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New Zealand Research

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the influences on
decision making

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back again: educating
midwives across a century

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a case for birth centres

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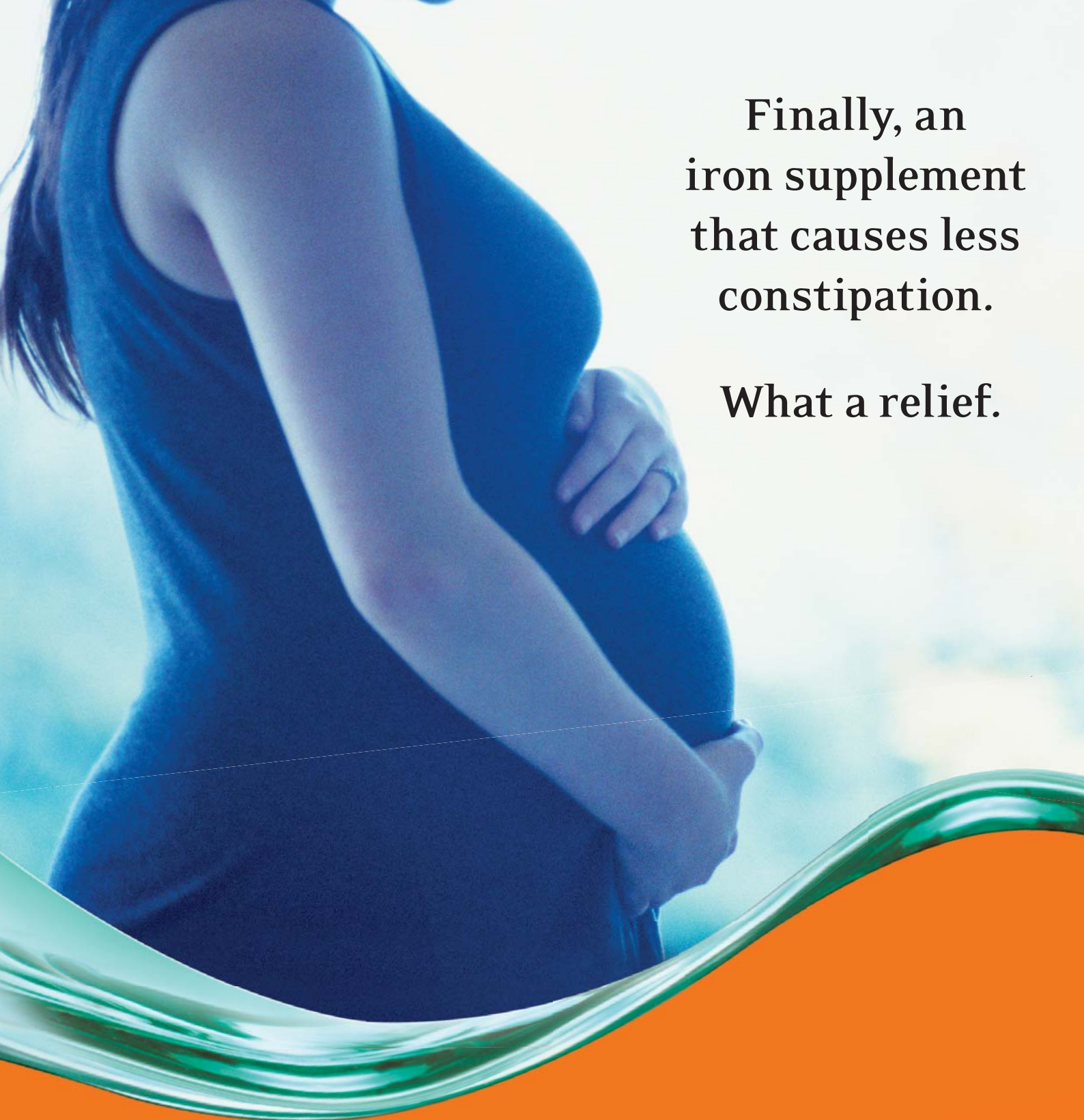
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Induction of labour: the influences on decision making

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Abstract

The study was undertaken to gain an understanding of why nulliparous women were having an induction of labour (IOL) and what influenced the decision to induce. Using an interpretive approach, 79 nulliparous women and 74 of the Lead Maternity Carers (LMC –Midwife, Obstetrician and General Practitioner) who cared for these women, were interviewed prior to induction, using a structured questionnaire with open ended questions, between December 2002 and April 2003. This paper focuses on the reasons identified for induction of labour by women and their LMCs, their understanding of the positive and negative effects of induction of labour, as well as some of the key themes identified from the interviews using a modified Boyatzis' method of analysis.

Introduction

Birth by caesarean section is an increasing occurrence for women in New Zealand (Ministry of Health, 2003). The rising caesarean rate for nulliparous women has been of concern at the unit where the primary author worked as a Research and Quality midwife. The unit's induction rate, during the 2-month retrospective review of nulliparous women, was 28% (Austin & Belgrave, 2002). The mode of birth was ascertained for induction and spontaneous labour. Twenty two percent of women who had a spontaneous onset of labour delivered by caesarean compared to 54% who had their labour induced. Although the audit was small it raised the question, does having labour induced increase a woman's risk of having a caesarean section? It also showed the need for a prospective study looking at the reasons for induction, the influences on that decision and the information women receive about the risks and benefits of an induction. This study also explored

the methods women use to initiate labour prior to admission to the maternity facility.

Induction of labour refers to the "initiation of labour by artificial means" and is indicated when the health of the mother and/or fetus would "be compromised by the continuation of pregnancy" (Stables, 1999, p. 501). The onset of labour is a normal progression in the process of giving birth but the aetiology of labour is complex and not well understood (Stables, 1999). Enkin et al. (2000, p. 374) state "the decision to bring pregnancy to an end before the spontaneous onset of labour is one of the most drastic ways of intervening in the natural process of pregnancy and childbirth." It is essential therefore that the benefits of and need for the action of induction of labour are clear and women are fully informed of both the risks and advantages.

Literature review

In preparation for this study a broad review of the literature covering a 10 year period of 1993-2005 was undertaken. Most of the studies related to induction of labour were based on retrospective data obtained from health databases. There seems to be little evidence to support the use of induction of labour for some of the common reasons identified in the literature, namely post-dates, large for gestational age and maternal choice (Dublin, Lydon-Rochelle, Kaplan, Watts, & Critchlow, 2000; Irion & Boulvain, 2000; Menticoglou & Hall, 2002). Common reasons for induction of labour given in the literature include post-dates, post-term or post maturity (Moldin & Sundell, 1996; Parry, Parry, & Pattison, 1998; Yeast, Jones, & Poskin, 1999). These terms are often used interchangeably to describe a prolonged pregnancy but the period of prolongation may differ from study to study thus making comparison of findings difficult. Menticoglou and Hall (2002, p.240) make the following strong statement about induction of labour:

the 'evidence' on which current practice and popularity of routine or as we prefer to think of it, ritual induction at 41 weeks, is based is seriously flawed and an abuse of biological norms. Such interference has the potential to do more harm than good, and its resource implications are staggering. It is time for this nonsense to be withdrawn.

The rate of elective or non-medical inductions ranged from 2% to 59.2% in the studies located (Dublin et al., 2000; National Women's Hospital, 2004). All the studies showed a significant increase in the rate of caesarean section following an induction of labour with no apparent medical indication, especially for nulliparous women (Dublin et al., 2000; Maslow & Sweeny, 2000; Seyb, Berka, Socol & Dooley, 1999). Despite this link it is not possible to talk about cause and effect as there may be other factors that may lead to the increase in caesarean sections, for example the initial reason for an induction, women's attitudes to intervention or the influence of the health practitioner.

Decision making can be influenced by factors other than clinical indications.

Consumerism is now part of health care with an expectation that in some situations services provide for the preferences of the individual (Fox, 2003). This can sometimes lead to a gap between what a woman may prefer and what may appear to be best clinical practice

(Savage, 2002).

The common means of induction used in hospitals are amniotomy, prostaglandins and oxytocin while the methods used in the community include homeopathy, herbal remedies, evening primrose oil, exercise, sex and nipple stimulation and sweeping of the membranes. The literature is limited or does not support the use of many of the methods of induction used in the community. However, there is a small amount of research evidence, from smaller rather than larger studies, that supports the use of sweeping the membranes, especially in multiparous women (Boulvain, Stan & Irion, 2005). The use of castor oil was found to be effective in one study of 103 women at term with intact membranes, in which 57.7% of women began active labour after receiving 60ml of castor oil diluted in fruit juice, compared to 4.2% of women in the control group who received no treatment (Garry, Figueroa, Guillaume & Cucco, 2000) but as only one study was found the authors of the systematic review (Kelly, Kavanaugh, & Thomas, 2001) indicate the need for more studies on this topic to provide the required level of evidence.

Kavanaugh, Kelly and Thomas (2005) undertook a Cochrane Review to investigate the effect of nipple stimulation on initiating labour. Six randomised trials with a combined sample of 719 women were included in the review. The nipple stimulation required of the women ranged from one hour per day for 3 days to 3 hours per day, alternating breasts every 10 minutes. The percentage

of women not in labour after 72 hours was reduced to 62.7% in the treatment group compared with 93.7% in the control group. Kavanaugh et al. do warn however that due to concerns about safety issues related to perinatal deaths in two of the three arms of one of the trials reviewed, nipple stimulation should not be considered for use in a high risk population.

Decision making can be influenced by factors other than clinical indications. Consumerism is now part of health care with an expectation that in some situations services provide for the preferences of the individual (Fox, 2003). This can sometimes lead to a gap between what a woman may prefer and what may appear to be best clinical practice (Savage, 2002).

Information sharing is an essential part of informed choice. However, ensuring the information is effectively passed on to women is not always easy. A randomised trial in the United Kingdom involved more than 6000 women in 13 maternity units and compared the effect on informed consent of women, reading 10 evidence based information leaflets produced by the Midwives Information and Resource Services (MIDIRS), with women who did not receive the leaflets (O'Cathain, Walters, Nicholl, Thomas & Kirkham, 2002). Although women reported they were more satisfied with the information they received there was no difference in the proportion that reported exercising informed choice. In a qualitative aspect to the study they also found the leaflets were seldom used to their maximum effect due to staff disagreeing with the content, the options suggested were not available locally, staff making inaccurate assumptions about the ability and willingness of women to participate in decision making and the leaflets being given out wrapped up in advertising material. Time pressure was another constraint to their use *"within a culture that supported existing normative patterns of care rather than informed choice"* (Stapleton, Kirkham & Thomas, 2002, p. 641). Women-held maternity records and decision making tools however have been found to increase the likelihood of women feeling they have been well informed (O'Connor et al., 2003; Rowe, Garcia, Macfarlane & Davidson, 2002).

The fear of litigation can sometimes influence practitioners to use technology rather than evidence based care (Stapleton et al., 2002). A study by Symon (2000) found that 3.8% of midwives and 2.4% of obstetricians used induction as part of defensive practice.

Study design and method

Following approval of the General Manager of the maternity facility, ethics approval was obtained from the Massey University Human Ethics Committee and the Auckland Ethics Committee to undertake a study primarily using an interpretive approach. A structured questionnaire with open ended questions was used to explore the reasons for induction of labour for nulliparous women and the influences on women and Lead Maternity Carers (LMCs –Midwives, Obstetricians and General Practitioners) in coming to that decision at a secondary care¹ maternity facility in Auckland. The interviews were part of a larger study that compared the outcomes for 157 women who had their labour induced and 347 whose labour began spontaneously.

This study aimed to identify:

- the outcomes for nulliparous women and their babies when labour is induced compared to labour that begins spontaneously
- the reasons for and methods of induction of labour and what aspects relating to these may be contributing to the high induction rate
- the risk of caesarean delivery following induction for nulliparous women.

Eighty-seven women were invited to be part of the study. Of these 79 women met the eligibility criteria (nulliparous, gestation ≥ 37 weeks, singleton pregnancy and planning a vaginal birth) and agreed to be interviewed. Seventy-four

LMCs were interviewed. The remaining six LMCs did not decline but were either too busy or the woman had been handed over to secondary care. The LMCs that were too busy were still able to tell the researcher the main reason for induction. When a woman declined to participate, her LMC was not interviewed.

