born. The atmosphere was "homely" and food was cooked on site:

[The Unit] was more relaxed, it was more comfortable. Being in a familiar place was a comfort. And I found the staff really good.

Place of birth

Women who chose to birth in the Unit were all supported by their midwives, and were confident to give birth in a "low-tech" environment. The Unit was not associated with hospitals and sickness:

You come here to have babies, you don't come here because you're sick and that's the difference. [Base hospital], you go there when you're sick and not for things like having babies.

One woman gave an unprompted comparison with a base hospital and recounted her past experiences:

At [previous base hospital] they were not focused on people, you were part of a process, you went upstairs, you were observed, then they induced you and then you did this and this and this, and then you popped out the other end with a baby sort of thing. I was very put off by staff at [base hospital] saying "then you'll do this, and this will take that long." And I thought, "Hang on, isn't it different for every woman?"

By comparison, the small Unit had an emphasis on natural processes. One woman felt the very nature of the Unit would change if the focus shifted away from a midwifery-based service:

[The Unit] is small and personal and provides a cosy environment. To bring machinery and stuff would be wrong, it would be just like [base hospital].

Midwifery care

All the women who delivered in the Unit were very satisfied with the care and support they received during labour. They felt confident in the decisions that were made and said they felt safe at all times. One positive aspect for women was the time for breastfeeding support and mothercraft.

I thought [the Unit] was a good intermediate point to go and learn the mothering aspect of it, your first baby and things like looking after their skin and looking after myself. I found it wonderful in terms of a half-way step – that was brilliant.

I had trouble with breastfeeding and if you pushed the button someone would come and help you, any time of the day and night. And they're not annoyed at all.

The difference in care is that they never judged me. They didn't care that he [baby] was my fourth, they never said: "Get a grip lady, it's your fourth baby." But at the other place I went to [in another

town] they said, "Get over it, lots of women have boobs [breasts] like you."

Some of the women had difficulties with conflicting advice around breastfeeding especially, and were distressed if midwives placed their hands on breasts without asking. Despite this, all the women found the midwives to be professional in their work, and whenever different advice was provided, they reported that it was done in such a way as to avoid criticism of their colleagues. Only one woman, out of the forty-three interviewed, reported that she had given up breastfeeding because of the difficulties she had experienced. One reason given for being successful was the lack of pressure put on women to leave before breastfeeding was established and most felt comfortable with their breastfeeding when they were discharged.

My well being when I got home was immeasurable because of my experience there.

There was some difference in opinion whether the Unit should remain as a birthing or postnatal only unit, though overall, women thought that the Unit provided a positive experience for women:

For a first experience it was very pleasurable. I've had good memories from it. It hasn't put me off having another one. I'd definitely recommend the Unit to anyone.

Midwives' perspectives

The perspectives of 'core' midwifery staff, independent midwives and a student midwife (31 participants in total) was gained. Hunter (2003) had indicated from previous research that midwives perceived they had greater autonomy and more clinical freedom in small maternity units and the researchers were therefore interested in the day-to-day activities and practice. Important aspects for participant midwives included the:

- relevance of the Unit for the community
- trust in the Unit's safety held by women and families
- philosophy of birth as part of a normal life event
- partnerships held with women and families
- autonomy of practice possible within a community setting and
- collegiality with other midwives.

Promotion of normal childbirth

Philosophy of birth

The overarching values held by the participant midwives were that the Unit enabled normal childbirth and the Unit's function was to meet the needs of the community. Midwives repeatedly linked the Unit with normal birth and noted that a high number of women (including Māori women) used the Unit and returned for subsequent births. One participant described the maternity Unit as follows:

The Unit is community based, it allows for women's choice and they have a belief that this is a good place for birth, especially Māori women and their whanau who have confidence in being at the Unit. Other ethnicities also tend to have this belief. There is a long history of positive birth out comes, and the environment is seen as supportive, caring and restful by the community… There is an affirmation of birth as a normal life event at [the Unit]. There is good rapport with GPs, Tamariki Ora, Plunket, and local Iwi. (Midwife H)

Another midwife described it as:

I have a strong belief in women's choice and some women don't like the hospital model. This can affect the way they birth, so it helps if the women like the facility they are in. If they feel comfortable being there, they will birth more easily. (Focus group midwives 2)

I have a strong belief in women's choice and some women don't like the hospital model. This can affect the way they birth, so it helps if the women like the facility they are in. If they feel comfortable being there, they will birth more easily.

(Focus group midwives 2)

Partnership

The New Zealand College of Midwives (NZCOM) philosophy (1993, 2002) emphasises the need for midwives to work in partnership with women and to protect the normal process of childbirth. Participants indicated their commitment to partnership and the provision of flexible midwifery care:

What is important for me is that it is the woman's experience. Women are given options, given the information they need, and supported to birth the way they should birth. I'm being invited into this woman's birth experience, so this is the basis for how I work. I believe in the process, and I believe in women and I believe that we can do it. (Focus group midwives 4)

Autonomy of practice

Although secondary services consultations were available by telephone, the distance from the base hospital created a need for autonomy in decision-making. The ability to practise autonomously was associated with being separate from tertiary facilities:

Autonomy of practice is fostered at [the Unit] as there are only midwives here, so the immediate decisions are made by midwives by the sheer nature of the distance from [the base hospital]. (Focus group midwives 3)

It makes a statement that no medical staff are available in small units which reinforces the normality of the pregnancy and this gives a strong message to the public that midwives are autonomous practitioners and have the skills. This has been a huge change from 10 years ago, and women expect us to be able to cope. (Focus group midwives 2)

A positive aspect to being separate from a larger organisation was an ability to operate within a different time-frame, more attune to women's needs and circumstances:

We are (the base hospital's) best-kept secret out here and we can practise the way we want to with more flexible timeframes and we are not rushed. (Midwife D)

Collegial relationships

A convivial relationship between midwives (regardless of employment status) seems to be essential for the success of a primary maternity facility. Physical support between colleagues was seen as being particularly helpful, for example during occasions of transfers. One midwife stated:

The staff are there for you. For example, getting the IV trolley. If there is thick meconium, the staff will assist you to get the woman out and get her transferred as quickly as possible. (Focus group midwives 1)

Participants also commented on the willingness of core staff to engage in discussion with an independent midwife concerning the progress of women in labour:

It is safer practice to use consultation, as no one knows everything... There is goodwill on both sides. (Focus group midwives 1)

There is a two way process where independent and hospital midwives help each other out and answer phones etc. You are able to discuss with colleagues what is going on and this stops that feeling of isolation. (Focus group midwives 2)

Best practice

Participants acknowledged that best practice was achieved through the high number of women birthing normally in the Unit. Waterbirth was also an option for women and many women had a physiological third stage. Participants believed that breastfeeding rates were better than in secondary and tertiary units and midwives were willing to spend time with women to ensure that breastfeeding was successful.

Maternal and infant birth outcomes

A retrospective analysis of birth outcomes at the small community maternity Unit was undertaken

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An evaluation of the midwifery services at a New Zealand community maternity unit (birth centre)

for the years 1999 to 2001 inclusive. Data on women who presented in premature labour or for reasons other than labour care were excluded.

Demographics

The number of women included for each year of the study, as well as transfers to the local base hospital during labour, are shown in Table 1. Data was analysed to identify if there were any changing trends in maternity care between the three years of the study, differences between ethnic groups or differences in birth outcome for those who birthed at the Unit compared to those who needed to transfer to the base hospital during labour.

Table 1: Number of women per year and place of birth

Place of birth		1999	2000	2001	Total
Community Maternity Unit	Count (n)	338	403	326	1067
	% within year of birth	89.2%	89.6%	87.2%	88.7%
Transfers to base hospital	Count (n)	41	47	48	136
	% within year of birth	10.8%	10.4%	12.8%	11.3%
Total	Count (n)	379	450	374	1203
	% within year of birth	100%	100%	100%	100%

The most frequently occurring age group at the Unit for the period was 21-24 years of age (23.2%), followed by the 25-28 year age bracket (22.9%). Women identifying as Māori (47.2%) and Pakeha (40.6%) were the two main ethnic groups using the Unit, with 9.3% of women identifying as Pacific Island. There was a significant relationship ($p<0.000$[1]) between age and ethnicity, with Māori tending to have their children at a younger age, as reflected in national figures (Ministry of Health, 2001). The Unit's rate of 28.4% for first-time mothers is remarkably close to national rates of 29% (Ministry of Health, 2001).

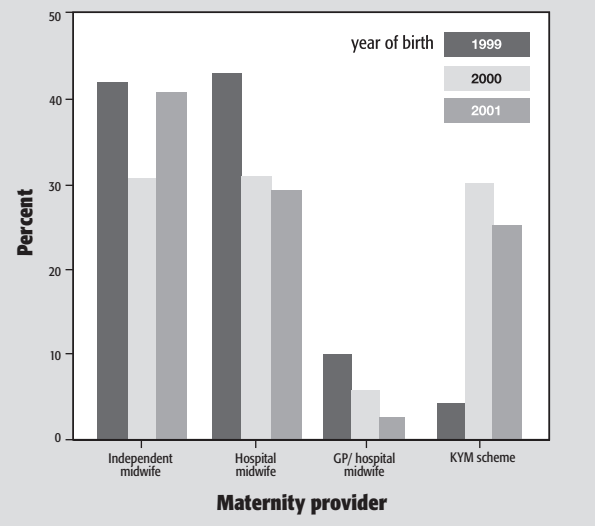
Maternity provider (LMC)

The only variable to show a statistically significant ($p<0.000$)[1] change over the three years of the study was the professional status of the maternity provider. The results obtained reflect national figures showing a continued decline in the number of general practitioners providing lead maternity carer (LMC) services (Ministry of Health, 2001, 2003). The results also revealed the positive impact that the introduction of a 'Know your midwife' (KYM) scheme during the latter part of 1999 had on birth numbers. It appeared from the results that the KYM scheme's objective to increase birth numbers at the Unit was achieved in 2000. This was further supported by the 2001 figures where there was a reduction in overall birth numbers noted when some of the midwives left the KYM scheme (Figure 1).

Method of delivery

The overall normal delivery rate for those birthing at the Unit, as well as those requiring transfer was 94.7% with a corresponding instrumental delivery rate of 2.5%, caesarean section of 2.4% and breech delivery of 0.4%. Instrumental and caesarean deliveries only occurred at the base hospital (Table 2).

Figure 1: Maternity provider by year



[1] *P value reported as this because calculated by a statistical programme which reports to greater than 3 decimal places*

Decision making in third stage of labour

Although it did not reach statistical significance ($p=0.198$), the only other variable to show a changing trend over the three years of the study was 'third stage management'. There appeared to be an increase in the use of 'physiological management' and a corresponding decline in the use of ecbolics, though the administration of syntometrine still remained the most frequently used method of managing the third stage (Figure 2), whilst blood loss rates remained unchanged.

Neonatal outcomes

Neonatal outcomes were good with over 99% of babies born at the Maternity Unit recording Apgar scores of eight or above at five minutes. Seventy five percent of babies required no resuscitation and of those that did, most only required suction.

Transfers

The overall transfer rate including third stage and neonatal problems immediately following birth was 12.1%. The most frequently occurring reason for transfer was 'failure to progress in the first stage of labour'. Transfer rates can be influenced easily by the restrictions or otherwise placed on women who are eligible to use maternity units and for this reason it is difficult to compare rates between one maternity unit and another. The transfer rates appear, however, to compare favourably with similar units and birthing centres overseas.

Fetal monitoring

The use of electronic fetal monitoring was also low with 91.8% of women birthing at the Unit receiving no electronic fetal monitoring (CTG). The usual practice was for the fetal heart to be listened to intermittently with a hand-held Doppler or pinards stethoscope.

Breastfeeding

Eighty-nine per cent of women breast fed their baby at the first feed, 6.7% artificially fed, and a missing count of 4.2% was not recorded.

Summary of birth outcomes

The Unit was particularly well supported by younger women and Māori, and appeared to be a viable birthing option for first-time mothers. Though the study did not identify many changing trends within the three year period, the consistency of results achieved does give some assurance that the good results achieved can be maintained over several years. There were very few adverse events recorded such as post-partum haemorrhage or the need for extensive neonatal resuscitation, so this should allay the fears of some LMC's and women who worry about *'what if things go wrong?'* This appears to demonstrate that midwives are successful in identifying risk factors

Table 2: Method of delivery by place of birth

		Place of birth		Total
		Maternity Unit	Base Hospital Transfers	
Normal vaginal delivery	Count (n) % within place of birth	1065 99.8%	74 54.4%	1139 94.7%
Forceps/ventouse	Count (n) % within place of birth		30 22.1%	30 2.5%
Breech	Count (n) % within place of birth	2 0.2%	3 2.2%	5 0.4%
Lower section caesarean section	Count (n) % within place of birth		29 21.3%	29 2.4%
Total	Count (n) % within place of birth	1067 100.0%	136 100.0%	1203 100.0%

in the antenatal and intrapartum period thus minimising the potential for adverse events to occur. Collaboration with secondary services and good transfer outcomes reflect teamwork and medical support when necessary.

NZCOM provides guidelines for evaluating midwifery outcomes statistical data (NZCOM, 2000) and the *Report on Maternity 1999, 2000, 2001* (Ministry of Health, 2001, 2003) provide records of outcomes, availability and utilisation of New Zealand maternity services in 1999–2001. There are a number of limitations with the national data sets, nonetheless at face value the birth outcomes at the Unit compare favourably. By contrast, the consequences from poor birth outcomes can place burdens on non-maternity budgets such as mental health, paediatrics, child development, education, as well as personal and public social resources.

Discussion

The findings reported in this paper represent midwives' and women's perspectives and birth outcomes from a community maternity unit in New Zealand. The study has provided a valuable insight into the midwifery practice in the Unit and shown that such units can offer low risk women an alternate birthing option to large base hospitals, whilst still ensuring good outcomes for mothers and babies. The Unit achieved an extraordinary number of normal births, had appropriate referral and transfers and demonstrated high breastfeeding rates. It indicates midwives' ability to 'keep birth normal' for the women who gave birth there and provide pain relief such as water therapy and water births as alternatives to epidurals. These birth rates have remained relatively stable over the three year period, that is, they have been resistant to global caesarean section rate trends.

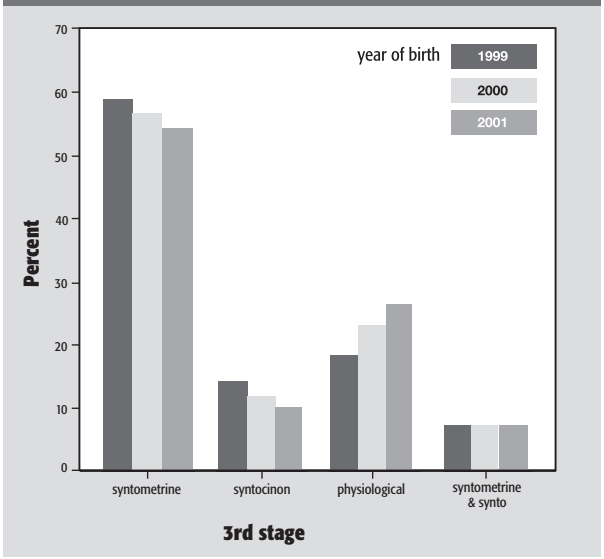
The beliefs of midwives in this study that the environment has a positive influence on birth outcomes was also suggested by Stojanovic (2003) in a report on Otaki Birthing Centre. Page (2001) writes of the oases of good practice found in birthing centres and stand-alone units where continuity is more likely to be practised. Kirkham (2003) records also that the whole ethos of birth centres is one of normality and the philosophy focuses on the concept of midwifery being at the heart of a social, rather than a medical model of care. Women in this study reported that midwifery care in the Unit gave them and their families strength and supported normal birth, and they could clearly differentiate between care provided in the Unit and in larger hospital contexts. They said they were given good opportunities to birth naturally and exercise choice.

Midwives in this study demonstrated 'real midwifery' (Hunter, 2000, 2003) meaning that the midwives utilise all of their midwifery skills when they practise within primary maternity units. Participants believed that the Unit met the needs of women, especially Māori, as shown by the high percentage of Māori women choosing to give birth there. The larger evaluation report contained some minor suggestions for practice and management.

Implications for midwifery practice

Many women and midwives stated that threats of closure were unsettling to all of the community and emphasised the need for a better utilisation of primary maternity units. Hendry (2003) studied rural maternity services in the South Island and encouraged LMC midwives to support small units in order that these services could be sustained and fulfil community needs. Women in this study were more likely to choose the Unit if they and their midwives were confident in a 'low tech' environment. It has been recognised that students and new graduate midwives especially need opportunities to learn the skills practiced in small units. It is becoming increasingly difficult to find satisfactory clinical placements for students and meet Nursing Council of New Zealand registration requirements and competencies with the current static birth trend (Jackie Gunn, personal communication, 2001; Nursing Council of New Zealand, 1998). It is critical, therefore, that midwives have confidence to inspire women to give birth naturally and safely in these environments and contribute to positive experiences for women and their families.

Figure 2: Third stage management by year



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NEW ZEALAND RESEARCH

"Leaving your dignity at the door" maternity in Wellington 1950 – 1970

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After thirty years in various midwifery roles in hospital and self-employed midwifery Jane is currently teaching in the Massey University Bachelor of Midwifery Programme at Palmerston North. This article reports research undertaken as a thesis for the Master of Arts (Applied) Midwifery degree at Victoria University of Wellington, which she completed in 2003.

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Abstract

This descriptive historical research traces the sociopolitical changes in New Zealand maternity from 1900 to 1970 to create a backdrop against which the place of women in society, the hospitals, the workforce, maternity practices and the childbearing process are illuminated using the insights of women and midwives who experienced them.

Introduction

The intent of the research was to illustrate the maternity experience of the time and to examine the historical, environmental, sociopolitical and cultural factors which created and maintained the maternity environment in which these women laboured and these midwives worked. For centuries birthing in most cultures had happened in a traditional, women centred environment with birth attendants who had usually experienced birth themselves.[1] The period in this study was characterised by a medicalised public maternity system with a workforce dominated by single women who worked as nurses, rather than as midwives. A woman's comment took me back to my student days when a common saying was *"You leave your dignity at the door when you go in to have a baby"*. These comments suggested the title for the thesis and gave my research direction.

Noeleen: *That's what this lady who had had her baby, said to me, she said, You lose your dignity when you have your baby.*

Personal impetus

When I was a child, as children do, I enjoyed listening to my mother tell stories of my birth and babyhood. It was a way of validating who I am and made me feel secure and wanted. We laughed at my father's anxious behaviour and I was always pleased that I was a breastfed baby and that my mother had none of the problems caring for me, a second child, that she had caring for my older brother. My mother always attributed this to the care she had received in the homelike environment of a small private maternity home in Johnsonville, Wellington. I was born in 1945 in a small four-bed private maternity home, 'Ranui', in Fraser Avenue.

When I reached adulthood and bore my children in the mid 1960s and early 1970s there were limited choices of where to have a baby. Homebirth was not available and it appeared that most of the small private maternity homes had disappeared. Later, as a trained midwife I realized that many of my colleagues were unaware that these facilities had existed at all, yet they had been quite numerous in

the greater Wellington area. This piqued my curiosity. I wondered why such places had disappeared.

I was 'trained' as a nurse in the early 1960s then later as a midwife at a time when midwifery education was strongly influenced by nursing and medicine. I had a perception, fostered by my educators, of childbirth prior to medical control and hospitalisation as a wilderness where 'Sairey Gamp'[2] type midwives harmed women with their lack of knowledge, negligence and lack of cleanliness. The view that many women had died because they were not in hospital and did not have access to hospital was common among the midwives and nurses at that time. The medical men who were our educators constantly reinforced to us the importance of medicine and hospitalisation as methods of saving women and babies. The changing social conditions and the advent of antibiotics were not mentioned as possible contributors to the lowering of the maternal mortality rate.

Exploring the history of midwifery during my midwifery training in the mid 1970s made me realise that I was forming my conclusions about the past on misinformation and, therefore, it was likely that so were many other midwives and maternity consumers. Researching for my Master's degree gave me an opportunity to find some answers to questions raised during my experiences of the maternity system.

I decided that I would like to document the perceptions of the consumers and the midwives who experienced the environment of the apparently highly regimented maternity hospitals of the 1950s and 1960s and to attempt to illuminate some of factors which had created that environment. I hoped to demonstrate the effect that these had on the birthing experience of women and on midwives' practice.

Background to the study

Prior to the 1950s small, private maternity homes were common, many having just one maternity bed so that they could avoid the regulation from the Health Department that came with having more than one inpatient.[3] In Wellington, the capital city of New Zealand, as in most urban areas, there were also larger private maternity hospitals including charitable institutions,[4] epitomized in Wellington by Bethany and Alexandra hospitals. There were several private maternity hospitals in upper Willis St., one of the main city streets, including Harris Hospital and the Willis St. Obstetric Hospital pictured in Figure 1.

There was also the state owned St. Helens Hospital and Training School for Midwives in Newtown, an old inner city area. Wellington Public Hospital catered only for abnormal maternity cases such as women with breast abscesses, or other medical and obstetric complications, until 1947, when the Wellington Maternity Annexe was opened.[5]

The 1950s were a time when the post war baby boom was at its height, birth was almost totally hospitalised and there was a shortage of nurses and midwives.[6] It was also a time that small private maternity homes were giving way to larger hospitals provided by Hospital Boards.[7] The increasing medical control of childbirth culminated in the passing of the Nurses Act in 1971, when midwifery lost the legal right to be an autonomous profession for twenty years. The period of this study includes the years 1962 – 1965 when I worked in Wellington Hospital as a student nurse and my experience as a consumer of maternity services in St Helens Hospital in 1966, 1967 and 1970.