The women and their LMCs who consented to be part of the study were interviewed in the birthing suite prior to the induction commencing. This usually occurred during the preliminary cardiotocography (CTG) as both women and LMCs did not want the interviews to delay induction commencing. Most interviews took about 10 minutes although some participants wanted to talk further on the topic and this was encouraged.

The process of thematic analysis and code development, as described by (Boyatzis, 1998), was used to 'make sense' of the qualitative data obtained during the interviews. Boyatzis (1998, p. 11) identifies

four stages in developing the ability to use thematic analysis

1. **Sensing themes** - that is, recognizing the codable moment
2. **Doing it reliably** - that is, recognizing the codable moment and encoding it consistently.
3. **Developing codes**
4. **Interpreting the information and themes in the context of a theory or conceptual frame work** - that is, contributing to the development of knowledge.

Table 1. Main reasons for induction

Main reasons for induction	LMC	Women
Post-datest	45	47
GPH/Hypertension	12	12
Social	5	1
Reduced liquor	4	4
Large baby	3	3
IUGR	2	2
Diabetes	3	3
Age	1	1
Increased liquor	1	0
IVF/precious baby	1	1
Booking system	0	1
Lichen sclerosis	1	1
Previous myocardial infarction	1	1
History of previous miscarriages	0	1
Contractions but not dilating	0	1
Total	79	79

Table 2. Second reason that contributed to decision to induce labour

Second Reason	LMC	Women
Post-dates	2	2
GPH/Hypertension	4	5
Social	5	6
Reduced liquor	0	0
Large baby	1	4
IUGR	1	3
Diabetes	0	0
Age	1	2
Increased liquor	0	1
IVF/precious baby	0	1
Booking system	12	5
Specialist advice	11	4
LMC on call	2	2
Christmas	2	2

continued over...

Induction of labour: the influences on decision making

Some adaptations were made to Boyatzis' method to accommodate the style of research and the sample groups. A final code was developed that describes the influences on decision making for induction in the study sample. This code was made up of ten themes, four of which are presented in this paper.

It is important to identify that the sample of women interviewed represents a subset of the community, namely nulliparous women who had accepted the option of induction at the hospital. This is also true of the LMCs as only those who cared for women who were having an induction of labour were interviewed. It is also recognised that the set up of other hospital facilities for induction of labour may be different and therefore limit the generalisability of the findings to other maternity settings in New Zealand.

Findings and discussion

Reasons for induction

The main reasons given for induction are listed in Table 1. For most women there was a second reason that contributed to the decision to induce (Table 2). The main reason for induction as stated by the woman was different from that stated by the LMC in 8 situations. Five LMCs stated the main reason to be maternal choice or for social reasons but 4 of these women said it was for other reasons; post-dates (n=2 women)², raised blood pressure (n= 1 woman), and previous miscarriages (n=1 woman).

In some situations the reason for induction was not clear as the LMC, consultant obstetrician and woman considered the induction to be indicated for differing reasons. For example in one situation the reason for induction appeared to have become lost in the realm of it being a routine practice and merely an extension of a normal pregnancy. The LMC presumed the indication for induction stating "oh I thought it was just a routine post-dates." Another reason for the lack of clarity was the circular communication process between the woman, LMC (midwife or general practitioner) and consultant obstetrician i.e. each person passed on information to the next person rather than there being a three way discussion. One LMC was explaining the reason to be high blood pressure. The registrar on call later said it was not blood pressure but post-dates and a large baby. The LMC had been told by the obstetrician not to let the woman go 1 week past 40 weeks gestation, as he did not want her to have an abruption. As there was no documentation of the visit to the obstetrician and the LMC had not been present, the actual initial reason was not known. However, the indication was coded according to that given by the registrar at the time of induction.

The main reason for induction of labour identified in the study was post-dates which is consistent with other facilities in New Zealand and overseas (National Women's Hospital, 2004; Yeast et al., 1999). Only 2 women had a prolonged pregnancy that was consistent with the World Health Organization definition of 42 completed weeks gestation or more (Chua & Arulkumaran, 2002). In the research by Duff and Sinclair (2000) 33.2% of women whose labour was induced for post-dates had a gestation of less than 41 weeks and 3 days compared with 49% of the women interviewed in the current study. Nine (20%) of the women in the study were induced at 41 weeks or less. If the advice from the Cochrane review was being closely adhered to this is still earlier than the reviewers recommend: "...routine induction of labour after 41 weeks gestation appears to reduce perinatal mortality" (Crowley, 1997, p.3).

Other methods used to induce labour

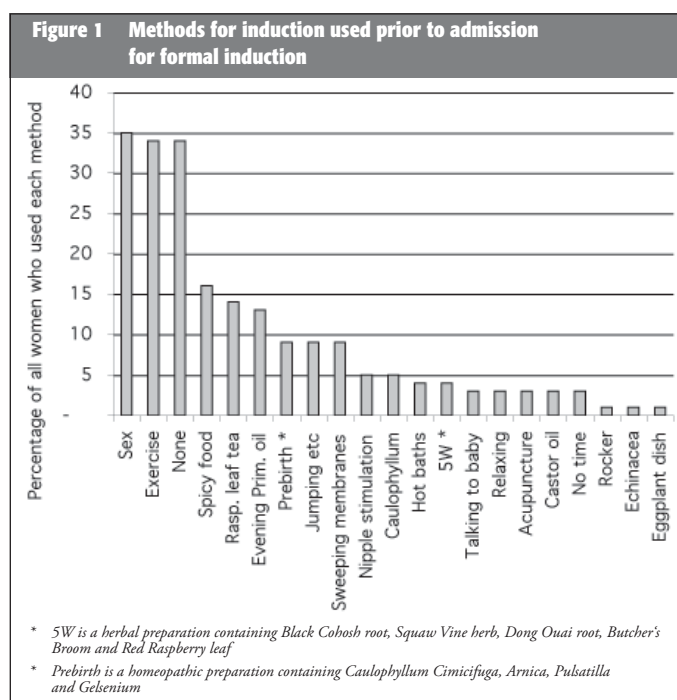
Women were asked if they or their LMC had tried any other methods to bring on labour. The responses are shown in Figure 1. Twenty-seven women (34%) said they had not tried any other methods before coming into hospital for an induction. For those who tried other methods, sex was the most common method used. Two women

last woman who was being induced under her care she had told everything to and nothing worked "so this time I didn't bother". Relatives had suggested castor oil but when women asked their LMC they were told not to use it.

The wide range of methods used by women in the community in an attempt to initiate labour indicates a desire by some women and their LMCs to avoid induction of labour in the hospital. The information about methods appeared to have been given in an ad hoc manner with the research literature being sparse to support many of these. Further research is required in relation to some of the alternative methods of induction being tried. Health professionals need to inform women of the research evidence to support 'sweeping of the membranes' and the use of castor oil as methods of induction of labour. The NZCOM consensus statement on complementary therapies advises midwives to either undertake "a recognised education programme or refer clients to appropriately qualified practitioners" (New Zealand College of Midwives, 2000, p.1).

Source of information regarding effects of induction

Women were asked what they understood to be the positive and negative effects of induction and how they had heard about these (Table 3). Of the 30 women (38%) who said they had heard about induction during childbirth education classes, 13 said it was only covered briefly, methods only were talked about or they couldn't remember much about it. Another woman said she received a booklet from the antenatal class but had not read the information in-depth. "Skimmed over it as the negative list always outweighed the positive". Others said they had read information received from antenatal classes either for the first time or reread it prior to induction.



knew of methods that could be tried but said they couldn't be bothered. One woman had been told by her LMC not to worry about it and 2 women said they had no time to try other methods prior to knowing they needed to be induced. One LMC made the comment to me that she had not told the woman about any other methods to try as the

The most common positive effects identified by the women were "the pregnancy coming to an end" (n= 31, 39%), "more control about when having baby" (n=30, 38%) and "less risk/stress for baby, safe" (n=21, 27%). The 3 most common negative effects mentioned by the women were "contractions

Table 3: Source of information for women prior to induction of labour

Source	Percentage
Verbal discussion with LMC	74
Written material	64
Friend/family	50
Childbirth education	38
Specialist	9
Internet	3
Hospital registrar	1

more painful, stressful" (n= 32, 41%), *"artificial, not natural"* (n= 25, 32%) and *"more likely to need more intervention"* (n=16, 20%).

Themes

In the development of a code for **'influences on decision making for induction of labour'** 10 themes were identified as listed in table 4. Only four of these themes are discussed in this article and are indicated in italics in the table.

Table 4: Code with themes

Code	Influences on decision making for induction of labour.
Themes	<ul style="list-style-type: none"> • Giving over and taking over of responsibility. • <i>Participation of women in decision making is limited.</i> • <i>Minimal evidence of women as informed decision makers.</i> • <i>Women are influenced for or against induction.</i> • Multidimensional balancing of risk for the LMC. • Focused risk for women. • <i>Hospital booking system.</i> • Induction of labour integrated into care as a routine practice. • Induction perceived as both taking from and giving to the birth experience by women. • Incongruence between LMC's stated belief about induction and their current situation of induction.

Minimal evidence of women as informed decision makers

The women interviewed for the study seemed to have limited knowledge of the negative effects of induction. Most women stated in some way that induction would reduce potential risk to themselves or their baby. Sixteen percent considered there to be no negative effects, another 3% said they did not know and 1% said they did not want to know. Sixty six percent of women were aware of less than 3 risks of being induced. The most common negative effect women said they

were aware of was contractions following induction were more painful and difficult. A LMC acknowledged the lack of information sharing by stating *"oops I didn't prepare her very well"*. When the primary author asked a woman the question "what are the negative effects of being induced?" she said she asked her LMC the same question and was told, *"she would be in hospital for longer rather than the first bit at home"* and that *"there were no distractions walking up and down the hospital corridor."* Some women may have forgotten, misunderstood or chosen not to hear the negative effects conveyed by their LMCs. Although women appeared to have minimal knowledge of the risks of induction prior to coming to the maternity facility in which the study occurred, the decision for induction and actual initiating of the induction is the responsibility of the obstetrician on call for that day. It is therefore expected that information sharing by the obstetrician (or registrar), prior to induction commencing, is a requirement of informed choice.

There is also no legal consensus on the right amount of information required for making informed decisions (Draper, 2004). However, neglecting the values of individual women in identifying relevant information required for consent *"fails to grant patient values their proper role in the decision-making process"* (May, 2002, p. 18).

Influences for or against induction

A woman may be influenced during pregnancy about induction by the LMC's approach. Prior to induction being necessary many LMCs had already expressed their opinions to the women. Some had said, *"[I] tell them at booking not to ask for [an] induction."* Other LMCs said they *"tell them [the women] at 40 weeks about induction then book them in so [they] don't miss out on a space."* The early booking for induction was identified as a problem: *"if [women are] booked in advance, it clogs [the booking] book up, women think induction – are programmed for induction."* The facility's protocol, at the time of the study, did not detail when a woman should be booked for induction for specific indications. However, a limit was put on the number of women who could have an induction on any one-day to ensure resources to care for women were adequate.

Participation of women in decision-making

All the LMCs were asked how the woman's attitude influenced the decision to carry out an induction of labour. Some commented that the woman had not asked for it but then later said they told them at the beginning of pregnancy *"I will not think of induction till [your pregnancy is] over 41 weeks"* or *"I tell them at booking not to ask*

for induction." On other occasions the LMC said they would have been happy to let the pregnancy go longer if the woman had been the type who was happy to push boundaries. It was not apparent from the interviews with the corresponding women that the women were aware they had been given a range of options relating to their own perceived philosophy.

Women appeared to be limited in their participation in decision making with evidence of paternalism by LMCs to either support or discourage induction for the woman they were caring for. This was illustrated by the occasions when women were given limited information and the event minimized as illustrated in previous quotes, such as being told there would be no distractions in the maternity suite. The reply by the LMC, *"no, she does what I say"*, when asked if the woman's attitude had influenced the decision to induce, was a more obvious example of paternalism.

A multidimensional balancing of risk for the LMCs was apparent with some expressing a concern about litigation or a fear of judgement from colleagues, factors that may have contributed to LMCs influencing women for or against induction of labour.