The study was planned to describe the maternity scene in Wellington during an era when midwifery had been subsumed by nursing, was controlled by medicine and nursing, and was practised in hospitals managed by those disciplines. The medicalisation of childbirth and the 'nursification' of midwifery changed the way maternity care was delivered and affected women's maternity experience.[8]

It is my belief that midwifery is a profession which desperately needs to understand its history because its knowledge and practice have been clouded by influences from the disciplines of medicine and nursing over generations. This has happened to such an extent that it takes major effort on the part of each individual midwife to identify what is in truth 'midwifery' as distinct from what are actually medical and nursing ideas of what should be midwifery practice and knowledge. Researching history through the eyes of midwives and women helps us to sift out what has actually happened in maternity and trace the introduction of changes that occurred in midwifery practice so that we can assess the reasons for and the appropriateness of some practices which may be problematic in the changed maternity environment.

Figure 1. Exterior view of the Willis St. Obstetric Hospital, Wellington, 1949.
(With permission from the Dominion Post Collection, Alexander Turnbull Library, Wellington, NZ Ref F-905677-½.)

Methodology

Historiography is the name of the process used by historians in carrying out historical inquiry.[9] It is the methodology of historical research, incorporating theories, techniques and ideas which need consideration in any historical research.[10] These include theories and principles which influence the choice of topic, finding and accessing the sources of data, and analysing, interpreting and reporting the data. The theory of historiography has evolved from the peculiar intricacies and interpretive requirements inherent in researching past events.[11] In historical inquiry it is preferable for participants to be identified so that the reader can assess their situation in relation to their testimony. The four women, Babs Le Page, Ivanka Marta, Helen van Kampen and Noeleen Ruston and the two midwives, Kathleen Brosnahan and Ruth Belton who participated in this research were happy to be identified and I would like to thank them for their generosity and acknowledge their contribution to this work.

The research reported in this article is a descriptive historical study of Wellington's maternity environment based on the testimonies of women and midwives as the main primary source. It describes how they perceived their maternity experience. Institutions, people, social issues and hospital routines that shaped the women's experiences were included, where necessary, as contextual information and to illustrate more fully what was happening in maternity in the 1950s and 1960s.

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"Leaving your dignity at the door" maternity in Wellington 1950 – 1970

I used oral history as the pivotal primary source to give life and direction to the study and increase its authenticity, and research into other primary and secondary sources to substantiate and explain the findings from the oral histories. The more alternative primary and secondary sources that reinforce the story, the more credible is the research.

> *The goal of the traditional historian is to determine what actually happened and why it was significant and to find the underlying causes of the events. Historians recognise that their evidence is incomplete and that we are viewing a past through 20th century eyes and with 20th century values whereas many values and beliefs of the period under study were quite different.*[12]

In relation to this study we, the readers, are viewing the past through twenty-first century eyes at a time when midwives are able again to practice autonomously. The study was not intended as a criticism of past midwives or their practice, but as a way to examine the influences that produced the environment in which they practised, and to record the way that they practised.

The four women consumers who experienced maternity in Wellington and two midwives who worked in Wellington's maternity hospitals during this period provided their oral testimonies as the main primary sources for this study. My recollections of being a student nurse and a consumer in Wellington and other primary and secondary sources were used to substantiate, explore and explain the topic.

Ethical approval for this study was granted by the Victoria University of Wellington's Ethics Committee. The audio-taped interviews were conducted in the homes of the participants except for one woman, Ivanka, who chose to be interviewed at my home.

The study

The women who were interviewed experienced maternity in a variety of Wellington's maternity hospitals over a number of years, 1953-1970. Between them they had thirteen maternity episodes in the study time period and experienced eight maternity facilities. The women were all of European descent.

The interviews were transcribed and then analysed with each woman's story being summarised and written from the information given. Information concerning topics such as breastfeeding, hospitals and staff, labour care and others was then extracted from the transcriptions and compared with the other women's comments, contemporary textbooks and the midwives' testimonies.

Although my research is specific to Wellington the findings could reasonably be used as an example when describing what was happening in maternity throughout New Zealand as the social, political and economic influences on maternity in other regions were closely aligned to the Wellington experience.[13] The study therefore, should add to our knowledge and understanding of the history of maternity in New Zealand. The oral testimonies of the six participants described both positive and negative aspects of their maternity experiences, but the three strong themes that arose from the women's accounts included **'being alone'**, **'lack of autonomy'** and **'uncaring attitudes'**.

Researching history through the eyes of midwives and women helps us to sift out what has actually happened in maternity and trace the introduction of changes that occurred in midwifery practice so that we can assess the reasons for and the appropriateness of some practices which may be problematic in the changed maternity environment.

The historical background

The professionalisation and 'nursification' of the midwifery service began with the passing of the Midwives Act 1904 and the formation of the St Helens Hospitals and Training Schools for Midwives. The Act placed midwives under medical control and by introducing a new type of midwife, the 'nurse-midwife', began the process of the 'nursification' of midwifery.[14] Despite homebirth and midwifery being supported by the Health Department, technological progress, especially the developments in asepsis and anaesthesia, aided the medical profession in making hospital and medically controlled birth attractive to women.[15]

The restrictive practices introduced by the Health Department to combat the rise in maternal mortality due to puerperal sepsis had a highly significant influence on the manner in which maternity services developed and on the women's experience of birth. The Obstetrical and Gynaecological Society was formed to resist control from the Health Department, and once formed became a strong lobby group, achieving its aims which were the setting up of a Chair of Obstetrics at Otago University and the reformation of the maternity service. The Social Security Act 1938 granted free medical, midwifery and hospital care to women thus accelerating the hospitalisation of birth and establishing doctors as the gatekeepers to the maternity service. Midwives became skilled in their specialised areas of hospital nursing, but lost the knowledge and confidence to care for birthing women outside the hospital system. [16]

The examination of women's role in society during the 1950s and 1960s showed that marriage and family life were idealised as proper fulfilment for women but that women were often deprived of the ability to make choices, particularly in regard to fertility and childbirth, because of the lack of information available to them. Married women were expected to be full-time mothers and homemakers and only a small percentage of women worked outside the home, thus creating a situation where the maternity service was provided mainly by a hierarchy of single women who staffed the hospitals.[17] From 1950 to 1970 with the advent of reliable contraception and some changes in attitude, there was a slow increase in the numbers of married women joining the workforce but not until the end of the period of the study were there any significant changes to its composition.

At the start of the twentieth century homebirth was still the norm but gradually disappeared as an option because of the growing medicalisation of birth and the establishment of doctors as 'gatekeepers' to the maternity service. From 1925 onward the small private hospitals slowly closed because of political and financial pressures and were replaced by state provided maternity beds. These were usually in facilities administered by the Wellington Hospital Board in response to the government's requirement that Hospital Boards provide sufficient beds for maternity in their areas. This was occurring at a time when there was increasing demand for hospital childbirth, due to the Obstetrical and Gynaecological Society's successful selling of hospital birth as safer and less painful, combined with the postwar upsurge in the birth-rate. The Hospital Board's situation was also exacerbated because of the postwar shortage of nursing and midwifery staff. [18]

The two most important maternity hospitals in Wellington during the study period were the Wellington Public Hospital, a teaching hospital for medical and nursing students, and St Helens Hospital which was a teaching hospital for student midwives and maternity nurses. St Helens was under the auspices of the Health Department until the Wellington Hospital Board took over in 1966. The two charitable institutions, Bethany and Alexandra (also a maternity nurse teaching hospital), were still available until the end of the

study period. Karitane Hospital was an important complementary facility and 'backup' to the maternity hospitals, providing care for small, weak babies or mothers who needed help caring for their babies, particularly prior to the development of neonatal units in the early 1970s.[19]

Not only the 'bricks and mortar' of some of the maternity facilities were important to the maternity experience of women, but also the working conditions for staff, with particular emphasis on nursing and midwifery students and midwives. Using the testimonies of the two interviewed midwives, my own memories, and other primary and secondary sources the hospital culture which framed the environment in which the women laboured and birthed was explored. Long hours, heavy workloads and a culture of control and discipline in the workforce were identified as possible contributing factors to the reported lack of empathy among some nurses and midwives toward the women. The workforce of the time was almost exclusively made up of unmarried women. This was a monumental change from the centuries of midwifery care by women with experience of birth. Obviously, there are many excellent midwives who are childless, but it can be speculated that a workforce consisting almost entirely of single women, combined with other factors such as the hierarchal, oppressive nature of the system in which these women were employed could possibly have changed the 'culture' of the maternity service.[20]

Women and maternity

The women interviewed displayed pragmatic attitudes toward pregnancy and childbirth. It was the expected outcome of marriage. They expected to have children and work in the home. This was illustrated by Mab's answer to my question regarding contraception "If the children came quicker, it didn't worry you?" She replied, *"It didn't matter because that was our aim in life."* Adding, *"the wife stayed home and the man went to work and that was it"*.

Society fostered the idea that marriage and the consequent bearing and nurturing of children was the most desirable and fulfilling role a woman could attain. The acceptance of this role is shown by the comments of the women and is represented in the photograph of the "ideal family" (Figure 2). However, although most tolerated their childbearing experience with the attitude that the doctors and nursing/midwifery staff were the experts, discontent with the system was demonstrated in the wider maternity area with the formation of the Parent's Centre movement. The Parent's Centre achieved some improvement, introducing antenatal classes and encouraging natural birth, but the system had become so entrenched that change was slow in coming. Rooming-in, for instance, although first mooted in the early 1950s did not arrive in Wellington until the new Kenepuru and St Helens Hospitals were opened in the mid to late 1960s.[21]

The acceptance of the health professional as 'the expert' had became part of New Zealand's culture in line with the wider acceptance of technology as the modern miracle that would solve all problems. The adoption of Truby King's teachings on infant care also reinforced the idea of the expert health professional. Women's belief in their own instinctual knowledge was downgraded and minimized. Expertise in childbirth had been lost to mothers and midwives with the promotion of medical knowledge and technology. This not only supplanted women's ways but treated women in a manner that was detrimental to their emotional and cultural well-being. The women were isolated from their support systems and required to adapt to alien institutions and routines at a time when they were at their most vulnerable, adapting to their new roles as women. [22]

Figure 2: The 1950s or 1960s family entitled 'Of such is the kingdom of Heaven' from the Old Otaki Maternity Home. (Used with permission from the Otaki Birthing Centre Ltd).

The childbearing process over the two decades became increasingly technical and intrusive and women's psycho-social and emotional needs were only just beginning to be recognised by the end of the 1960s with increased participation by fathers and the introduction of rooming in. While treatment of women was often kindly some maternity staff displayed little understanding or empathy toward the women. There was little or no opportunity to gather information upon which to make choices and little, if any, opportunity to refuse treatment or to choose care other than that laid down by medical protocols based on the prescriptive practices which had been introduced by the Health Department in 1923. [23]

Lack of autonomy

A major issue which emerged from the study was the lack of autonomy for the women who were obliged to become 'patients' and conform to the requirements of the institutional environment and the maternity hospital staff. They had no ability to control their birth including positions for birth, interventions or even basic privacy.