Effect of hospital booking system

The booking system influenced the timing of an induction and was manipulated as practitioners tried to overcome the control thereof. To begin an induction a space needed to be available within the daily allocation in the booking book. Two inductions could be started each day with one more space reserved for an urgent situation. The idea that the booking system was possibly an iatrogenic influence on early inductions was suggested by an LMC early in the study: *"People are induced two days earlier than needed, [booking system is an] iatrogenic effect."*

Eleven LMCs and five women made further complaints about the booking system confirming the notion.

Inductions for post-dates were being done a couple of days earlier than the LMC considered necessary, as *"apart from today there were no spaces available till next week when [the pregnancy] would have been 42 weeks."* For 19 women (24%) the booking system had influenced the day of induction. When there was a lack of space LMCs tended to go for the earlier date available rather than later. *"Waiting for someone to ring with an available space is stressful for women and me, especially going to term plus 14 and waiting."* *"I would have let her go a week, but*

continued over...

Induction of labour: the influences on decision making

this is when there was a vacancy, rather than wait a lot longer."

Accepting a space in the booking book earlier than was indicated frequently appeared unnecessary in hindsight. When the primary author interviewed the LMC they would explain that the woman was being induced earlier than they thought necessary. It was then noticed that most of the inductions in the booking book, for the next few days, had been cancelled as the women had gone into spontaneous labour. The day the LMC and woman would have preferred to commence induction, as stated in the interviews, had become free and there was no need for the induction to have commenced early.

To deal with the difficulties of the booking system many LMCs had developed ways of coping that perpetuated the difficulties and potentially increased risk. The book was clogged up with women who had been booked in at 40 weeks *just in case* they needed an induction later. Another method used to get a space in the book was to exaggerate the reason for induction and IUGR tended to be a reason used. The hospital booking system seemed to have considerable power over who was booked and when.

Implications for midwifery practice and maternity facilities

Midwives can use the findings from the study to review their own practice by developing an increased tolerance for pregnancy closer to 42 weeks for well women and babies. This has the potential to decrease the induction rate through a reduction in the number of inductions at 41 weeks or less for post-dates pregnancy. There is also a need to appreciate the risks of prolonged pregnancy for growth restricted babies rather than using the label of growth restriction as a means of securing a place in the induction book when such a risk is not actually present.

Decision-making around induction of labour should be a shared process whereby the woman, the LMC and the consulting obstetrician have input. Further research into this decision-making process is warranted. When the maternity facility guideline on induction is next reviewed, factors that could assist health professionals understand and clarify their responsibilities in regard to induction of labour could be included. The development and use of a decision making tool that coordinates the information sharing between women, LMCs, obstetricians and staff working in the maternity facility may be helpful to facilitate information sharing. The women should keep their own copy of this tool to enable open and on-going communication.

The use of information leaflets and childbirth education classes may help improve the quality of the information provided to women about induction of labour. Information should include positive and negative effects of induction as well as methods, including the evidence supporting suggested methods.

The use of an induction booking system needs to be considered and modified if necessary to allow bookings close to the preferred/required day and prevent early unnecessary inductions especially for women with post-dates pregnancies. The reasons or indications for induction should be clearly detailed in the booking book.

LMCs need to inform women of the available evidence relating to the effectiveness of complementary therapies, and midwives should acknowledge the recommendation of the New Zealand College of Midwives.

Conclusion

The study has provided insight into the reasons for induction and aspects of the decision making process at the facility under study. It provides invaluable local data and contributes to the wider knowledge base that LMCs, obstetricians and hospital staff can use to improve processes and stimulate a critique of their own practice in relation to induction of labour.

Postscript

Following the presentation of the study the hospital booking system has been changed to ensure that women who require a post-dates induction at a gestation of at least 41 weeks and 3 days are able to be booked on the day requested. Numerous practitioners have commented on the ease with which they can now book an induction on the day most beneficial to the woman. The information leaflet has been updated to include 'sweeping of the membranes' and detailed information of the risks of induction. A greater awareness, within the facility, of induction of labour and the need to inform women of the risks as well as benefits has occurred through the ongoing presentation of the results, and the inclusion of cases, in the regular case review meetings where women have had an induction of labour. An audit following the implementation of the recommendations from the study showed a 7-10% decrease in the induction of labour rate for nulliparous women.

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From autonomy and back again: educating midwives across a century Part 2

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Midwifery education as the focus of disagreement with nursing

By the time these women's groups were advocating for an autonomous midwife, midwifery itself was at its lowest point. By 1971 the word 'midwife' had been removed from the title of the legislation altogether. Although the separate register for midwives was retained, midwifery was seen as a specialist postgraduate area of nursing practice rather than a separate profession in its own right. Midwives had lost their relative autonomy and worked instead with delegated authority under the supervision of doctors. The maternity service no longer needed autonomous midwives because the majority of women gave birth in hospitals under medical care. Childbirth was seen as a pathological event requiring hospitalisation and medical intervention in order to achieve a safe outcome. In 1979 the six-month midwifery courses were closed and instead midwifery became an 'option' module within the polytechnic-based Advanced Diploma of Nursing (ADN).

Interestingly it was this downgrading of midwifery education that provided the catalyst for midwives to become politically active in an effort to claim a separate identity to nursing. For many midwives midwifery education highlighted their differences with nursing and through the 1970s and 80s the Midwives Special Interest Section of the New Zealand Nurses Association (NZNA) was largely at odds with their parent body over the issue of midwifery education. Eventually midwives realised that NZNA was always going to put the needs of the larger group of nurses ahead of those

of the smaller group of midwives and the decision to form the New Zealand College of Midwives was taken. The impetus for this was largely the result of two main areas of disagreement; how should a midwife be educationally prepared and was a midwife also a nurse?

Advanced Diploma of Midwifery

Midwifery education was swept along with changes made to nursing education in the 1970s. Canadian nurse-educator, Dr Helen Carpenter, was invited to New Zealand to advise on nursing education. Her report provided a catalyst for major change in the way that nursing education was understood and delivered. It culminated in a shift from hospital based apprentice-style training to a polytechnic-based student focused education system (Papps, 1997). It also shifted the prescriptive curricula to more liberal and theoretical nursing education that prepared the 'comprehensive nurse' who would be able to provide care in a variety of health care settings. Carpenter saw midwifery as post-basic nursing and argued that this course should be improved by shifting it into the tertiary system (Donley, 1986).

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lowest point. By 1971 the word 'mid-
wife' had been removed from the title
of the legislation altogether.*

The Midwives Section immediately sprang into action presenting remits at NZNA conferences in 1971 and 1973 calling for the St Helens hospital midwifery programme

to be strengthened by extending it from six to twelve months. The Section forwarded a draft curriculum for a one-year programme to the Nursing Council and received support for their arguments from a Department of Health report on Maternity Services (Hill 1982). However, these moves for a one-year hospital-based midwifery programme were unsuccessful. In 1979 the St Helens midwifery programmes were closed and midwifery training was only available through the ADN programmes offered in four polytechnics in Auckland, Hamilton, Wellington and Christchurch. Nurses with two years post-registration experience could undertake a one (academic) year full-time programme at a Polytechnic to advance their nursing knowledge and practice. Within the ADN programmes there were various options such as maternal and child health, community health nursing, medical / surgical nursing and

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¹ Secondary care refers to the availability and provision of specialist care in addition to primary care when required.

² Post-dates refers to the reason stated by the LMCs or women rather than according to a clinical definition of post-dates.

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psychiatric nursing (NZNA, 1984). Midwifery was incorporated into the maternal and child health option as a sub-option. Unlike the other options nurses in this option were required to meet not only academic requirements of the maternal and infant health option, but also the midwifery registration requirements of the Nursing Council of New Zealand, including passing the State Final examination.

The Midwives Section was active in its opposition to the ADN/Midwifery option. The main issues identified were the workload required to complete two programmes concurrently, the limitations of the theory and practice components (only 10-12 weeks of clinical experience), the loss of an apprenticeship model, and the resulting inadequate level of preparation for midwifery practice of the graduates (Kennedy & Taylor, 1987; NZNA, 1987). An unfortunate consequence of the transfer of midwifery education into the ADN programme was that many nurses decided not to pursue midwifery or they left New Zealand to undertake midwifery education overseas. From 1981 – 1987 the numbers of midwives training and registering in New Zealand dropped from an average of 157 per year to an average of 23 per year (Donley, 1986). The effect of this dramatic decrease in midwives is still being felt in New Zealand's midwifery shortages today.

The Midwives Section succeeded in changing NZNA policy from support of the ADN Midwifery option to support of the proposed separate midwifery programme by submitting remits to the NZNA annual conferences in 1980, 1982 and 1985, which were passed. Despite changes in policy direction signalled at these conferences, NZNA did nothing to give effect to the changes. Indeed, in its 1984 policy on nursing education, NZNA considered that the resolutions seeking the separation of midwifery training from the ADN programmes caused *"a problem as yet unresolved by NZNA"* that posed *"professional and educational difficulties"* (NZNA, 1984, p.33). NZNA argued that midwifery knowledge and skills were post-basic nursing because they built on nursing knowledge and skills. Educationally the ADN was designed to extend basic nursing skills and therefore, because midwifery involved advanced skills, it should be taught within the ADN (NZNA, 1984).

The second, and related, area of contention between midwives and NZNA was the generally held view that midwives must be nurses first and that midwifery education "builds on the nursing concepts learned in the basic nursing programme"

Interestingly this policy statement on nursing education was at odds with another statement released by the NZNA Midwives Section in April 1984 titled, *'Report of the Working Party looking into Education for the Role, Scope and Sphere of Practice of the Midwife in New Zealand'* (National Midwives Section, 1984). This policy retained nursing as a prerequisite to midwifery but supported

separation of midwifery education from the ADN. Thus by 1984 NZNA had two separate policies on midwifery education and each was at odds with the other. It was not until 1989 that NZNA produced a Midwifery Policy Statement that properly reflected the views of its midwifery members, but by then it was too late to

stop midwives leaving NZNA to form their own professional organisation (NZNA, 1989).

Is a midwife also a nurse?

The second, and related, area of contention between midwives and NZNA was the generally held view that midwives must be nurses first and that midwifery education *"builds on the nursing concepts learned in the basic nursing programme"* (NZNA, 1981, p.9). NZNA policy clearly stated that midwives were nurses but from the early 1980s the Midwives Section lobbied to adopt the World Health Organisation (WHO) Definition of a Midwife, which stated that a midwife was a 'person' rather than a nurse. The Section was successful in getting the WHO definition accepted as policy in 1985. However, disagreements remained about the preparation and role of the midwife and not just between nurses and midwives, but also between midwives themselves. A focus for this tension was the small number of domiciliary midwives in practice. Although the 1971 Nurses Act had removed midwifery autonomy and required a doctor to be present at every birth, the domiciliary midwives were almost an exception. These midwives came closest to the WHO definition of a midwife because they provided continuity of care in the community from pregnancy through to the postpartum period. They were out of step with the majority of doctors, nurses and midwives who objected to domiciliary midwifery and homebirth. Doctors, nurses and midwifery groups attempted to control the practice of domiciliary midwives and reduce the number of homebirths through the implementation of various policies.

NZNA proposed a set of minimum standards for all domiciliary midwives, including two years

continuous prior employment in a maternity hospital and an assessment of the midwife's suitability and competence to be carried out by the Principal Nurse and an Obstetrician (NZNA, 1981). Obstetricians influenced Board of Health policy that suggested ways to make maternity hospitals more appealing so that women would not choose home birth and that established so many 'risk factors' requiring referral to an obstetrician that hardly any woman fitted the category of 'normal' let alone met the criteria required to have a homebirth (Board of Health Maternity Services Committee, 1979, 1982). Some influential members of the Midwives Section also worked against their domiciliary midwifery colleagues by supporting these nursing and medical strategies and by writing their own policy in opposition to home birth (Midwives Section in NZNA, 1981).