Mabs: *…they took me down to theatre and they strapped my legs, of course. Terrible thing to do to anyone. They had me up there and in came, about, ten student doctors and all these nurses I'd never seen. It was quite traumatic.*

They received instruction from health professionals on all aspects of maternity including the physical act of birthing, breastfeeding and care of the infant. The women generally accepted the routines and the regimentation because they believed in the expertise of the health professionals and that acceptance would make themselves and their babies safer. This was partly in response to the excellent propaganda campaign which had been mounted by the doctors in the 1920s and 1930s and had kept up a degree of momentum throughout. Their belief in the safety of hospital birth waxed steady even in the face their awareness of dangers such as the 'H bug' (Staphylococcus aureus) epidemic of the 1950s. [24]

Mabs: *I forgot to mention to you that when I was in Wellington Hospital, it was almost the start of the H bug. That was a terrible thing. They didn't know how it was all happening. Mind you, I've been back to Wellington Hospital in this day and age and there's still cockroaches.*

Jane: So, you just remember being worried about the H bug?

Mabs: *Yes, everybody was.*

Jane: And had you known that some babies had died because of it?

Mabs: *Yes.*

A lack of autonomy could also have been felt by midwives. Their role was directed by doctors and nurses leading to their special status as 'midwives' being hidden. This was an era in which the increased birthrate and the shortage of midwives and nurses were putting severe pressure on the hospitals and their workforce.[25] Within that workforce midwives were quite 'invisible' to the women participants. My mother had often described the

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"Leaving your dignity at the door" maternity in Wellington 1950 – 1970

kindness and skill of the midwife who had cared for her in the 1940s, but, nevertheless, I had been 'delivered' by a doctor and my mother never mentioned the word 'midwife', always talking of her as 'the Matron'. Noeline speaks of the 'head nurse' and the matron and only speaks of midwives when she discusses 'Sister Ritchie' who had a Nursing Home, and the elderly lady 'Mrs. Sullivan' of Tawa, who cared for her mother during her births at home and was 'probably a midwife'. Ivanka mentions a midwife once and otherwise talks of nurses. Mabs who was more aware of midwifery because her great-grandmother had been a midwife was definite that the word 'midwife' was not used in the hospital.

The lack of recognition of the hospital staff as midwives reflected their invisibility and is indicative of the 'nursification' of midwifery and possibly also reflective, at least in Wellington Hospital, of the use of nursing students to deliver much of the direct care.

Being alone

Another major issue to emerge from this study was that of *"being alone"*. The maternity system and the culture of the study period isolated women from their families, their support systems and their babies. The change from the 1900 system of a woman birthing at home usually with family and other women supporting her had changed to one where the woman was removed from society and placed in an institution, alone. Her husband was sent home and it was not until later in the study period that he was able to stay for part of the labour. Visiting hours were controlled quite strictly and children were usually not allowed to visit or were allowed only at certain times. Even at home after the birth and the postnatal period women were often expected to sit alone in their rooms to breastfeed as the prudish culture of the day meant that many women felt uncomfortable breastfeeding in company, particularly in front of men, even within the family circle.[26]

The other sense of *"being alone"* the women experienced was that of being isolated from their babies. Sharing a bed and cuddling baby were also forbidden by the strictures of the day which dictated that this was 'spoiling' the baby. Before rooming-in became accepted practice, babies were taken to the nursery and mothers and fathers could only view them through the window. Some did not see their baby for days.

> Noeline: *But just after she was born – 'cause they took her out, straight away, in those days and put her straight into the nursery – so I never saw her. … in those days I never saw her. I didn't see her for seven or eight days.*

Separation from babies was even more acute for women who became ill and were transferred to Wellington Public Hospital, as babies were not admitted to the hospital with their mothers. In Helen's case her first baby was transferred to the Karitane Hospital while she was admitted to Wellington hospital with medical complications and did not see her baby for eight weeks. Even when rooming-in began to be adopted, it was usual for babies to be held in the nursery for the first few days with limited visits to their mothers for feeding.[27]

The sense of aloneness while hospitalised was exacerbated because of shift work and task oriented nursing practices. The people who were caring for the woman changed constantly because midwives and nurses work in shifts. In hospitals where task nursing was practised there would be no particular nurse or midwife assigned, which increased short-term contact with a large number of staff. Even if, over time, a woman began to recognise and become familiar and at ease with individuals, there was no guarantee that they would be available at the birth of her baby or at any crisis point.[28] Women expressed that they felt alone.

> Helen: *I was so scared, I really was, I was terrified. One of the nurses came and checked me and she said to me, "Don't you know what's going on?" and I said, no. She said, "We're going to prepare you, we shave you and then we test to see how high the baby is." Then they left me all night. I was on my own all night.*

The birth of the baby was another time when many women experienced feelings of aloneness with no family support allowed, and the sense of alienation made more intense by the masks and gowns which hid the attendant's facial expressions. The position of the woman and the sterile drapes put her in the situation of 'being delivered' which in many ways divorced her from full involvement in the birth of her baby often with a resulting sense of disempowerment. [29]

Uncaring attitudes

The women indicated that the lack of autonomy and feelings of aloneness were mitigated somewhat because the staff treated them well. They described care and kindness from nursing and midwifery staff. However, although there were many instances of kindness from staff, this was not always the case, and perhaps negative incidents remain longer in memory because a number of incidents were described by the women that demonstrated an uncaring attitude.

> Mabs: *…anyway we had this particular Sister, who used to delight somehow, in leaving us all in tears in the night. Everyone would be crying because of this wretched woman. She never helped you…. All these women around trying to feed these babies, with not a great success rate because it was said to us that, if we couldn't manage, they went on to the bottle.*

Ivanka also felt a lack of empathy from the staff caring for her and was subjected to a severe 'telling off'.

> *I don't remember who it was, a short lady, and wow, she laid into me. Oh, she gave me such a hard time. "Get back on the bed! What do you think you're doing? You're killing your baby … and da da da da … Y'know, she was probably just being sensible. I thought okay. So I get back on that bed and I … That's when I felt, oh, I'm at their mercy.*

Annette Stevenson discussed the authoritarian control and discipline of nurses in her thesis[30] and Kathleen gave an account of the unkindness of some of the midwives in the old St Helens to the midwifery students, It would seem that the authoritarian control and discipline that nurses and midwives were subject to was passed on to women by some staff.

It is interesting to consider the idea that the unmarried workforce may have been less empathetic to the women because they had never experienced marriage and childbearing themselves. This, of course, is a huge generalization, and there are many excellent midwives who have never had children. However, when I asked Ruth Belton whether she thought that having a large number of single women in the workforce made a difference she replied:

> *Yes, I think it did. I think once we had more married Sisters too, at St Helens, I felt that it was ever so much easier for the patients, as the registered nursing staff, the married women seemed to understand the patients much better. Actually, getting married when I did in the 1970's, I thought I would have been a much better midwife, of much more help to people, had I had known more about what it was like to be married, beforehand.*

I have been the recipient of comments from midwives who have had babies that the experience has changed their midwifery practice but Ruth's comment stands alone in this research and must be taken only as one opinion.

It is however possible that the combination of the authoritarian discipline, the busyness and the large number of single women created a culture in which some nurses and midwives were able to ig-

nore the feelings and wishes of other women, staff or 'patients'. The emergence from the interviews from the study participants of experiences of uncaring attitudes and even unkindness by some staff cannot be lightly dismissed. Certainly the busyness and unavailability of staff was mentioned by several of the women and Kathleen revealed the amount of work that needed to be done by the midwives.

We had very long hours. We had to do all our own packing; we brought our own equipment, making swabs and things like that, which we stayed until 2 or 3 in the morning to do. We were on call for days and days and days. Our conditions were very poor indeed and we worked extremely hard.

Annette Stevenson also identified workforce issues concerning unpaid overtime at Wellington Hospital.[31]

Conclusion

The findings of the research suggest that childbearing women of the 1950s and 1960s passed through a medicalised and interventionist ordeal in order to give birth in what they understood to be a less painful and safer manner. They coped with it because they believed in the health professionals' expertise and good intentions and they believed that the process was necessary for their own and their babies' well-being. Because other women were managing and everyone went through the same process they realized that they could also cope.

Noeline: *I thought, Oh heck. It was a bit frightening but however, I soon got over all that, and realised that there were other women in the same position.*

Women were role models for each other. The process could be seen as a rite of initiation into motherhood. Body exposure and invasive procedures and pain although, of course, disliked by most women do not appear to have been the factors that engendered lack of faith in the system or caused the most stress.

While I had envisaged the loss of modesty and the indignities visited upon childbearing women during their preparation for birth, from such ritual procedures as shaves and enemas, as epitomising the saying "leaving your dignity at the door", comments were made by women that these procedures were endured and thought of as a necessary evil but nevertheless were not of great concern to them.

Helen: *I just thought it was part and parcel of the thing. I just did everything I was told to do. To get it over with, you know.*

The issues which were elicited from this study as being difficult for women to cope with were those of **"lack of autonomy"**, as they were forced into a situation where they lost control over decision making for themselves and for their babies, **"being alone"**, which included separation from social support systems such as family, separation from their babies and alienation because of certain hospital practices such as task nursing and the wearing of gowns and masks in the birthing room, and **"uncaring attitudes"** particularly when the women's physical and emotional needs were not met or ignored and minimized by busy or unsympathetic attendants. These issues were engendered by the hospital culture which had developed from a hierarchal regimented nursing workforce, the busyness caused by the high birth rate and the nursing shortage, the task oriented nature of practice and the stringent medical requirements demanded by the Health Department [32] which were time-consuming for staff as well as depersonalizing for the women.

The findings of the research suggest that childbearing women of the 1950s and 1960s passed through a medicalised and interventionist ordeal in order to give birth in what they understood to be a less painful and safer manner. They coped with it because they believed in the health professionals' expertise and good intentions and they believed that the process was necessary for their own and their babies' well-being.

I set out to describe the 1950s and 1960s maternity 'scene' in Wellington. I explored the history to discover what had produced the 'scene'. That created an important framework for the structure of the study. I needed to study women's role in society in the 1950s and 1960s to understand why women, including the hospital staff, behaved as they did. The women's stories and the midwives' accounts posed more questions than they answered necessitating more exploration into the physical and cultural aspects of the maternity system in Wellington. The women's stories told some of the story but I found that I needed to expand this by including a description of the management of the birth process to complete the picture.

Within a mainly state-provided hospital system, maternity care in Wellington during the 1950s and 1960s was provided by a very busy workforce composed of mainly single nurses and midwives who had been socialised into medicalised midwifery and had lost the knowledge of women-centred midwifery and the confidence and ability to work outside the hospital.[33] Homebirth was almost non-existent, hospitals were becoming fewer, larger, increasingly medicalised, interventionist and regimented.[34] Women suffered the loss of autonomy, feelings of aloneness and the uncaring attitudes of some health professionals because they had been socialised into the belief, promulgated by doctors, that they were safer in hospital. The mitigating factors that arose from the participant's stories were the enjoyment of a hospital 'rest' for some women who had several children and the kindness and caring attitudes of many of the nurses and midwives.

The study incorporated the stories of four women and two midwives in relation to maternity in Wellington, 1950 – 1970. It also contains contextual information from documentary primary and secondary sources as well as from my own experiences as a student nurse and consumer of maternity services in Wellington at this time, and from my later experience as a midwife. I did not set out to prove any particular theories although having experienced the maternity system of the 1960s I suspected that the regimentation and rigidity of the system might come to the fore, but did not know in what form. The participants were recruited as a convenience sample but the commonalities in their stories were inescapable and evolved quite spontaneously. Through the loss of autonomy, loss of social support systems, enforced isolation, and sometimes not being treated with respect, each of the women *"left their dignity at the door".*

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EVIDENCE REVIEW

Nuchal translucency screening for Down's syndrome: the midwife's role

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Abstract

Nuchal translucency screening (NTS) for Down's syndrome is carried out in New Zealand despite the absence of a national screening policy, information, guidelines or training. This article explores NTS in relation to its effectiveness, the issues generated for women and society, the midwife's role and responsibilities and makes recommendations for midwifery practice.