These actions caused a major rift amongst midwives and led to domiciliary midwives leaving NZNA and establishing the Domiciliary Midwives Society (DMS) to represent their views. Fortunately for midwifery the DMS was able to successfully oppose moves to transfer domiciliary midwives' contracts for service from the Health Department to hospital boards and under medical control. This meant that when the Nurses Amendment Act was passed in 1990 there was an existing mechanism to enable midwives to claim payment directly from the Maternity Benefit Schedule managed by the Department of Health. This provided the opportunity for midwives to work independently rather than be employed by hospitals, a factor that has been crucial to the development of midwifery professional practice since 1990.

Separate midwifery programmes

The continual lobbying of the Midwives Section for separate one-year midwifery programmes for registered nurses from 1971 onwards finally bore fruit in 1987. Karen Guilliland and I represented the Midwives Section at the NZNA conference in 1987 where it was announced that there was soon to be a meeting to discuss midwifery education. Against strong opposition from the NZNA Executive Director, who had not planned to take any midwives to the meeting, we insisted on the Midwives Section being represented at the meeting. At the Annual General Meeting of the Midwives Section soon afterwards, Karen and I were nominated to represent the Section at this meeting (National Midwives Section 1987).

At the meeting we were the only midwives amongst a number of nurses including the NZNA Director, Gaye Williams and the Chief Nurse, Sally Shaw. Sally Shaw presented four options for midwifery education: direct entry, separate one-year course,

status quo (ADN) or a dual option of ADN and separate. Not surprisingly we were the only two in favour of direct entry and the nurses did not consider it a serious option. One person told us it would happen 'over her dead body'. The nurses were in favour of the status quo or dual option. Gay Williams supported the status quo option rather than the (by then) NZNA policy of separate courses. The Chief Nurse listened to the discussion but had the power to make the recommendations to the Minister of Health.

Eventually on 7 December 1987 the Ministers of Health and Education and the Acting Minister of Women's Affairs issued a joint press release announcing that a "dual training option" would be introduced in 1989 (Ministers of Health, Education and Women's Affairs, 1987). Midwifery education would be available separately to the Advanced Diploma in Nursing, although the ADN Midwifery Option would continue to be available in a limited number of places. It would also remain available for midwives seeking further qualifications. Midwives met this compromise with some excitement. Following the recommendations of the Working Party on Midwifery, Bridging and Related Courses separate courses were commenced in 1989 at Auckland Institute of Technology (AIT), Wellington Polytechnic and jointly between Otago and Southland Polytechnics (Pairman, 2002). The ADN Midwifery option continued at Waikato and Christchurch Polytechnics.

In the first example of the collaborative approach that has characterised midwifery education over recent years, representatives of the educational institutions were brought together for a week in Auckland in 1988 to develop guidelines for these new separate midwifery programmes. The intention of the Health and Education Departments was to evaluate the separate programmes against the ADN programmes over three years and then decide which type of programme would continue.

However, the evaluation was overtaken by other events. Nurses refused to enrol in the ADN/Midwifery programme, insisting instead on access to the one-year midwifery programme. This demand from students led to both Waikato and Christchurch Polytechnics closing their ADN/Midwifery programmes in 1991 and commencing one-year separate programmes in 1992. The polytechnics were able to commence the separate programmes without approval from the Health and Education departments because of the Education Act passed in 1990. Amongst other things this Act removed government control over funded places for health education programmes and opened up a more

free-market approach. The Ministries of Education and Health were restructured, the evaluation was never completed and the ADN/Midwifery option ceased without any policy decision to do so being made. The separate midwifery programmes themselves only lasted another few years, as eventually registered nurses were able to enter the direct entry Bachelor of Midwifery programmes. With some credit for prior learning nurses could complete the degree programme in two years instead of three.

Despite their brief time span the separate midwifery programmes were important milestones in midwifery education development. The provision of one year of specific midwifery education instead of the briefer 'option' within a post-basic nursing programme was the first step to raising the profile of midwifery and recognising the potential of midwifery as a major provider within maternity services. It also set the direction for further separation from nursing that would follow the 1990 Nurses Amendment Act. Although the separate programmes began before the legislation changed they used the WHO Definition of a Midwife to set the boundaries of what a midwife needed to learn in order to practise. The curricula used words such as 'autonomy' and 'continuity of care' and follow-through clinical experiences were sought for midwifery students. Indeed when the Otago/Southland programme drafted a brochure to inform pregnant women about the needs of midwifery students to access 'follow through' clinical experiences, the Southland Branch of the New Zealand Medical Association (NZMA) tried to take legal action to stop its development (Macalister Mazengarb, personal communication 10 March 1989). They objected strongly to the WHO definition of a midwife that was listed on the pamphlet and were worried that midwives might try to work as autonomous practitioners in Southland. The notion of informed decision-making was another they had difficulty with.

Separating from nursing

From 1986 midwives discussed the need to separate from nursing's professional body (now called the New Zealand Nurses Organisation) and during 1988 the 10 regional Midwives Sections of NZNO all closed down and reopened as regions of the New Zealand College of Midwives (NZCOM) (Pairman, 2002). NZCOM was formally

opened on 2 April 1989. They were heady days and midwives were buoyed with support from women and the shared political activity of the time that in 1990 would result in legislative change and the reinstatement of midwifery autonomy. NZCOM presented an exciting vision of the future of ma-

ternity services for women and the role that midwives could play in this.

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Direct entry midwifery

In midwifery education the focus had moved to direct entry. The Direct Entry Midwifery Taskforce was established in 1987 as a sub-group of Save the Midwives, a consumer group that was itself established in 1983 to fight the proposed 1983 Amendments to the

Nurses Act 1977 (Strid, 1987). The Midwives Section formally supported the Taskforce but both groups agreed to focus on achieving the separate midwifery programmes as a first step and then on reinstating midwifery autonomy before both would put their energies into achieving direct entry midwifery education (Midwives Section 1987). In the event direct entry and midwifery autonomy were achieved in the same piece of legislation, the 1990 Amendment to the Nurses Act.

The Direct Entry Midwifery Taskforce did a huge amount of work that cannot be underestimated in the eventual achievement of direct entry programmes. In 1988, with funding from the McKenzie Trust Foundation, it distributed a discussion paper and questionnaire about direct entry that served to raise awareness amongst many midwives and others. The 691 replies received indicated strong support for direct entry (NZCOM, 1990). The Taskforce, in association with Carrington Polytechnic and with support from NZCOM, distributed a draft curriculum and further discussion paper in 1990 (Save the Midwives Direct Entry Midwifery Taskforce, 1990). Again there was a huge supportive response. Carrington Polytechnic submitted their direct entry midwifery curriculum to the Nursing Council for approval in 1990 and this was turned down with the Council citing legislative barriers as well as philosophical disagreement with direct-entry midwifery as their reasons (Strid, 1991).

This stance by the Nursing Council concerned Minister of Health Helen Clark who sponsored the Nurses Amendment Bill to reinstate midwifery

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autonomy. Helen Clark considered that Council was empowered to administer the Nurses Act, not to have a philosophical position on the direction of midwifery education. At the first NZCOM National Conference in Dunedin in August 1990 she told midwives she intended to remove legislative barriers to direct entry midwifery. If the Council still showed no tolerance for such a programme it would 'open up to question whether the Nursing Council is the appropriate body to govern midwifery' (Clark, 1990, pp.9-10). During the second reading of the Nurses Amendment Bill, Helen Clark introduced legislative changes that would enable the introduction of direct-entry midwifery.

Section 39 of the 1990 Amendment paved the way for direct entry midwifery and two three-year programmes commenced in 1992 under this experimental clause. These were a diploma programme at AIT and a Bachelor of Midwifery degree at Otago Polytechnic. These first two programmes were extensively evaluated over the first four years and in 1996 another three institutions were approved to provide direct entry midwifery programmes. Partway into its first course AIT upgraded its curriculum to a Bachelor's degree and there are currently five direct-entry programmes available, all of which award a Bachelors degree.

The significance of direct entry midwifery

Direct-entry midwifery education at last gave the profession the opportunity to prepare midwives for their full scope of practice. Without the pre-requisite nursing registration midwifery had the opportunity to consolidate its professional identity separately from nursing. Establishing a pre-registration education programme for midwifery in parallel to preparation for nursing clearly identified midwifery as a different career option. The new programmes were able to provide the in-depth focus on midwifery knowledge and practice necessary to produce midwives who were 'specialists' in normal childbirth and with the skills to practise independently of doctors. Midwifery had always supported apprenticeship-type midwifery education and these new programmes combined the best of theoretical educational models with apprenticeship models to facilitate development of evidence-based knowledge from a strong practice base. In creating midwifery academics, direct-entry midwifery education also set the scene for definition and construction of midwifery 'discourse' (Tully, 1999). Midwifery has begun to articulate and record its knowledge base, to carry out original research and to identify what it is that distinguishes it from other professional groups involved in maternity care.

Direct-entry midwifery also provided a framework into which nurses could be incorporated

on midwifery's terms. With the rapidly changing practice opportunities for midwives and increasing expectation of independent caseload practice, the one-year separate midwifery programmes could no longer prepare nurses with the necessary knowledge and skills for this new practice context. The one-year programmes for nurses were phased out from 1992 and nurses were admitted to the Bachelor of Midwifery degrees with some credit in recognition of skills and knowledge shared between midwifery and nursing. By combining direct-entry and nursing midwifery students together in one Bachelor's level programme, midwifery has cemented itself as a separate profession alongside nursing, preventing any attempts to re-establish midwifery as a post-basic course for nurses.

Direct entry midwifery education has played a critical role in midwifery's consolidation of its status as a profession in its own right. Current and future education developments such as post-graduate midwifery programmes and increasing continuing education programmes are important strategies in strengthening midwifery as a profession. A profession must educate its own members. Not only to ensure that appropriate knowledge, skills and attitudes are taught but also because education is an essential part of professionalisation. It is how we learn to understand our identity as midwives, how we learn what values we share and what standards are expected of us as members of this profession.

Conclusion

In examining midwifery education over the last 100 years similarities and differences can be identified in relation to midwifery practice and the maternity service context. In 1904, as now, midwives provided the majority of the maternity care and had the legislative right to provide this on their own responsibility. Midwives could be businesswomen and maintain some independence. They had status in the community and women and families valued their work. While midwifery faced near demise through the middle of the century because of medicine and nursing's almost successful attempt to take control of maternity services, it managed to survive. Thanks to the political activities of some midwives and maternity consumers midwifery saw resurgence in the latter part of the century that enabled it to claim its professional autonomy and define its scope of practice.

Throughout the century midwifery education has reflected the scope of practice of the midwife and developments in educational theory and practice. Early in the century midwives were prepared for their semi-autonomous role through midwifery 'training' that appears to have relied heavily on experiential learning through clinical practice alongside a more experienced midwife. As the midwife's role reduced to one of 'assistant' midwifery education became more hospital based and task focused. When nurses moved midwifery education into the tertiary education sector as part of the larger shift in nursing

education, midwives criticised the limited time available for both theory and practice and decried the loss of opportunity for the development of clinical midwifery skills.

One hundred years on midwifery education is again separate to nursing. Developments in educational theory and current expectations of midwives mean that the curricula have moved from their task and routine focus in 1904 to emphasise critical thinking and evidence-based practice. The place of women in society is improved and there is increased emphasis on notions of choice, informed consent and individual rights. Advances in science and in research mean that knowledge of childbirth is greater, but the physiological process remains the same and the role of the midwife to support and protect the childbirth process is unchanged across the century.

That midwifery can move from autonomy to near extinction to autonomy again in the space of only 100 years shows that midwifery's existence is not secure. While women will always have babies they do not always have midwives to care for them in childbirth. This is true in other western countries like Canada and America where nurses take on this role. New Zealand women have fought to keep midwives and midwives must now ensure the profession survives to meet the needs of birthing women.

Midwives today have significant advantages over midwives in 1904. Midwifery has a professional organisation to provide leadership and represent midwifery's interests. Midwifery is self-regulating and therefore has control over various aspects of its work such as definition of the scope of practice, entry to the profession, setting of standards, maintenance of competence and discipline. An important mechanism for ensuring that midwives

That midwifery can move from autonomy to near extinction to autonomy again in the space of only 100 years shows that midwifery's existence is not secure.

meet these professional expectations is education. Education can assist midwives to understand the lessons of the past, to articulate their scope of practice and philosophy, and to gain the knowledge and skills necessary for practice in today's context. Midwives today must understand the meaning of autonomy and responsibility and partnership with women as these are defining characteristics of the New Zealand midwifery profession in 2005. Education is a key strategy for the survival of the profession.