Introduction

Ten years of independent midwifery practice in New Zealand have seen many changes in maternity care but the introduction of the nuchal translucency screening (NTS) test for Down's syndrome has caused a major dilemma within that practice.

There are implications related to the effectiveness of the test and consequences for the parents and society which impact on the role of the midwife.

Knowledge concerning availability and effectiveness of NTS varies amongst health professionals and consumers alike. One woman at her first antenatal visit in my practice produced an ultrasound report which gave the nuchal translucency (NT) measurement of her baby. She asked what this meant as the general practitioner, who ordered the scan, had requested a dating assessment. On further questioning of the ultrasound department it seems that they were *"just practising"*. Some knowledge of the test has brought women to their first antenatal visit with requests such as *"please may I have that new scan to see if the baby is alright?"* or *"my friend had a scan to see if the baby has Down's syndrome"*. The inference is that performance of the test will provide an immediate indication as to whether or not the baby is affected. Nothing could be further from the truth. Discussions amongst colleagues have indicated that there are huge variations in practice. Some practitioners are unaware of the test while others, who are aware, do not offer the test. Within my own practice the test is offered but this usually results in a large part of the first antenatal visit focusing on fetal abnormality.

The dilemma that midwives now face is that they are obliged to provide women with clear, accurate, objective information regarding the implications of NTS despite the fact that there has never been any information, training or guidelines provided by the Ministry of Health. The risk of false positive or false negative results further complicates matters and women may be faced with invasive testing such as chorionic villus sampling (CVS) or amniocentesis which carry a risk of fetal loss in the range of 1:100 (Enkin et al., 2000) in order to confirm a definitive chromosomal diagnosis.

There is also the dilemma for the parents of whether or not to continue the pregnancy if Down's syndrome is identified or indeed if a less severe abnormality is identified when termination of pregnancy would not usually be an option. Recently a colleague was caring for a 33 year old woman who was delighted at being pregnant with her second child. NTS was performed after counselling and the result showed that the risk for Down's syndrome was increased. Subsequent amniocentesis identified a fetus with Turner's (XO) syndrome which does not always cause major disability. The pregnancy was terminated at 17 weeks gestation at the woman's request.

This article explores the literature in relation to the effectiveness of NTS and the issues the test generates for women and society. The role and responsibilities of the midwife working in partnership with the woman are discussed in relation to NTS and recommendations are made for midwifery practice. A glossary of terms is provided at the end of the article.

Effectiveness of NTS

Evidence based clinical practice involves use of the best evidence available to arrive at the best decision for practice. In order to use evidence in practice it is important to assess the needs and values of the woman. The evidence needs to be interpreted and used wisely with discussion and reflection on outcomes, feelings and consequences taking place (Page, 2000). NTS is currently practised in New Zealand without any clear evidence of its effectiveness or consideration of the consequences. The test is funded by the Health Department whilst maternal serum screening is not. There is no evidence however to support the use of NTS without the associated use of maternal serum markers (Wald et al., 2003).

Ultrasound measurement of nuchal translucency (NT) was developed in the early 1990s and stud-

ies which have examined its implementation in routine practice have demonstrated varying detection and false positive rates. Using NTS alone Bewley, Roberts, Mackinson and Rodeck (1995) found detection rates of only 33% with a false positive rate of 6.0%. Hafner, Schuchter, Liebart and Phillip (1998) demonstrated higher detection rates of 57% but also a much higher false positive rate of 17%.

The rates of detection improved when NT measurements were adjusted in accordance with maternal age. Nicolaides, Sebire and Snijders (1999) identified 75% of affected fetuses with a false positive rate of about 5%. The Fetal Medicine Foundation Multicentre Prospective Intervention Study (Snijders, Noble, Sebire, Souka & Nicolaides, 1998) of almost 100 000 women found that assessment of risk by a combination of maternal age and NTS gave a detection rate of almost 73%.

Schuchter, Hafnet, Stangl, Ogris and Phillip (2001) argue that the combination of NTS at 10-13 weeks gestation and the triple test at 16 weeks gestation results in a higher detection rate. They conducted a retrospective study over a 5 year period of 9342 women and found that the combined approach had detection rates of 95%. The rate of invasive testing was 7.2% which was lower than a rate of 10.7% which resulted from screening by maternal age alone. False positive rates however were not given.

Wald et al. (2003) conducted a large prospective study of 47 053 women with singleton pregnancies to identify the most effective method of antenatal screening for Down's syndrome; the Serum Urine Ultrasound Screening Study. Varying combinations of NT, maternal serum and urine markers and maternal age were assessed in women who booked at 8-14 weeks gestation with a singleton pregnancy. NT measurements were included if obtained between 9-13 weeks gestation. Efficacy was assessed by measuring the false-positive rate for a detection rate of 85%. NTS used alone had the highest false positive rate of 20%. When performed at 10 weeks gestation as part of the integrated test, the false positive rate was reduced to 1.3%. NTS performed at 10 weeks gestation as part of the combined test had a false positive rate of 6% which was significantly lower than NTS alone, but the serum integrated test without NTS had a false positive rate of only 2.7%. The results showed that NTS used alone was the least effective whilst the integrated test was the most effective. Indeed, the serum-integrated test was more effective than the combined test which included NTS. The authors also suggest that the integrated test is safe and cost effective as the low false positive rates reduce the numbers of invasive diagnostic procedures required.

The only maternal serum screening test currently available in New Zealand is the triple test. Higher detection rates when using combined NTS and triple test have been demonstrated (Schuchter et al., 2001) but the rate of invasive testing is still significant. Reduced rates of fetal loss or damage as a result of invasive diagnostic procedures can only be achieved by using screening tests which significantly reduce the false positive rate. These tests are not currently available in New Zealand.

There is also the dilemma for the parents of whether or not to continue the pregnancy if Down's syndrome is identified or indeed if a less severe abnormality is identified when termination of pregnancy would not usually be an option.

Issues for women and society

New Zealand currently lacks a national screening policy for Down's syndrome yet NTS has been introduced and funded by the Maternity Benefits Department under the Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2002). Before a screening test is introduced into society consideration should be given to balancing the cost of not screening against the prevalence of the disease. Also, the test should be simple, sensitive, cost effective and reliable (Beaglehole, Bonita & Kjellstrom, 1993). There should be an effective, acceptable, safe treatment should the test prove positive. NTS has never been evaluated to see if it meets the required criteria and the only treatment is termination of the fetus.

Down's syndrome is the most common cause of severe mental retardation in the developed world with a birth incidence of 1-3:1000 (Mulvey & Wallace, 2000) with obvious financial implications. In the United Kingdom, Gilbert et al. (2001) found that there are long term financial benefits to the country if a fetus, detected by antenatal screening as having Down's syndrome is aborted. This view ignores the contribution a disabled person can make to their family and society. Indeed, many parents of Down's syndrome children express the joy the child brings to the family. The emphasis on identification also needs to consider assisting those affected families to avail themselves of all of their options and help those who choose to continue with the pregnancy to prepare for the event.

The affordability of NTS requires consideration. Although the test is funded by the government, most ultrasound scanning departments or businesses charge the woman a 'co-payment' which means that it is not readily available to all women. The triple test which is the only available serum screening test for Down's syndrome currently available in New Zealand, is not funded in the same way and the woman is required to pay the full cost. This occurs despite evidence that detection rates are increased when NTS is used in conjunction with triple test (Schuchter et al., 2001). These factors support the view that technology and subsequent intervention occurs amongst those who can afford to pay. The cost of counselling, further tests such as CVS or amniocentesis and the rate of fetal loss have not been taken into account. No pregnancy is replaceable and the cost of screening in human terms has not been evaluated.

A reliable test provides consistent results and correctly categorizes people into groups (with or without disease) (Beaglehole et al., 1993). Wald et al. (2003) have demonstrated that NTS alone is not reliable and should be used in conjunction with maternal serum markers. Furthermore, the test estimates the woman's 'risk factor' and does not provide a definitive diagnosis. It has also been demonstrated that the accuracy of NTS depends on the availability of well trained and certified ultrasonographers (Snijders et al., 2002). Only the larger centres in New Zealand have the staff and equipment to undertake this type of programme which makes screening available only to women who have access to those centres.

The social implications of NTS include the risks of anxiety and possible effects on bonding and parenting. The mere implication of 'increased risk' can cause anxiety in the mother (Cheffins et al., 2000) and prenatal screening tests that indicate a risk of fetal abnormality can induce clinically significant anxiety and distress in women (Santalahti, Lattika, Ryynanen & Hemminki, 1996). Maternal anxiety has been associated with behavioural problems in early childhood (O'Connor, Heron, Golding, Beveridge & Glover, 2002). Some women view ultrasound as a rewarding experience with expectations of reassurance but Filly (2000) has found that women experience overwhelming confusion and worry when those expectations are not fulfilled. Ultrasound may strengthen maternal and fetal bonding which then poses a problem for those who have an abnormality diagnosed and find that they are faced with the decision

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Nuchal translucency screening for down's syndrome: the midwife's role

whether or not to terminate the pregnancy (Garcia et al., 2002). Alternatively the use of technology can affect the bonding attachment and women may *"suspend"* their attachment until results are known (Wolf, 2001, p. 31). Midwives need to be aware of the risks related to anxiety so that appropriate reassurance can be provided.

False positive and false negative results result in further problems. False positive results can expose the pregnancy to invasive testing such as CVS or amniocentesis, both of which have significant risks of infection, haemorrhage, fetal damage or loss (Alfirevic, Sundberg & Brigham, 2003). False negative results whereby the parents are falsely reassured can have psychological consequences. Hall, Bobrow and Marteau (2000) found that a false negative result can have a small but adverse effect on parental adjustment for between 2 to 6 years after the birth of an affected child.

New Zealand currently lacks a national screening policy for Down's syndrome yet NTS has been introduced and funded by the Maternity Benefits Department under the Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2002).

The variety of options and possibilities for health care often conflict with the values and realities in the lives of women, their families and society. It would seem that NTS could give rise to those conflicts.

The midwifery partnership and NTS

The midwifery partnership refers to the relationship between the woman and the midwife as one where trust, control and responsibility are shared between the two (Guilliland & Pairman, 1995). The main principles include individual negotiation, continuity of care, informed choice and consent (ibid, 1995). The underlying premise is that individual negotiation acknowledges the expertise that both partners bring to the relationship. The woman brings self knowledge and experience to the partnership whilst the midwife brings scientific knowledge, midwifery experience and intuition.

Midwifery practice has become more complex as a result of new and advanced technology. The decision to undergo NTS should only be made after the woman has received clear, accurate unbiased information so that she is able to make a decision based on the information presented. The scientific knowledge and experience of NTS brought to the relationship by the midwife may be very limited as formal training programmes for NTS are not available in New Zealand for health professionals. New Zealand does not offer a national screening policy for antenatal detection of Down's syndrome and the screening currently offered varies depending on the individual centre, individual woman or lead maternity carer. Women need accurate information in order to make an informed choice which in this case may prove a significant challenge for the midwife.

Continuity of care allows time for the woman and the midwife to get to know each other, clarify expectations and develop trust. NTS is problematic in that it is carried out between 11-13 weeks gestation so the giving of information and counselling often needs to take place at the first antenatal visit when the relationship has not yet established. Women may attend that first visit with no thought of fetal abnormality and leave with that as their only concern. The challenge for the midwife is to initiate the relationship, bring valid knowledge and provide information in a way that does not influence the woman's decision but allows her to make a truly informed choice. Continuity of care and effective communication allows that relationship to continue to develop regardless of the woman's decision.

Recommendations for midwifery practice

When counselling with regard to NTS, midwives working in partnership need to ensure women are aware of the following points.

- NTS is a screening test only, it will not provide a definitive answer.
- When used alone NTS is not the best screening test for Down's syndrome and predictive outcomes only improve when the test is used in conjunction with maternal serum screening.
- There are risks of false positive and false negative results with NTS. False positive results can lead to invasive testing such as CVS or amniocentesis, whilst false negative results give inappropriate reassurance.
- Invasive testing carries a risk of fetal loss or damage.
- Testing may result in identification of less severe abnormalities for which termination of pregnancy is more contentious.
- NTS is carried out in order to offer termination of affected fetuses.

Any screening service is available for people to use as they choose. Choice is based amongst other things, on the provision of appropriate information and technical advances in screening can only lead to improved outcomes if those offered the screening are fully informed of the process.

Conclusion

Technological advances should be implemented into health care only after clear evaluation and consideration of the implications, side effects, accuracy and cost. The implementation of screening tests should make a positive difference to the woman and her baby and should occur only after clear evaluation and judicious use of the evidence. The way in which NTS is currently employed in New Zealand does not demonstrate either.

The evidence does not support retaining the use of NTS alone as low detection and high false positive rates have been demonstrated (Bewley et al., 1995; Hafner et al., 1998). NTS used in conjunction with maternal age improves detection rates (Nicolaides et al., 1999) and those rates are significantly improved when NTS is used in conjunction with the triple test (Schuchter et al., 2001). The most effective method of screening for Down's syndrome however is the integrated test (Wald et al., 2003) but this is not currently available in New Zealand.

Midwives are obliged to provide quality care by ensuring they are fully informed of the services available. It is important that the information they convey to women includes the nature and birth prevalence of Down's syndrome. Detection rates, false positive and false negative rates of NTS alone and when used in combination with maternal serum markers should be identified. The woman needs to be made aware of the invasive diagnostic tests that would be offered if the test result is 'high risk' and the risks of fetal damage or loss than can result from those tests. She should understand the implications of increased anxiety while waiting for results and the choices to be made in the event of a positive result. The possible outcome of termination of pregnancy should be made very clear to women as those who would continue with the pregnancy regardless of abnormality may choose not to be screened.

Counselling women with regard to NTS for Down's syndrome requires great care and consideration of the consequences.

Glossary of Terms

Combined test. First trimester test based on combining nuchal translucency measurement with free beta-human chorionic gonadotrophin (beta-hCG), pregnancy- associated plasma protein A (PAPP-A) and maternal age.

Double test. Second trimester test based on the measurement of alpha-fetoprotein (AFP) and hCG (either free beta-hCG or total hCG) together with maternal age.

Integrated test. The integration of nuchal translucency and PAPP-A measurements in the first trimester with the quadruple test markers in the second trimester.

Nuchal translucency (NT) measurement. The width of an area of translucency at the back of the fetal neck, usually measured at about 10-13 weeks gestation using ultrasound.

Quadruple test. Second trimester test based on the measurement of AFP unconjugated oestriol (uE3), free beta-hCG (or total hCG) and inhibin-A together with maternal age.

Serum integrated test. A variant of the integrated test using serum markers only (PAPP-A in the first trimester and the quadruple markers in the second trimester).

Triple test. Second trimester test based on the measurement of AFP, uE3 and hCG (either total hCG or free beta-hCG) together with maternal age.

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General information from the Editorial Board

Guidelines for contributors to the journal are published in the journal annually and were included in the April 2004 issue. They are also available on the journal website at: www.midwife.org.nz/index.cfm/journal.

Copies of the journal. The PDF version of each journal issue is placed on the journal website 6 months after publication. The purpose is to make ideas and information widely available to midwives, women and families.

The Joan Donley Midwifery Research Collaboration has developed an on-line database of research abstracts relevant to midwifery and maternity services. The following website provides access to the database to both read and submit abstracts – www.nzcom.org.nz/index.cfm/research.

Referencing style in articles

The American Psychological Association (APA) format is utilized in the journal unless a discipline-specific style, such as historical style of endnote and footnotes, is more suitable.

Reviewers of articles. In addition to the permanent reviewers listed on the inside cover of the journal, we are grateful to people who provide their specific expertise to review a particular article. During 2003/ 4 this has included:

- Norma Campbell
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- Ruth Surtees
- Anne Yates

Midwives' experiences of working with women in labour: interpreting the meaning of pain

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Abstract

What is it like to stand by and watch a woman go through the pain of labour? How do midwives show that they care? How do they go about helping? These questions underpinned my study which explored the meaning of the experience of midwives working with women and their pain during labour. A qualitative study, using hermeneutic phenomenology, allowed me to talk with seven midwives about their experiences of providing intrapartum care. This article offers an interpretation of their narratives and, in presenting the findings, reveals aspects of practice frequently taken for granted in their everydayness.

Introduction

For most women labour involves pain. Often the pain of contractions is the most severe pain that a woman ever has to face and she can approach labour with considerable trepidation about what lies in store. She may have endeavoured to prepare herself by attending childbirth education classes and talking with friends, family and health professionals. In the end, though, a woman's labour is a unique experience. It is a private and totally subjective experience because it is her labour and only she can feel her contractions. In working with a woman in pain, the midwife occupies a privileged position. She is sharing a momentous occasion in the life of this woman and her family. The nature of the relationship which forms with the midwife can influence the woman's confidence in her own ability to cope with labour. Most midwives understand the importance of the rapport which needs to be established with a woman in order to foster in her a sense of security and trust. Communication is of vital importance in forming a relationship (Ralston, 1998). Depending on the woman's choice of lead maternity carer, the midwife could be someone she has become acquainted with throughout her antenatal period, or she could be a total stranger whom she is meeting for the first time. Midwives also know how important their very presence is to a woman in labour. Continuous midwifery support has been shown to have a positive effect on a range of outcomes including the need for pharmacological pain relief, duration of labour and a more positive birth experience for the woman (Berg, Lundgren, Hermansson, & Wahlberg, 1996; Hodnett, Gates, Hofmeyr, & Sakala, 2003; Lavender, Walkinshaw, & Walkin, 1999). Women in labour also value the chance to be involved in making decisions regarding their care (Halldorsdottir & Karlsdottir, 1996).

This article examines some of the midwifery literature pertinent to the way in which midwives work with women during labour. It briefly discusses the methodology employed and give an overview of the way in which the study was conducted. The three major themes to emerge are described and illustrated by verbatim excerpts from the study's participants. The central finding, the essence of the phenomenon, seems to be that midwives interpret the meaning of women's pain. This finding is seen in context as it emerges from the participants' stories and the themes in which they are contained. Finally this article suggests ways that these findings can have relevance to the practice of all midwives.

Literature review

An examination of the literature surrounding the pain of labour found much written from the woman's perspective about the pain of childbirth. Less apparent is information about the midwife's approach to pain in labouring women. Three studies were located which add to our knowledge about the way that midwives provide care to women in labour with regard to their pain. First, Leap's research (1996) which adopted a modified version of the grounded theory approach to interview ten midwives with extensive homebirth experience. Leap found that these midwives viewed the pain associated with normal labour as pain which can be borne by most women because it represents a normal physiological process. Leap characterised this approach as *"working with pain"*, contrasting this philosophy of care with the more traditional emphasis on *"pain relief"* (p.47).

The second study was conducted in a Northern Ireland hospital (McCrea, Wright & Murphy-Black, 1998). Eleven midwives were observed interacting with fifteen women during labour and three types of approach to pain relief were identified. These ranged from an emotionally aloof carer who may have met the physical needs of a woman, but not the psychosocial needs – a *"cold professional"*; to a *"disorganised carer"* who exhibited little professional competence or good communication skills; to a *"warm professional"* – a midwife who provided care in a holistic way and treated the woman as *"special"* (p.179). Furthermore, the 'warm professional' promoted an attitude of partnership and a positive portrayal of labour pain through her presence and support, but also by encouraging the woman to voice her fears and seek clarification about aspects of pain relief.

The third study, by Lundgren and Dahlberg (2002), described nine midwives' experiences of their encounters with women and their pain during childbirth in Sweden. The study used a phenomenological approach, collecting data via tape-recorded interviews. The authors conclude that the midwife should strive to be an *"anchored companion"* (p.162). This definition encompassed notions of a physical, psychological and emotional presence and a relationship built on mutual trust and confidence.

Although the pain of childbirth has been extensively researched from the woman's perspective, the literature I examined in the course of this study revealed a relative lack of information about the midwife's approach, particularly to pain in labour. Only the three studies discussed in this section appear to address this gap in knowledge, citing qualities such as warmth, trust, physical and emotional presence as desirable traits in a midwife.

A brief discussion of the philosophical underpinnings that have informed my approach to this phenomenological study follows. I will explain how my research question and the method used are congruent with Heideggerian hermeneutic phenomenology and highlight some aspects of the method including recruitment of participants, data gathering and data analysis.

Methodology and method

Phenomenology is a philosophical methodology that allows for the chance to explore the nature and meaning of human experience (van Manen,

1990). The research question for my study asked *"What is the experience of midwives working with women and their pain in labour?"* Posing the question in this way allowed me to interview midwives to obtain their description of working with pain from their own personal context as well as the context of the environment and the women with whom they interacted. I sought the opportunity to better understand everyday lived events through the words of the participants. Phenomenology challenges us to look beyond the taken-for-granted nature of our lived world, to see afresh phenomena that are frequently hidden from view or partly obscured by their everydayness (Heidegger, 1962).

The Auckland University of Technology Ethics Committee granted ethical approval for my study. I tape-recorded interviews with seven midwives and sought to encourage them to provide detailed accounts of their experiences. The participants were drawn from a range of practice backgrounds and levels of experience and were both hospital-employed and independent practitioners. I used purposive sampling to approach midwives whom I determined would have sufficient clinical experience and be sufficiently articulate and reflective practitioners to enhance the opportunity for an account of the lived experience to be expressed as fully as possible.

A question I frequently asked to begin an interview, because many of the participants had experience of caring for women in labour in a home setting and in a hospital, was *"Is there a difference in the way you work with women depending on where they choose to birth?"* Sometimes I prompted a participant with something like *"Tell me about a time when you wrestled with a decision about pain relief".*

An important ingredient in the interpretation of data in a phenomenological study informed by Heidegger is the process of the researcher openly engaging with her pre-assumptions. Prejudices and pre-conceived opinions are held by all of us and are inextricably linked to the way in which we view the world and interact with it. Heidegger (1962) argues that we bring these pre-assumptions to our analysis and we are unable to lay them to one side as it colours our very being in the world.