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Promoting normal birth: a case for birth centres

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Abstract

Interest in birth centres has arisen in response to consumer pressure for a birth centre in Wellington. Recent literature supports claims that birth centres reduce intervention in labour. The twentieth century in New Zealand saw women move from home to hospital to give birth. This transition for many entailed giving birth in small maternity homes. A strategy is proposed encouraging the use and development of primary units and reversing the recent trend to deliver in secondary and tertiary units. There are three areas requiring attention: working for policy changes, involving the community and supporting midwives to use primary birthing facilities.

Introduction

Increasing levels of unease about rising birth intervention rates in western societies have led to proposals for alternative ways that maternity care might be provided, in the hope of protecting and promoting normal birth. Research presented in this paper was undertaken in response to one such proposal: a community-led initiative to establish a freestanding birth centre in Wellington. A birth centre was seen as a way of offering a community focused, normal birth environment for healthy women, who currently have no choice other than an obstetric unit birth or a birth at home.

This article begins with a brief introduction to the history of primary birthing services in New

Zealand and then describes where New Zealand women are currently giving birth. It then provides a review of the international literature regarding the outcomes of birth centre care. Using the Wellington region as example, it presents some of the challenges associated with promoting existing primary birthing services, or in establishing new ones. We conclude by proposing ways that midwives might become proactive in the promotion and use of primary birth units or birth centres.

The choice of place of birth

During the 20th century there was a radical shift in the place of birth. This shift was consistent through most of the western world. In New Zealand, for example, according to Mein-Smith (1986) only 35% of births in the 1920s occurred in hospital, and by 1935 the number of hospital births had risen to 78%. Mein-Smith suggests two reasons for this increase in hospitalisation.

Hospital births elevated the status of midwifery within the medical profession. This in turn reinforced the trend towards hospitalisation. Certain forms of meddlesome midwifery', namely Caesarean section and painless childbirth, became fashionable with both the medical profession and the public in the period from 1920 to 1939. (p.69)

The changes were also based on new understandings about science and safety. As a nurse in the 1960s¹ in Wellington, Stojanovic (2002) describes the prevailing attitudes of those times:

I had a perception fostered by my educators, of childbirth prior to medical control and hospitalisation as a wilderness where 'Sairey Gamp' 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 the time. (p. 13)

In New Zealand, the shift from birth at home to birth in obstetric units was interspersed with a period during which birth commonly occurred in

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small maternity homes, hundreds of which were spread through New Zealand towns and cities. Despite the importance of these maternity homes in the childbearing experiences of thousands of New Zealand women, their history has not been thoroughly investigated or recorded. Many of these homes were privately owned and run by midwives (Wood & Skinner, 2004). They could be seen as the precursors of today's freestanding birth centres. Prior to the 1960s many women gave birth in such units. At this stage there were fewer specialist obstetricians and paediatricians than at present, and cooperative working arrangements existed between general practitioners and their obstetric colleagues about the requirements for referral (Rosenblatt, 1984).

By the 1960s however, only 25% of women gave birth to their babies in these primary units and in the two decades that followed all the private maternity homes had closed, along with 33 small public maternity hospitals. Twenty nine of these were in rural areas, representing 30% of all rural hospitals (Rosenblatt, 1984). There were many causes for this shift which included increasing urbanisation, a rise in medical technology and an increased number of specialist obstetricians and paediatricians.

By the 1980s there was an even greater push for centralised maternity care. The Auckland Hospital Board's 1984 Strategic Plan, for example, stated that its objective was "[...] to ensure that all births can occur in obstetric units with specialist obstetric and paediatric services and the necessary supporting facilities" (Auckland Hospital Board, Draft Strategic Plan, 1984, cited in Donley, 1986, p.110). This argument for centralisation was also based on a statement that, as women were willing to travel 30 miles for shopping they should not expect to stay in their own areas for giving birth! In relation to the issue of safety however, the Rosenblatt Report (Rosenblatt, 1984) claimed that:

[...] there is a very strong relationship between the size and level of sophistication of maternity units in New Zealand, and the hospital-specific perinatal mortality. Small, peripheral units have very few perinatal deaths and very low perinatal mortality rates; perinatal mortality rates rise linearly with the size and complexity of the hospital. (p.113)

Tew (1985) also challenged the assumption that primary birth units were unsafe. Nevertheless the closure of primary birth environments continued unabated.

What the research says about birth centre outcomes

With increasing intervention rates, the focus of the

debate has returned to investigate whether there are fewer interventions when care is provided in these woman-centred, home-like environments. There is no doubt that women show improved levels of satisfaction when care is provided in a birth centre (Stewart, McCandish, Henderson & Brocklehurst, 2004). There are three key pieces of recent work related to birth centre outcome, which are important to consider when investigating birth centre care. These studies are systematic reviews that have sourced and critiqued the results of most of the birth centre studies conducted internationally.

The first to consider is the systematic review prepared for the Cochrane Collaboration by Hodnett, Downe, Edwards and Walsh (2005). This review identified six randomised controlled trials (RCTs), which evaluated the effects of care in home-like birth centre settings compared with care in a conventional labour ward. These RCTs were undertaken in the United Kingdom, the United States, Sweden, Scotland and Australia. The birth settings were all situated either in, or alongside hospitals. There were no RCTs found that were conducted in free-standing birth centres. The review concluded that the benefits of delivering in a home-like setting were consistent. There were lower rates of epidural anaesthesia, and an increased incidence of spontaneous birth. This review also suggested the possibility of an increase in perinatal mortality although this did not reach statistical significance. The authors concluded that *"policies and practices must address the dual challenge of supporting an orientation towards normality concurrently with vigilance in detecting and prompt intervention in the presence of abnormality"* (Hodnett et al., 2005, p.6). They recommended that further clinical trials be conducted, alongside qualitative studies, examining the impact of transfer and the decision-making processes leading to intervention.

The second study is a structured review of free-standing birth centre outcomes and was conducted by two of the same reviewers who undertook the systematic review cited above (Walsh & Downe, 2004). They assessed five controlled, but not randomised, studies. There was a mixture of retrospective and prospective studies in their review. Although there were concerns expressed about the quality and heterogeneity of the studies, every study that they examined reported benefits of birth centre care, thus challenging the use of secondary and tertiary units for low-risk women. There were definitional difficulties between the studies about what a 'normal' vaginal delivery was (some included augmentation and epidural), so they recommended that future studies needed to differentiate between these types of births.

They supported the contention however, that although quality research was lacking and that the current research results could not be generalised, that birth centres should be considered safe unless proved harmful and that there was no evidence to reject them on the grounds of potential adverse outcomes.

The third piece of research to present is a structured review of birth centre outcomes, undertaken recently in the United Kingdom (Stewart et al., 2004). This comprehensive report looked at clinical, psychosocial and economic outcomes for women with straightforward pregnancies who planned birth centre care. The reviewers concluded that the research into birth centre care was in general of poor quality, and that although women clearly supported birth centre care, there was no reliable evidence either about benefit or harm. The reviewers recommended that perinatal mortality must be monitored by effective clinical surveillance and management. None of the studies used a robust design which could demonstrate causality (well-conducted RCTs) nor are they large enough to give confidence in their findings. What has tended to happen is an over-interpretation of the meaning of the data. This debate has been ongoing in the recent literature (see Fahy & Colyvas, 2005; Gottvall, Grunewald & Waldenström, 2004).

It would appear that despite the findings that suggest improved outcomes for birth centre care in descriptive and randomised controlled studies, further research is required in order to provide definitive evidence. In New Zealand we are now starting to see the emergence of midwifery research looking at midwifery and birth outcomes in the primary birth environment (Barlow, Hunter, Conroy & Lennan, 2004; Hendry, 2003; Hunter, 2003; Stojanovic, 2003). A large scale multi-centre study needs to be conducted and New Zealand is in an excellent position to participate in such a study.

Where do NZ women currently give birth to their babies?

In 2002, 16% of New Zealand births occurred in primary birth facilities. Forty percent of births occurred in secondary hospitals and 44% occurred in one of the five large tertiary hospitals (New Zealand Health Information Service, 2004)². There are a considerable number of women with uncomplicated pregnancies being cared for by midwives in facilities that have complex maternity care as a key part of their focus. Many of these women may be better served in a primary unit.

New Zealand's primary birth facilities are predominantly rural. Only 10 of the 65 primary

birth units could be described as urban, and six of these are situated at the edges of large cities, at some distance from an obstetric unit. These facilities, as they exist in New Zealand, in the main provide a local birth place for women who live at a distance from obstetric units, rather than to provide an alternative birth environment. There are some exceptions to this, including such places as River Ridge Birthing Centre in Hamilton and Birth Care, Auckland. The facilities are also quite diverse in the way they are owned and funded, and in the services they provide. They are called by a variety of names: primary facilities, birthing centres, birth units, health centres, maternity hospitals and community hospitals (New Zealand Health Information Service, 2004). Stewart et al. (2004) recommended a consistent definition for birth facilities.

A birth centre is an institution that offers care to women with a straightforward pregnancy and where midwives take primary professional responsibility for care. During labour and birth medical services including obstetric, neonatal and anaesthetic care are available should they be needed, but they may be on a separate site, or in a separate building, which may involve transfer by car or ambulance. (p.8)

Renaming our primary birth facilities as birth centres may go some way in achieving clarity of purpose and definition.

Another aspect of maternity care in New Zealand to be considered is that many midwives provide care across all spectra of the maternity service. Midwives can cross birthplace boundaries. They can provide care at home, in primary birthing units and in secondary and tertiary facilities. Where there is a change in the planned place of delivery, usually from a primary unit to a secondary service, midwives can follow the woman and continue to provide care. One New Zealand study has revealed that midwives who lived more than 20kms from an obstetric unit (those most likely to be using primary birth facilities), continued to provide midwifery care for 73% of women whose clinical responsibility for care had been transferred to an obstetrician (Skinner, 2005). Midwifery care in New Zealand then has had a strong focus on continuity of carer. Being 'with women' is valued. What needs to become valued now is being 'with women' in an appropriate birth place.

The Wellington situation

The Wellington situation exemplifies this challenge and the maternity services provided in the Wellington region reflect the difficulty associated with making a case for a birth centre. The Wellington region has both a secondary and a tertiary maternity service operated by separate District Health Boards (DHBs). The Hutt Valley District

Health Board (HVDHB) serves a population of 138,000. It has a secondary maternity facility but no primary birth facility. The Wellington DHB (Capital and Coast DHB) has the region's tertiary unit but also operates two primary units, one in the Porirua basin (Kenepuru) and one on the Kapiti coast (Paraparaumu). Within the tertiary hospital there are also two labour and birth rooms designed to offer a 'home like' atmosphere for low risk women. In a sense these rooms might be regarded as an 'in hospital' birth centre. One of the most significant factors about the region's two primary facilities is that they are considerably underutilised and are therefore expensive to maintain. The number of births in these units is also showing a steady decline (See Table 1).

Table 1 – Place of delivery in C&CDHB (numbers of mothers)

Name of Facility	1997	1998	1999	2000	2001	2002	2003
Wellington	3064	3329	3301	3389	3293	3305	3541
Kenepuru	320	370	342	334	352	277	263
Paraparaumu	120	135	107	111	125	106	99
TOTAL	3504	3834	3750	3834	3770	3688	3903

(Source: K Fisher, C&CDHB, Personal Communication)

The Paraparaumu maternity unit is situated in the Kapiti Coast area, about 50 kilometres from Wellington and serves a population of 42,000. The unit has one delivery bed and although it could theoretically be used for 300 births a year it actually does only 1/3 of this number. Only 20% of women who are pregnant in the area give birth at the unit. It is currently used principally as a postnatal ward for women who are transferred to it after having given birth at the tertiary hospital. Ironically labouring women who wish to give birth there are sometimes diverted to the tertiary unit, because there are no postnatal beds for them.

The Kenepuru birth facility is situated about 20 kilometres from the tertiary hospital and serves a population of 50,000. It has two birth rooms and 4 postnatal beds so, as in the case of the Paraparaumu unit, is also significantly underutilised. It too functions largely as a postnatal service for women transferred after having given birth at Wellington hospital. Neither unit is financially self-sufficient and thus are heavily subsidised from other DHB funding sources. The two birth rooms situated within the tertiary unit itself are also similarly under-utilised and can be used as a 'nice place to be' before moving rooms for the planned epidural.

It would appear then, that women are not given enough opportunity to give birth in primary birth units, and that where they are, many do not avail themselves of this choice. This then poses a particular problem for any group wishing to set up a birth centre in the region, as there is at present clearly little demand for one. If a community wishes to set up birth units in urban areas they are faced with some real barriers, the most problematic of which is getting access to ongoing financial support from the DHBs, in the form of a facility fee. Despite strong community protest, the Hutt DHB closed its last remaining primary birth facility in 1989, based on claims that it was expensive and underutilised. The Wellington DHB continues to provide primary

birth facilities, which are also underutilised. It seems unlikely that, without a clear policy change, any DHB would release funding for a service for which there was little exhibited demand, and at the expense of its already underutilised primary birth facilities.

Reinvigorating primary units and midwifery

Given the concern for rising rates of unnecessary intervention, and the evidence that giving birth out of obstetric units is likely to reduce the incidence of these interventions, it is worthwhile to attempt to promote increased utilisation of primary birth facilities. Reversing the current pattern of overuse of secondary and tertiary maternity facilities and promoting the use of primary units is an exciting and challenging prospect.

In the Wellington area there are a number of possibilities to be considered which may be of interest to others wishing to encourage the use of existing primary birth facilities or the opening of new ones. There are three areas that require attention: working for policy change, involving the community, and supporting midwives to provide care away from obstetric units.

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Working for policy change

- Developing a national strategy to promote birth in primary birth centres.
- Working to put normal birth and primary birth centres on the policy agenda for local DHBs, and at a national level. Participating in any local meetings where the provision of maternity services is being discussed.
- Becoming actively involved with the running of existing birthing units. Reviewing admission criteria and transfer policies. Proposing that there is a name change of any local primary birth facility to 'birth centre'.

Involving the community

- Working in partnership with existing consumer groups or community representatives in the planning for and implementation of new and existing primary birth centres.
- Putting 'Place of Birth' on the agenda at all antenatal classes. Women need to become aware that the place where they choose to give birth to their babies, has implications for birth outcome.
- Each existing or proposed primary birth centre should have an advisory group of community members, with direct input into policy and promotion. The community needs to own 'its' centre.
- Get the community into the birth centres-antenatal visits, antenatal classes, new mothers support groups, information centres, centre support workers and any other forum that might be appropriate.

Supporting midwives to use the centres

- Developing a mentoring or 'buddying' process, whereby those midwives comfortable using primary birth centres offer to work alongside midwives who have not been using them.
- Holding skills workshops at existing primary facilities, focusing on competencies required to work away from obstetric units, including how to provide informed choice for women regarding place of birth.
- Implications about place of birth could be discussed at the annual practice review of midwives' standards of practice and in the training of midwifery and consumer reviewers.

This article is arguing for a rethink about the place of birth for healthy pregnant women. Although women are free, within the boundaries of their level of complexity, to choose the place of delivery, questions must be asked about the part played by the midwife in this decision. Shifting the attitudes of women and midwives will require a concerted effort at a variety of levels. Midwives' perceptions of managing risk outside secondary or tertiary hospitals have been explored in New Zealand by Hunter (2003). She showed that midwives felt

they practised differently in the different contexts. In small units they felt they could practice 'real midwifery' but when they worked in the bigger obstetric units they felt pressured to watch the clock, to control the noise and use technology. There are challenges for midwives then across the spectrum of care.

These ideas regarding the choice of place of birth are in keeping with the New Zealand College of Midwives' recent innovation to increase normal birth rates. This NZCOM project focuses on collecting evidence for best practice at critical decision points of the pregnancy, birth and the postpartum period. The first of these decision points is choosing the place of birth. This project holds the promise that midwives will be reassured and encouraged to reduce intervention rates and that women will have the confidence to trust the evidence, their bodies and their midwives. We would like to suggest 10 steps to hasten the change to an appropriate place of birth for all women.

1. Personal action by midwives in changing their own and others' attitudes.
2. Working closely with consumer groups.
3. Accurate information for women in order to offer them real choice.
4. Supporting existing primary maternity centres.
5. Making use of the places in hospitals currently designed for uncomplicated births.
6. Buddying midwives, especially the new ones, who are unfamiliar with supporting birth out of secondary and tertiary settings.
7. Creating a demand by putting normal birth in primary units on your agenda.
8. Creating or being part of an activity in your region to reduce intervention.
9. Research is needed in order that accurate and useful data is collected and analysed. New Zealand midwives need to collaborate in any international birth centre research.
10. Support the NZCOM "Keeping Birth Normal" initiative which is happening through the local branches of the NZCOM.

Birth centre research suggests that there is an increased chance of a woman achieving a birth without intervention, if she plans to give birth away from secondary or tertiary maternity hospitals. There is a growing understanding both about the importance of the birth environment, and of the implications of the attitudes of women and midwives towards birth. However there remains a lag in changing practice. It would seem a worthwhile project to attempt to encourage both midwives and women to look at the evidence and reassess the appropriateness of the place of birth.

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¹ The term meddlesome midwifery is an historical term referring to unnecessary medical intervention.

² No home births are reported.

The sunshine vitamin - is there really a need for dietary vitamin D?

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Abstract

Vitamin D plays an important role in skeletal development and bone mineralisation during pregnancy and lactation. A deficiency in vitamin D causes skeletal abnormalities such as rickets in infants and osteomalacia in adults. There are limited food sources of vitamin D in New Zealand and the majority of vitamin D in the body is synthesised in the skin through the action of ultra-violet light. Supplementation of vitamin D during pregnancy and lactation may be beneficial for pregnant and lactating women, particularly those with dark skin and those who avoid sunlight exposure.

Introduction

Adequate vitamin D status is important throughout the lifespan but is of particular importance during pregnancy and lactation to promote skeletal development. Optimal skeletal development is dependent on maintaining adequate maternal vitamin D status. Vitamin D can be obtained from few foods or can be synthesised in the skin through the action of sunlight. In New Zealand the majority of our vitamin D comes from sunlight exposure; however anything that limits sunlight exposure will reduce vitamin D synthesis. It has been assumed that New Zealand women obtain sufficient vitamin D from sunlight, however this assumption has recently been questioned (Skeaff & Green, 2004). The focus of this article is to illustrate the importance of vitamin D during pregnancy and lactation, and to highlight the difficulties in attaining adequate vitamin D status.

What is vitamin D?

Vitamin D is formed in the body when 7-dehydrocholesterol, a steroid present in the skin, is converted to cholecalciferol (vitamin D₃) in the presence of ultra-violet light (Figure 1). Cholecalciferol is modified in the liver to calcidiol. Calcidiol is converted in the kidney into calcitriol in response to parathyroid hormone (PTH). Parathyroid hormone is secreted from the parathyroid gland when plasma calcium levels fall below normal range (2.25-2.75 mmol/L). It raises plasma calcium concentration by increasing reabsorption of calcium by the kidneys, promoting calcium release from bone and increasing calcitriol production.

Calcitriol, the active form of vitamin D, is a hormone with receptors in various tissues including

the small intestine and bone. In the small intestine it enhances calcium absorption, and together with PTH stimulates release of calcium from bone by stimulating the breakdown of bone tissue. Calcitriol also controls the rate of bone calcification during skeletal development and maintains bone health during pregnancy and lactation.

The amount of vitamin D produced in the body through sun exposure is dependent on season, latitude and skin colour. These are factors that affect the amount of ultra-violet light reaching and penetrating the epidermis of the skin. In winter people require more sunlight exposure to produce vitamin D, especially at higher latitude in both the northern and southern hemispheres. Dark skinned people require more sunlight exposure than fair skinned people to produce an equivalent amount of vitamin D.

Vitamin D deficiency results in inadequate mineralisation or demineralisation of the skeleton. In infants this results in rickets and in adults, osteomalacia and osteoporosis. Rickets is characterised by slow closing of the fontanels and failure of leg bones to mineralise resulting in bowed or knocked knees. Rickets has been described as far back as the seventeenth century (Abrams, 2002). A

resurgence of vitamin D deficiency in infants has been described in many countries including New Zealand (Abrams, 2002; Blok, Grant, McNeil & Reid, 1998; Hatun et al., 2005; Weiler et al., 2005). In 1998, 18 infants and children aged less than five years were identified as having rickets at Starship Children's Hospital in Auckland (Blok et al., 1998). The majority of these children were dark-skinned from the Indian sub-continent.

In the adult, bone is continuously formed and removed, a process referred to as bone remodelling. With inadequate levels of vitamin D these processes still occur however the bone formed contains lower amounts of calcium resulting in osteomalacia, meaning 'soft bones'. In osteoporosis the amount of bone removal exceeds that of bone formation resulting in fragile bones. Both osteomalacia and osteoporosis result in weakened bones.

An increasing number of chronic diseases such as diabetes and certain cancers have also been associated with vitamin D inadequacy (Hypponen, Laara, Reunanen, Jarvelin & Virtanen 2001; John, Schwartz, Dreon & Koo, 1999).

Vitamin D recommendations for pregnancy and lactation

The New Zealand recommendation for vitamin D intake during pregnancy and lactation is 5 mcg/day or 200 IU/day (National Health and Medical Research Council, 2004). These recommendations are similar to those in North America (Institute of Medicine Standing Committee on the Scientific Evaluation of Dietary Reference Intakes, 2001), however recommendations from the United Kingdom are higher (10 mcg/day or 400 IU/day) (Committee on Medical Aspects of Food and Nutrition Policy, 1991). Some experts are calling for even higher intakes (Hollis & Wagner, 2004).

Do pregnant and lactating women consume adequate intakes of vitamin D?

There is limited data on the vitamin D intakes of pregnant and lactating women. Vitamin D intakes in a British cohort of pregnant women were extremely low with only 1.2% of women meeting the recommended intake of vitamin D (Mathews & Neil, 1998). The Australia New Zealand Food Authority (now known as Food Standards Australia New Zealand) estimated mean Australian population intakes to be 2.2 mcg/day, well below the recommendations for vitamin D (Australia New Zealand Food Authority, 1999).

Strategies to ensure adequate vitamin D status during pregnancy and lactation:

- Consume dietary sources of vitamin D including fatty fish, eggs and fortified milks.
- Consider vitamin D supplements for women at risk of vitamin D deficiency.
- Obtain adequate sun exposure – however to minimise skin cancer risk it is recommended to avoid unprotected sun exposure between 1100 and 1600 and use sunscreen, clothing and hats for sun protection during the months of daylight savings (Cancer Society New Zealand, 2004).

There is no data available regarding the vitamin D status of pregnant New Zealand women however data from the 1997 New Zealand National Nutrition Survey found 50% of women aged 15-40 years had blood vitamin D levels indicative of vitamin D insufficiency. Higher rates of vitamin D insufficiency were found in Maori and Pacific people versus European women (Skeaff & Green, 2004).

Nozza and Rodda (2001) reported that 80% (n=25) of mothers residing in Melbourne with infants who had rickets had biochemical indices suggesting osteomalacia. The authors do not state how many of these mothers were lactating, however the majority of infants in this study aged 12 months or less were exclusively breastfed.