It is necessary, therefore, to keep these pre-assumptions to the forefront during the questioning and reflecting which is so much a part of the quest for meaning that embodies data analysis. Participants' stories are interpreted and re-interpreted during the process of writing and rewriting which is essential in phenomenological work. Data analysis is a gradual process. It began with several readings of each participant's transcript in order to pull out passages which directly related to my research question. These passages contained metaphors or phrases which resonated for me by their relevance to my topic area. I played with the possible meanings contained within words and phrases as I sought to take my level of understanding deeper. Gradually I accumulated groups of stories expressing similar ideas, and some with contrasting data, from the transcripts. I was encouraged to look at the 'bigger picture' concerning each story in an effort to capture a tentative 'handle' or theme. After engaging with the writing of Heidegger and van Manen I came to see the stories, with their interpretations, as parts of a larger whole again. As I continued to reflect and re-write deeper interpretation of the individual stories, they fell into a number of sub-themes and gradually the themes became apparent to me. The stories come to be seen as parts of a larger whole, whilst at the same time being whole in themselves. There are stories about:

- *"before the pain"* – the antenatal period and the pre-assumptions that the midwife and the woman bring to labour
- *"working with the pain"* – the 'how' of the mid wife's work
- *"after the pain"* – the period when the birth is over, but the pain may not be.

Phenomenology challenges us to look beyond the taken-for-granted nature of our lived world, to see afresh phenomena that are frequently hidden from view or partly obscured by their everydayness

(Heidegger, 1962).

Themes

Interwoven throughout all of the stories are three central themes which each contain elements of the central finding of this study – the essence of the phenomenon of midwives' experiences of working with women and their pain.

"Leaping ahead/leaping in"

The first theme is *"leaping ahead/leaping in"*. These are terms coined by Heidegger (1962) to describe the way a person can show concern for another. They represent the two extremes along a spectrum of *"showing concern for"* that Heidegger calls solicitude.

"Leaping ahead"

"Leaping ahead" of a woman may be one way a midwife seeks to prepare her for the pain of labour. By helping to show the woman what the future might contain in the course of antenatal discussions, the midwife hopes to make such a course of events recognizable for her so that she is better prepared for them and more likely to engage in decisions about her pain management if they arise.

Another example of 'leaping ahead' can be glimpsed in the concern Amanda expresses about men providing support for women without their own back-up:

*I often get quite anxious when women are just going to have their partners for support… Sometimes I think men have **their** needs and they override what their role is in terms of being there for that woman. Sometimes you're giving the epidural for the partner who's really unhappy and uncomfortable and feels very anxious about their loved one. I think men often **do** need to have support and that helps them put things in perspective a bit because the responsibility is not 100% theirs. I think that's where they crumble often and they see what the women are doing in labour as a reflection on them as opposed to it just being a normal process.*

Amanda talks of men who 'crumble' at the sight of their partner in pain. She knows that a 'crumbly' man may result in a 'crumbly' woman who is unsettled by the loss of a reassuring presence. By highlighting the need for adequate support to the woman, she may ensure an effective support team is in place before labour begins. *"Leaping ahead"* also carries connotations of preceding women into the future in order to empower them in the provision of their care.

"Leaping ahead" is also apparent in accounts by midwives during labour when they try to anticipate what a woman might be feeling and explain it to her.

*As the labour goes on further and further, and gets more intense, I creep closer and closer. But all the time I'm listening to what's happening… If I feel that she's losing it, I'll say to her "What's happening for you?" so that I can connect with where she's at and… when I get the feedback from **her**, then I'll interpret what's going on for her. So there's that tuning in to her **all** the time and as **soon** as I sense any panic in her, I'm in there immediately and re-anchoring her back in the process and reassuring her that it's alright.* [Catherine]

Catherine's focus is totally on the woman as labour progresses. Gradually, but inexorably, her

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Midwives' experiences of working with women in labour: interpreting the meaning of pain

presence is more and more necessary. By giving her full attention to the woman, Catherine invites her to describe the feelings and sensations that she is experiencing. She tunes in to the woman's words and to her body's voice as she seeks to understand what might be happening. The midwife is poised, not to *"leap in"* and take over, but rather to discern what is happening so she may *"leap ahead"* to prepare the way. By such foresightedness, panic may be kept at bay. With this information, Catherine is able to interpret what is happening for the woman and put it into the context of her labour.

"Leaping in"

"Leaping in", by contrast is a way of executing care which is much more directive. It conveys a sense of taking over, doing things for the 'other' in a situation of more urgency. Midwives in this study related times when it was necessary to *"leap in"* during labour. Gemma describes such a time:

I recall a primip [sic]. She was in established labour and she was doing good, then all of a sudden, exploded. She didn't ask for pain relief. She couldn't. She was just completely screaming and wanting to jump off the bed with contractions… I stepped in finally and said "I think you need Pethidine."

Gemma has taken over the decision making in the presence of a woman who has lost control due to pain. Such an action may be totally justified under the circumstances as the woman is unable to converse, let alone discuss options for pain management.

Midwives also talked of times when *"leaping in"* seems to involve using their presence to work with a woman in pain. Diane's words illustrate how *"leaping in"* with "self' can be a powerful intervention for a woman in pain:

*She had been sexually abused by her father, a really bad history… she was **absolutely** terrified… and she needed **quite** a lot of calming. I put a lot of hot water on her back, a lot of pressure, a lot of rocking, a lot of holding, a lot of coaxing, a lot of stroking, my voice in her ear. Later, she said that's all she heard, was me saying "You're alright, just calm down, it's OK, don't be frightened"… So you as a person, using yourself, are very instrumental in what happens.*

This midwife is physically and emotionally present in this woman's pain. She describes all the practical measures she employed and also the constant explanations and reassurance for the woman. Diane reminds the woman to relax, to submit to the pain, to trust her confidence in the process. She is like an interpreter, deciphering the foreign language that is labour into plain English. The meaning behind the words is what the woman recalls because this was more important that the content. Diane has conveyed a sense of deep understanding of the woman's pain by her words and her instinctive *"leaping in"* to enfold her with support.

Paradoxically, there may be times when **not** *"leaping in"* is required. The midwife may make a conscious decision to hold back, to bide her time. Evelyn describes her conflicting thoughts as she watches a woman in distress:

Most of the time it's OK, but there are times when I feel that the woman does need something. But I've got to hold back and not say anything because I don't want her to distrust what she's going through and distrust herself. Obviously her not saying that she needs something means that she's trusting her body and I've just got to allow myself to be quiet. And it's amazing, they do do it. So if she cries, she cries and she'll let me know.

Evelyn talks of the effort sometimes to *"hold back"* and not try to save a woman who is crying with pain. It seems that giving oneself permission to bide one's time and wait can be hard when one's instinct may be to *"leap in"*. One way of working with a woman in pain seems to be making room for her to be-in-labour by maintaining a watchful presence and trusting her to determine when she needs more midwifery input.

> *The midwife is poised, not to "leap in" and take over, but rather to discern what is happening so she may "leap ahead" to prepare the way. By such foresightedness, panic may be kept at bay.*

Working with time

The second theme which threads its way through many of the narratives in this study is the notion of lived time. Time is always present in the way that midwives help women to interpret their labour pain, although it is more apparent on some occasions than others.

For instance, there is a sense that time is somehow different for the midwife who practises in a home setting compared to a hospital environment, as this midwife describes:

*There's less time pressure. People are not watching the clock… so I guess it makes you feel more relaxed as a midwife. It's a two-way thing isn't it, if you're feeling confident and relaxed, then you work better with the woman and are more able to help **her** feel confident and relaxed.* [Frances]

Time as measured by the clock seems to have less meaning in the home. Labour takes its course and the woman, and all those who are sharing the journey with her, adapt to its pace. Frances does not have the jarring reminders of time that she encounters in a hospital. Consequently there are not the whispers of doubt about adequate progress to deal with constantly. The result is a more relaxed midwife who can celebrate the progress of a normal experience and project that confidence onto those around her.

Midwives in this study understand how a woman's experience of lived time alters when she is in pain. Amanda breaks time down into small segments when she is faced with a woman who is beginning to doubt her ability to continue without pain relief:

They want to know *"how much longer am I going to be at this point?" and I don't know and they don't know, so I think you have to contract with them and say "well, let's do a,b,c and d and then review the situation in …forty minutes time.*

Amanda knows that lived time slows for the woman as labour becomes more intense. She suggests a focus on small chunks of time rather than trying to look too far ahead. Amanda tries to move the woman's gaze from the distant horizon of her *"future"*, an unknowable number of hours stretching ahead of her, to a finite section of *"future"* in the forty minute segment. In this way, Amanda works with the woman in the *"now"*.

By contrast, other midwives in this study invite women to see their pain in terms of small units of time while, **at the same time**, helping them to take a larger overview of their labour. Barbara describes the way she works with a woman during labour:

Just really jolly her through, one at a time, one contraction at a time, not looking too far ahead. I tell her not to be overwhelmed by it because very soon it's going to be over and in the past.

Barbara endeavours to limit the potentially destabilising effect of looking too far ahead by supporting the woman through each contraction. She also invites her to look towards her future when the labour has finished and the pain will be a memory, relegated to her past.

Time as friend

Lived time can work in the midwife's favour at times. On occasion, a woman will request pain relief at an advanced stage of labour. The midwife can be placed in a difficult position when faced with such a request, as Barbara recalls:

She said right from the beginning that she didn't want anything for pain relief… She was 9cm dilated and she began to lose it a bit and was determined she wanted an epidural at that stage. The head, when I examined her was really well down, the cervix had almost gone and she was demanding an epidural. I intimated that the anaesthetist wasn't far away. She went on and had the baby within 20 minutes. After it was all over, she thanked me for not arranging an epidural promptly, but even if I had done, it wouldn't have been prompt enough.

Barbara used her clinical expertise to assess that the woman did not need an epidural anaesthetic. She was faced with a dilemma and chose to give the impression that the epidural was being arranged, which probably helped the woman to take heart amidst her growing panic. Then Barbara stepped in closer to the woman with encouragement and support. Once safely on the other side of birth, the woman is delighted with the strategy of procrastination. The woman can now see that there was insufficient time to organise an epidural and Barbara's gamble in not seeking an epidural as requested paid off. On this occasion her interpretation of the woman's pain was congruent with her own.

Time as enemy

There can be times when a midwife is castigated by a woman **because** she complies with her request for pain relief. Amanda describes a difficult situation:

She was very far advanced in labour with her second baby and she …wanted an epidural. As the epidural was going in she had a strong urge to push and the baby was born. She then asked me why I didn't examine her, because if I had, then she wouldn't have had an epidural. But it wasn't actually possible to examine her because she was so agitated and intent on the epidural that I felt that if I had even offered her an examination, she would have felt it was tantamount to an assault or another delaying strategy. She was really upset about that and … couldn't let it go afterwards.