Breast milk is a relatively poor source of vitamin D irrespective of mother's vitamin D status and therefore breastfed infants with insufficient sun exposure are at risk of vitamin D deficiency, in particular dark skinned infants (Abrams, 2002). Thompson, Morley, Grover and Zacharin (2004) reported that breastfed infants in Australia were

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more likely to have vitamin D deficiency and decreased bone formation, indicative of rickets, than infants fed formula or those fed both breast milk and formula. The authors stress the importance of breastfeeding however also state that breast milk is not sufficient to prevent vitamin D deficiency. In the USA and Canada vitamin D supplements of 5 mcg/day and 10 mcg/day, respectively, are recommended for all breastfed infants (Gartner & Greer, 2004; Health Canada, 2004). No such recommendation exists in New Zealand however the National Research Council (2004) have indicated that lactating mothers and their infants

Vitamin D supplements may be required by some women, in particular women with limited sun exposure or those with dark skin. When considering supplementation it is important to remember the dosage and form of vitamin D present in the supplement. Supplementation of up to 25-50 mcg/day (1000-2000 IU/day) has been suggested to prevent vitamin D deficiency during pregnancy and lactation (Hollis & Wagner, 2004). Vitamin D, however, when consumed in high doses can be toxic resulting in hypercalcaemia, anorexia and calcification of soft tissues. Toxicity does not result from excessive sunlight exposure but may result from excessive supplementation. The Institute of Medicine Standing Committee on the Scientific Evaluation of Dietary Reference Intakes (1997) has established an upper safe limit for vitamin D intake of 50 mcg/day. Therefore, when supplementing with vitamin D it is prudent to avoid supplements greater than 50 mcg/day, unless treating rickets or osteomalacia.

Conclusion

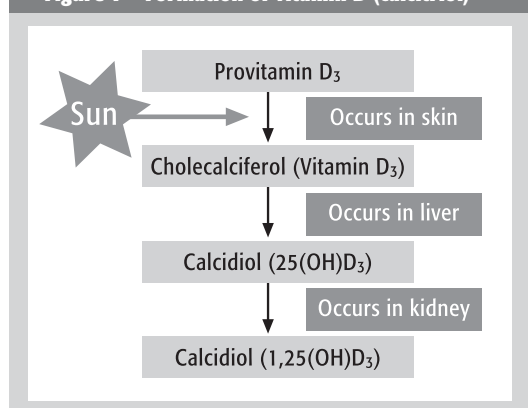
The importance of vitamin D for bone health is well described. In pregnancy and infancy vitamin D is critical for the rapid growth of the fetus and infant, respectively. At present there is debate amongst health professionals and researchers as to whether food, sun or supplements are the answer to ensure adequate vitamin D status. There is no simple answer to this debate, however with few dietary sources of vitamin D, women and infants with limited sun exposure are at increased risk of vitamin D insufficiency. The use of supplements therefore is a practical option but should be considered on an individual basis.

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Figure 1 - Formation of vitamin D (calcitriol)



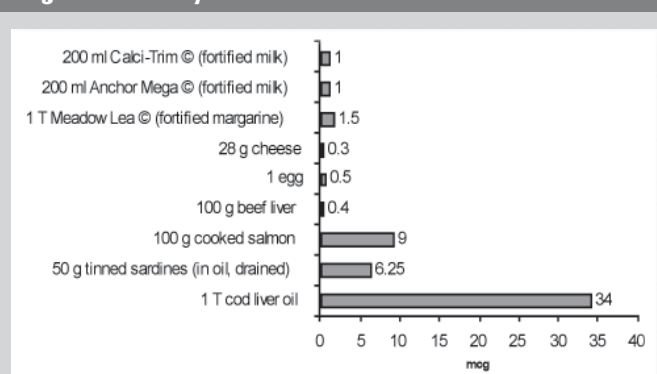
with limited sun exposure may benefit from supplementation with 10mcg of vitamin D/day.

How do we ensure adequate levels of vitamin D?

There are three ways to obtain vitamin D, by consuming foods that contain vitamin D, through sunlight exposure and by consuming vitamin D supplements. Vitamin D is present in the food supply in two forms, cholecalciferol (vitamin D3) and ergocalciferol (vitamin D2). Cholecalciferol is present in fatty fish (herring, sardines, tuna and salmon), egg yolks and liver (Figure 2). In New Zealand fortification of vitamin D is permitted in certain foods such as milk, margarine, cheese, yoghurt, dairy desserts and soy milk. Few foods, however, are fortified with vitamin D. Ergocalciferol is present only in plant foods and some supplements and is less biologically active than cholecalciferol indicating reduced absorption and utilisation by the body (Trang, Cole, Rubin, Pierratos, Siu, & Vieth, 1998). The limited number of foods containing vitamin D in the New Zealand food supply makes it difficult to consume adequate intakes of vitamin D.

Due to high rates of skin cancer New Zealanders are encouraged to follow sun-safe messages. These practises however may limit production of vitamin D and increase risk of vitamin D deficiency in some women. In addition, poor vitamin D status has been reported in dark-skinned (Nesby-O'Dell et al., 2002) and veiled pregnant women (Grover & Morley, 2001), presumably due to limited sun exposure.

Figure 2 - Dietary sources of Vitamin D¹



¹ Values collected from product information and from the National Institute of Health. <http://ods.od.nih.gov/factsheets/vitaminD.asp>

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Keeping birth normal: midwives experiences in a tertiary obstetric setting

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Abstract

This qualitative interpretive study explored the experience of eight core midwives employed within the labour ward of two tertiary obstetric hospitals in the Auckland region. The purpose of this study was to gain a deeper understanding of how midwives' work within these busy settings in relation to their challenges with respect to 'keeping birth normal'.

The key themes from this study include: being a midwife is keeping birth normal; stepping back or stepping in to achieve normal outcomes; and interacting with doctors, which included being caught within doctor's decisions. In this article, the theme of 'stepping back or stepping in' in order to achieve normal birth outcomes will be explored. This includes a sub-theme of 'using minor interventions to prevent major interventions'.

Introduction

The core midwife is a District Health Board employee and the core midwives in this study work in labour wards providing midwifery care to both high-risk and low-risk women who have the hospital obstetric team as their Lead Maternity Carer (LMC). In Auckland it is common for women to use the DHB as their LMC due to shortages of LMC midwives, their need for obstetric care or from choice. Core midwives also care for women transferred or 'handed over' from LMC midwives to the secondary/tertiary service

and provide primary midwifery care for clients of private obstetricians.

In New Zealand the Ministry of Health (2003, p.146) defined normal birth as 'the birth of a baby without obstetric operative intervention'; that is as vaginal birth. A woman might have received many other interventions throughout the process of labour, yet her birth is classified as 'normal' if it did not result in delivery by ventouse, forceps or caesarian section. The midwives in this study had varying definitions of normal birth but all of the participants felt that normal birth meant an outcome of a spontaneous vaginal birth. Participants shared stories of trying to keep birth normal and described the notion of 'stepping back or stepping in' where they would 'step in' only when their judgment pointed to an intervention being warranted. The participants gave examples in their narratives of how they consider that minor interventions can prevent major interventions.

In this article the background to the topic is presented and the research method is outlined. Verbatim data from participants is used to support the themes of 'stepping back or stepping in' and 'using minor interventions to prevent major interventions'.

Background

Keeping birth normal has been widely discussed in the literature for more than three decades, including suggestions of how this might be achieved (Balaskas, 1989; Banks, 2000; Inch, 1989; Page, 2000 & 2003; Warwick, 2001). Use of technology and obstetric interventions such as: epidural analgesia, continuous cardiotocograph (CTG) monitoring, artificial rupture of the membranes (ARM) and induction of labour are suggested as some of the reasons why midwives find it difficult to keep birth normal within the hospital setting (Donley, 1986; Katz Rothman, 1991; Papps & Olssen, 1997; Rowley, 1998; Wagner, 1994; Warwick, 2001). Australian research has demonstrated a cascade of interventions associated with induction of labour or augmentation (Tracy & Tracy 2003). Donley (1986) stated that, "Given support and patience, 85% of women can give birth normally and naturally. They don't need the routine intervention backed by high technology that is common practice in large obstetric hospitals today" (p.15). Despite this assertion, the overall caesarean section rate in New Zealand during 2002 was 22.7%, the operative vaginal birth rate 9.6% and 84% of all live births took place in secondary or tertiary facilities (Ministry of Health, 2004). Although the majority of women have midwives as LMCs, only

67% achieved a vaginal birth in 2004 (Ministry of Health, 2004). The reasons for this are likely to be complex. Indeed, Skinner (2003) acknowledged the impact of the birth environment and societal attitudes on midwifery care and suggested that one of the dilemmas a midwife might face is from women themselves.

The midwifery philosophy aims to keep birth "normal" for women (New Zealand College of Midwives, 2004) and Skinner (2003) emphasised the need for midwives to consider the notion of "normal" very carefully. She said, "the normal can be found and protected in the most complex of situations" (p.6). Earl et al. (2002) explored the role of core midwives with regard to reducing abnormal birth rates. These authors asked the question: "Can (core) midwifery practitioners also lay claim to being guardians of normal birth?" (2002, p. 32). With this question in mind, a study was designed to explore the experiences of core midwives in relation to keeping birth normal within tertiary obstetric hospitals.

Research design

Ethical approval was obtained from the Auckland University of Technology Ethics Committee. Purposive sampling and snowballing (referral from earlier participants) was used to recruit eight core midwives (with a range of experience from two-30 years) from two tertiary hospitals within the Auckland region. In keeping with phenomenological research the number of participants is small to enable the researcher to conduct in-depth interviews where the participants share their stories of practice. Participants were asked how many years they had practised midwifery and their definition of 'normal birth'. They were then invited to "Please tell me about an experience where you recall trying to keep birth normal". van Manen (1990) cautions researchers against interrupting participants to ask 'why' questions which tend to assume a critical stance and might restrict the ability of the participant to relate their stories. In order for the researcher to extract the full story from the participant, one must encourage the participant to describe the experience in detail and to describe what it was like, how they felt and their actions. It is beyond the brief of this article to describe phenomenological research in any depth; however, interested readers could pursue this methodology further.

The participant interviews were conducted over a 10-month period and each participant was interviewed for one to two hours. The tapes were

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transcribed into text and van Manen's method (1990) of data analysis was used in order to interpret the text. The researcher undertakes data analysis through the editing of participants' stories and writing out the meaning of each of these stories. Eventually, similar stories are grouped together into themes. The aim of van Manen's method of research is to show the reader the data from the participants and to provide an interpretation as to the meaning of this data. This article discusses two themes: 'stepping back or stepping in' and 'using minor interventions to prevent major interventions'.

Theme: stepping back or stepping in

'Stepping Back or Stepping In' comes from a phrase used by one of the participants in relation to the decisions she makes about whether to intervene or not. The participants in this study show that they do have an influence on normal birth outcomes, by making their own judgments about whether intervention is appropriate or not:

I think it is definitely important to support other midwives, especially junior midwives, in order to enable them to have normal outcomes with women... If everything is normal then I "step back" a bit and allow them as much time to do this birth themselves, not to jump in too quickly and start shouting out for this woman to push better. I don't need to jump in there heavy-handed, unless I feel there really is a need to "step in" and take charge, if I think there is a problem. I feel that not only the junior staff, but also other staff members of the team need this support.

Judging when to step back or step in requires confidence in practice to allow the woman as much time as needed to do the birth herself. This experienced midwife applies her judgment and will not hesitate to step in if there is a problem, but she indicates that she leaves things well alone if there is not a problem. It is important that midwives share their skill of stepping back and this enables midwives to develop confidence in normal birth, particularly during the second stage of labour.

On the other hand, another midwife describes the need to 'step-in' during second stage of labour:

I was trying to work out how much time I could give them and said, "Keep going," and then I thought after a while if I don't "step in" now we are going to run out of time. Then I said, "OK we need to change things," ... Well, the woman became so effective at pushing, and the baby wasn't that huge, and so the midwife didn't have time to put her gloves on. That was just like effectively managing second stage or picking which babies will fall out and which babies will actually need to be pushed out or directed.

A junior midwife and a student were caring for this woman who was not making progress during the second stage of labour. The senior midwife "steps in" and changes how the woman is pushing (through change of position and by giving feedback to the woman) to prevent a need for medical intervention. Doctors may be more likely to intervene with the duration of the second stage of labour as a shorter timeframe is associated with increased neonatal pH values. However, shorter second stage of labour is also associated with an increased rate of operative deliveries (Hofmeyr, 2005).