Here is an example of the way that time can be the enemy of a midwife. This woman seems to have been unable to look beyond her pain 'now' and recognize that labour is nearly over. Amanda feels compelled to acquiesce to her request for epidural and this was the right decision in the woman's eyes at the time. Now that she has time on her hands, it seems that the correct decision has become a wrong one. Over time, the wisdom of a course of management can be judged and found wanting. There is a disparity in the interpretations of both the woman and the midwife.

Believing

The third theme to emerge from this study is the sense of belief that midwives employ when working with women and their pain. There seems to be an inner conviction within some midwives which communicates itself to women and incites them to call upon something inside themselves when they are at their most vulnerable. The following story is a telling example of the power of the midwife's belief propelling a woman through labour:

*I remember a woman who wanted a homebirth because she'd had an epidural [and instrumental birth previously]. She said to me ' I don't think I can cope. I think I need to go to hospital to have an epidural.' I said 'No, you are only saying that because you're **right** at the place where you had the epidural last time and you haven't got any experience of what happens from here on in without an epidural, but this is what you wanted. You **wanted** a normal birth, you **wanted** a home birth and **that's** what you're having. So, I want you to say this, 'I'm **having** a normal delivery and I **can** do this.' So she just went round and round the couch saying that… She kept walking and saying it and then she started (involuntary pushing noise) and I said 'There you go. Come on.'… She was just **fantastic**, she was totally rapt. The woman just changes instantly from being this frightened person to being this 'Oh, I can **do** it!'* [Diane]

Diane empowers the woman to take a huge leap of faith. When she begins to doubt her ability to cope without an epidural like last time, Diane doesn't hesitate. By asking the woman to verbalise a positive and helpful message which can be heard by all present, Diane encourages her to dispel any doubt and await the birth. The darkness that is the future holds unknown experiences, but Diane is prepared to accept that she cannot see, or yet understand, what lies ahead. Her message to the woman is that together they will face the darkness and look for signs of light which might allow for more understanding. The birth provokes elation and self-congratulation in the woman who has truly worked to realise this goal. In Diane's words we can also hear her admiration for that hard work. Behind it all though, is Diane's unswerving belief in the woman which never wavers and which conveys confidence and certainty to the woman. The result was an exciting and satisfying birth experience.

> *Amanda tries to move the woman's gaze from the distant horizon of her "future", an unknowable number of hours stretching ahead of her, to a finite section of "future" in the forty minute segment. In this way, Amanda works with the woman in the "now".*

Sometimes midwives impart their belief in the woman in the apparent absence of any need. Catherine talks of a seemingly self-contained woman:

*In labour she was completely composed and didn't seem to need much input, but I was doing my usual talking her through and when I sensed she was getting stretched, just anchoring her again and talking her through. But after she had the baby she was a different woman. She was just this effervescent, outgoing, bubbly person that I hadn't seen through the whole pregnancy. She started it off. She said 'I wanted to say to you that when you were saying the things you were saying to me in labour, even though I wasn't responding to you because I couldn't – it was too intense, that was **really** important to me. You kept me going and if I had had midwives who had said the same things to me with my first labour, I think I would have got through without needing all those other things that I had.'*

Catherine describes how she 'senses' when the woman is 'getting stretched'. Small cues within the woman's body language are sufficient for Catherine to respond with more intense praise and encouragement. This serves to 'anchor' the woman again, to provide a steadying and dependable message that helps to maintain her sense of control. Although the woman gives little sign of needing, or heeding the midwife's words, she recounts later that they were extremely necessary to keep her going.

The meaning of pain

An important part of working with women and their pain is the meaning which is attributed to labour pain. Although not a theme in this study, this was an area I explored during my analysis as elements of the notion appeared to be part of many of the stories.

Pain has negative connotations for most people. They associate pain with trauma or illness. Some midwives in this study seek to redefine pain as it is experienced in labour in order to help women work with it more effectively. Frances tells her clients:

The pain of labour is a good thing. It's functional. There's nothing bad about it. Occasionally I've used words that I've heard Sheila Kitzinger use like 'welcoming the pain' because it's bringing your baby. So I try and always use positive words without making it sound like it's easy.

continued over...

Midwives' experiences of working with women in labour: interpreting the meaning of pain

Diane is even more eloquent in her description:

Pain – it's part of the birth, isn't it? It's normal. It's pain with a purpose… It's there because it's doing a function and it's ***not*** *something that's to be feared. You relax into it, you go with it, all those sort of words. Just go down to* ***meet*** *the pain, don't run from the pain, go to it, accept it.*

The words these midwives use to describe the pain of labour underlines their understanding of the meaning of labour pain. By giving voice to the positive imagery about yielding their bodies to the pain, the midwives are attempting to permit a new understanding or interpretation of labour and its pain to women.

The essence – interpreting the meaning of pain

A phenomenological study seeks to answer the research question by distilling the central themes into an essence. The essence of a phenomenon is that which constitutes the true being of a thing. So, in answer to this study's research question *"What is the experience of midwives working with women and their pain in labour?"*, the findings seem to indicate that midwives do this by interpreting the meaning of their pain. Interpretation always occurs in the context of the world as we are in it. It occurs in the way that midwives are with a woman and how they can 'be' with her – what Heidegger (1962) called *"Dasein"*. Before the pain begins, they *"leap ahead"* to encourage them to anticipate what the pain will be like and how they will confront it. Midwives give pain meaning for women by naming it and defining its purpose in bringing a baby. When labour begins, midwives help women to translate their embodied pain in its context. They *"leap in"* when required, sometimes using self as an intervention. When midwives interpret women's pain, they risk misjudging a physical pain they can't feel, thereby causing mental pain they can't always salve. On many occasions though, midwives can convey belief to women with such conviction that they will trust in their pain to keep them safe. Midwives help to unlock the mystery of labour pain and accompany women on the profoundly moving and humbling journey that is the miracle of childbirth.

Diane reminds the woman to relax, to submit to the pain, to trust her confidence in the process. She is like an interpreter, deciphering the foreign language that is labour into plain English.

Implications for practice

Much of the practice described by participants in this study is familiar to midwives working with women in labour. Nevertheless, the ways in which time is manipulated by midwives to help women with their pain is important to acknowledge, and to celebrate. The concept of breaking time down into smaller chunks to help women concentrate on the *"now"* is recognized by many midwives but may not be acknowledged by them as a valuable strategy. Similarly, the way that time as measured by the clock can prove to be a tyranny for some midwives working in a hospital setting who wish to avoid the constraints of an institution's timekeeping practices. Midwives know that women labour in different ways and blanket adoption of policies for assessing progress can have a detrimental effect on the way that midwives work with women and their pain. Perhaps the views expressed in this study lend weight to the opportunity for review of hospital policies in this regard to consider less rigid expectations of normal labour situations.

Much of the midwife's work with women and their pain in labour passes unseen by other midwives. This may be because the woman is labouring at home and will only require the presence of another midwife at the time of delivery. If the woman is in the hospital setting, the door to her room may be closed for privacy and peace. Only the support people gathered with her will witness the way in which the midwife works with a woman's pain. So, the opportunity to learn aspects of expert midwifery practice, such as the way some midwives inspire women through the strength of their belief, is limited. It is imperative, therefore, that avenues be created to 'show' this important aspect of practice. This could be achieved by establishing a forum for the sharing of stories from practice in places of work and at professional gatherings such as seminars, conferences or New Zealand College of Midwives' meetings. In this way, practice wisdom can be acknowledged and disseminated to other midwives.

Finally, the findings from this study suggest that midwives need to understand the subjective nature of their decision-making in the area of pain management. They rely on their interpretation of the woman's perception of pain to formulate their midwifery care. The data in this study suggest that the closer the congruence between the midwife's and the woman's interpretation of her pain, the more likely there is to be satisfaction about the management of her pain once labour is finished. This has significance for all midwives working with women and their pain in labour. A dissatisfied, or worse, angry woman is likely to harbour ongoing hurt which may have ramifications for her transition to motherhood or even delay decisions about future pregnancy. The decisions a midwife arrives at with women in regard to their pain have the potential to cause lingering anguish, but it is difficult to predict which situations have the most risk. In the end, the midwife makes a judgement based on the context of the moment and hopes the relationship has a strong enough platform of trust to guide her to an action with which the woman will concur.

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Ina May's Guide to childbirth

Author: Ina May Gaskin, 2003
New York: Bantam Books
ISBN 0-553-38115-6
Price: approximately $40 NZ
Available from local bookshops by ordering.

Reviewed by Jean Patterson, Midwifery Lecturer

Who can forget the impact of Ina May's 'Spiritual Midwifery' published in 1975? Every midwife I knew had at least heard of it, read it or owned it. Many well thumbed and tea stained copies remain on bookshelves as testament to its popularity and appeal. Ina May, from the Farm Midwifery Centre in Tennessee which she founded with her husband and community in 1970, has now published her new book *Ina May's Guide to Childbirth*.

This publication falls neatly into two parts. The first, fittingly, captures the voices of women telling their stories of triumphant birth. The second part is a mix of practical advice for women and practitioners alike, plus stories and anecdotes from practice. The 348 pages also include an index and several appendices.

Women are offered a wealth of advice on strategies to employ for optimising their chances of experiencing a normal birth in a hospital setting. Acknowledged and welcomed is the work of the Cochrane Collaboration especially their recommendations as to the effectiveness of continuous emotional and psychological care for the labouring woman. In relation to this aspect of birth, Ina May introduces the power dichotomies of the mind – body and pain – pleasure. She encourages women to *"let the monkey in them do it"* (p. 243); thus allowing the primate to emerge in the birthing process. Another central concept is Ina May's version of *"sphincter law"* which suggests that our sphincters close when we are startled or frightened and that we function best in private without time constraints. Thus the environment for birth needs to be familiar and filled with laughter if we are to be primal and allow our sphincters to relax.

The strength of Ina May and her partners' 'science' is that it is grounded in practice. It emerges from the respectful and curious observation of birthing women and the births of 2200 babies (including 15 sets of twins at home or at the Farm) over a period of twenty years. Some labour stories may alarm even seasoned midwives - for example the woman who stalled at 7cm dilated for over a day despite continuing good contractions, though finally going on to birth normally after the resolution of an emotional issue. However for the sceptics Ina May lets her statistics do the talking. She cites a caesarean section rate for the year 2000 of 1.4%. There were no maternal deaths and the neonatal mortality was 0.69%, which included babies born with *"lethal anomalies"*. Further the Farm, though functioning like a birth centre, has included the outcome statistics for all of the women who booked with them, regardless of their final birthplace.

I am sure this book will be welcomed and enjoyed by women, midwives and students alike. One of the highlights for me was the inclusion of a chapter on benchmarks for midwifery excellence of the past which celebrated the impressive outcomes achieved by Catharina Schrader who practised in the Netherlands between 1693 and 1745. Ina's book is a mix of stories, anecdote, wisdom, advice and history. It is what it is. A bit like birth I guess.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

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- Diagrams, tables or photographs supplied in computer generated form
- Separate sheet containing biographical details of all authors (name, occupation, current area of expertise/practice, qualifications, contact address including phone and / or email details).
- Letter signed by all authors stating that they submit the article for publication
- All referencing in American Psychological Association (APA) 5th edition format.

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