Sub theme: something minor to prevent the major interventions

The midwife participants acknowledged that there are many situations where women have both midwifery and medical interventions within a tertiary hospital during labour and birth. Trying to achieve the balance or the right timing of an intervention seems to be important for the midwife participants in their efforts to keep the birth outcome normal and to prevent the major obstetric interventions such as instrumental delivery or caesarian section:

I suppose that's a judgement call of when you can sit back and do nothing versus when you get in and do "something less minor to prevent the major interventions". I think it is balancing technology and balancing what is happening with the women. You sometimes think "Well it doesn't matter if I ARM her or not she will progress; versus I need to ARM her otherwise she is going to get stuck and will not progress". It's a real judgement and I don't think we are as patient as we used to be and that's a problem. To me it's prevention of caesarean... It's getting harder because caesarian section is becoming more the norm. It's not quite the norm yet, but to have a caesarean section is not as problematic as it used to be...

This core midwife expresses a passionate desire to prevent caesarian section. She needs to judge when and if to intervene, balancing the use of technology and intervention with patience and non-intervention. She recognises that sometimes it may be necessary to step in and do something minor to prevent the major interventions. "Minor" might mean an artificial rupture of the membranes (ARM), or giving the woman some intravenous fluids. El-Hamamy and Arulkumaran (2005) stated that amniotomy has a "potent labour-augmenting affect for women with slow labour" but should be reserved for women with abnormal progress of labour in view of an association between early amniotomy and caesarian delivery for fetal distress (p. 4).

A participant shares a story of a woman transferred in from a primary unit:

She's a primip who's been contracting for 12 hours and is distressed, she hasn't progressed and is transferred in to our care. You can instantly see that she needs pain relief and intravenous fluids. When you have done an abdominal palpation, then actually done a VE (vaginal examination) and thought, "Well, this woman could have had her membranes ruptured". That's exactly what you do after discussion with her, and give her some pain relief and some IV fluids and she delivered actually quite quickly and normally.

This woman was transferred to the tertiary hospital very distressed and was probably disappointed to need to transfer. The participant feels that reluctance of the LMC to intervene during poor progress of labour can sometimes hold a woman back from having a normal birth. The transfer to the tertiary hospital might have been avoided if these smaller interventions (ARM and possibly a small dose of Intravenous Pethidine for the woman's pain) had been employed earlier within the primary maternity unit.

The following data illustrates the midwife's use of a manual rotation that she called a 'twizzle' to try to prevent an abnormal outcome:

A young primip who had been pushing for ages wasn't getting anywhere and had basically given up and they were going to do a ventouse. I was asked to examine her and it was not quite occiput anterior so I manually rotated it and we had a nice normal delivery with the next few contractions. If nature ain't doing it, then you've got to help her by rotating the head if it's slightly off. A little bit of a twizzle and it doesn't really matter if you rotate it the right way or not. It's just getting it off the ischial spines and the parietals and it comes down nicely.

This midwife used her skill of manual rotation of the baby's head to prevent a Ventouse delivery. A manual rotation is perceived by this midwife as being less intrusive than a Ventouse, even though they are both interventions. Who teaches midwives how to do manual rotations? Is it a skill predominantly used by doctors? Is it an "old" midwifery skill that has been replaced by technology? It appears to be a skill that is no longer in vogue; one that may no longer be passed on with the advent of the Ventouse. The American Academy of Family Physicians (2000) Advanced Life Support in Obstetrics (ALSO) course indicates that manual rotation can be attempted with a vaginal examination. If the manual rotation works then birth can be expedited, and if not no harm has been done. They point out that it is a "neglected skill and can prevent an instrumental or caesarean birth" (p.5).

The following data echoes the theme of smaller interventions:

I suppose what I have found with the use of

intervention is that you look at the end result and what you want in the end. So it's the ARM at the right time. It's the pain relief at the right time. It's the bolus of fluids at the right time. Unfortunately, instead, you see people who want to keep everything normal, like the really "normal" people will go so far with the "normal" that they end up with major complications because they end up having done nothing simple when it was needed.

People will somehow accept a caesarean at the end of a labour but won't accept an ARM or putting in a drip because it's intervention earlier in the labour. So I think it is actually looking laterally and looking at what does this woman want? Does she really want a caesarean at the end of the day, or is she happy to have an ARM or is she happy to have an IV put in? I think we have to get that balance and I think some people have lost that balance and they are so focused on the "normal" that they actually can't see down the track and see it becoming abnormal.

Interventions need to be undertaken "at the right time". It appears that some midwives might leave the smaller interventions too late and then a woman may end up with a greater intervention like an epidural, instrumental delivery, or a caesarean section. It seems important to identify when labour is becoming abnormal, and when the use of small interventions might result in a normal birth outcome. The participants appear to understand that some women or midwives might not want to use any intervention, but there needs to be a balance of accepting that smaller interventions might be appropriate in some cases. Bugg, Stanley, Baker, Taggart and Johnston (2006) suggest that there needs to be significant improvements in the management of labours which fail to progress as the use of one intervention such as oxytocin has failed to reduce the rate of operative delivery. They suggest that an improved "package of care" of identifying poor progress, providing one to one care during labour and ensuring effective uterine activity are all necessary components to improve the management of problematic labours (p.40).

On the other hand, it is also important to understand that smaller, ill-timed interventions can also lead to major complications and interventions in their turn and there is research evidence of this effect (Leighton & Halpern, 2002; Tracy & Tracy, 2003; Tracy, Sullivan, Wang et al., in press). Midwifery decision-making needs to rely both on sound research evidence and experience that is individualized to meet the needs and context of each woman.

Summary and concluding thoughts

In summary, the core midwives in this study try to enable women to birth normally by employing judicious use of technology and medical interventions as demonstrated through the themes of

'Stepping Back or Stepping In', and 'Using minor interventions to prevent major interventions'. Interventions such as amniotomy, intravenous fluids or manual rotation are considered by the midwives in this study to be worthwhile in order to prevent caesarian section. To "Step In" or not is always in question and open to possibilities. The 'right time' is always contestable and each midwife has to judge normal progress and abnormal progress of labour on an individual basis with each woman.

Wise and experienced midwives have a legacy of knowledge that is most effectively passed on through working together, watching one another, and talking about their experiences. Junior midwives need the opportunity to work with experienced colleagues, both watching and being watched. Perhaps selected experienced core midwives could be available for consultation and support where needed to try and reduce the rate of operative deliveries. This support could be formalized within the Ministry of Health (2002) Maternity Services Notice pursuant to Section 88 and potentially be beneficial to women and midwives.

Opportunities need to be made for practising midwives to attend conferences and workshops, and to be involved in postgraduate education. These are valuable forums for collectively safeguarding, examining and reconfirming the belief in normal birth and the importance of reducing Ventouse and caesarean outcomes. They are also important opportunities for midwives to learn how to become critical and informed users of research evidence so that practice is based on more than philosophical belief and experience. Stories from practice experience need to be documented in order to pass on the art of midwifery. Students need the opportunity to work with midwives who have a fundamental belief in keeping birth normal and also need to learn when intervention might be appropriate such as using smaller interventions in order to prevent major interventions.

This study has shown that a strong midwifery philosophy and belief in normal birth does exist within this sample of core midwives who work within tertiary obstetric settings. However, the culture of the tertiary care environment can affect the midwife's role, and in some cases the culture of a tertiary labour ward causes the midwife to have a daily battle trying to keep birth normal or to at least reduce the number of operative deliveries.

Core midwives in this study do initiate 'minor' interventions during labour in order to prevent a Ventouse birth or a caesarean section. While for some women the timely use of 'minor' medical interventions might prevent the major intervention of abdominal surgery, untimely and inappropriate 'minor' medical interventions may also cause major complications. The reflections of the midwives

in this study demonstrate some of the complexity of midwifery decision-making and judgment, particularly within the more medicalised context of tertiary maternity hospitals.

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Midwives as mentors

Elaine Gray RM, RN.

Elaine is the Continuing Education Advisor for the NZCOM. Originally from the UK, Elaine has been living and practising in NZ since 1987. This article is an edited version of the NZCOM discussion document on mentoring.

The NZCOM welcomes your feedback. Contact for correspondence: education@nzcom.org.nz

Introduction

Currently there is no formally recognised mentorship framework for New Zealand midwives and this has been the subject of discussion in the profession and Ministry of Health (MOH) for some years. Recent research (Kensington, 2005; Stewart, 2005) has highlighted the need for a mentorship framework for New Zealand. Although midwives have been informally acting as mentors there is a range of opinions on the definition of mentorship and the roles and responsibilities of the mentor and the mentored midwife in the mentorship relationship. Anecdotal evidence of the need for a supportive mentoring framework is now supported by research identifying that midwifery is an aging workforce and that midwives remain in the profession for less time than previously thought (NZCOM, 2005a). One aspect of creating a supportive professional framework for all midwives is to formalise a model and framework for mentorship.

The New Zealand College of Midwives' (NZCOM) Strategic Plan 2004-2006 aims to strengthen the midwifery workforce and one strategy to achieve this is the development of a mentorship framework and the establishment of a culture of mentorship for New Zealand midwives (NZCOM, 2004). The importance of mentorship is also recognised by the Midwifery Council of New Zealand (MCNZ) in its identification of mentoring as a professional development activity that attracts points within its Recertification Programme and in which all midwives are required to participate in order to demonstrate their continuing competence to practise (MCNZ, 2005). This article introduces a conceptual model and framework for mentorship that reflects New Zealand midwifery's founding principle of partnership (NZCOM, 2005b). In developing this model and framework an extensive literature search has been conducted; a limited selection of which is included in this article. The full discussion document is available from the New Zealand College of Midwives.

Definitions of mentoring

The Midwifery Council of New Zealand defines mentoring in its Recertification Programme document as:

Entering a formal relationship with another midwifery colleague for a defined period of time for the purposes of support and guidance as the midwife colleague adjusts to a different practice context or to practice as a new practitioner (MCNZ, 2005, p.42).

The New Zealand College of Midwives consensus statement on mentoring ratified in 2000 defines mentoring as follows:

The mentoring relationship is one of negotiated partnership between two registered midwives. Its purpose is to enable and develop professional confidence. Its duration and structure is mutually defined and agreed by each partner.

A mentor listens, challenges, supports and guides another midwife's work. A mentor does not always give answers but encourages the mentored midwife to research, explore and reflect on her practice.

The mentored midwife remains responsible and accountable for her own practice in accordance with statutory obligations of a registered midwife (NZCOM, 2000).

As a first step in the development of a conceptual framework for mentorship a postal survey was conducted by PhD candidate Sarah Stewart with support from NZCOM to explore midwives experiences and current ideas on mentorship (Stewart, 2005). The findings of this study informed the framework development and highlighted that midwives have diverse, and sometimes opposing views, on both the definition of mentorship and the process and roles of mentors and mentoring. Certain themes have emerged which will be explored later.

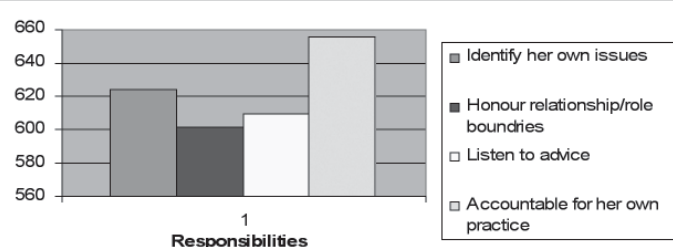
Stewart's (2005) study is limited as it was not inclusive of the total population of 2440 practising midwives in New Zealand in 2004 (New Zealand Health Information Services, 2004). Nevertheless, it reflects the views of 684 midwives (28% of the total number of practising midwives); 33 (4.8%) of these respondents identified as Maori (Stewart, 2005).

The findings of Stewart (2005) indicate there is some confusion within the New Zealand midwifery

profession in relation to the complementary but different concepts of "clinical supervision", "preceptorship" and "mentorship". Overall the vast majority of respondents supported the New Zealand College of Midwives position statement but many midwives lacked a clear definition of mentorship. Holland (2001) also identified the need for a universally accepted definition of mentorship for the New Zealand context.

New Zealand midwives are not alone in their understandings as the extensive international literature demonstrates similar diversity in definitions. According to Vance & Olson (1998) the core components of mentorship are based on intuitive, nurturing, objective and directive harmonies. Mentors have been portrayed through the centuries as wise people who are guides, advisors, protectors. Mentoring has been described as an empowering relationship which extends over time with mutual sharing and learning and creates an atmosphere of respect, collegiality and affirmation.

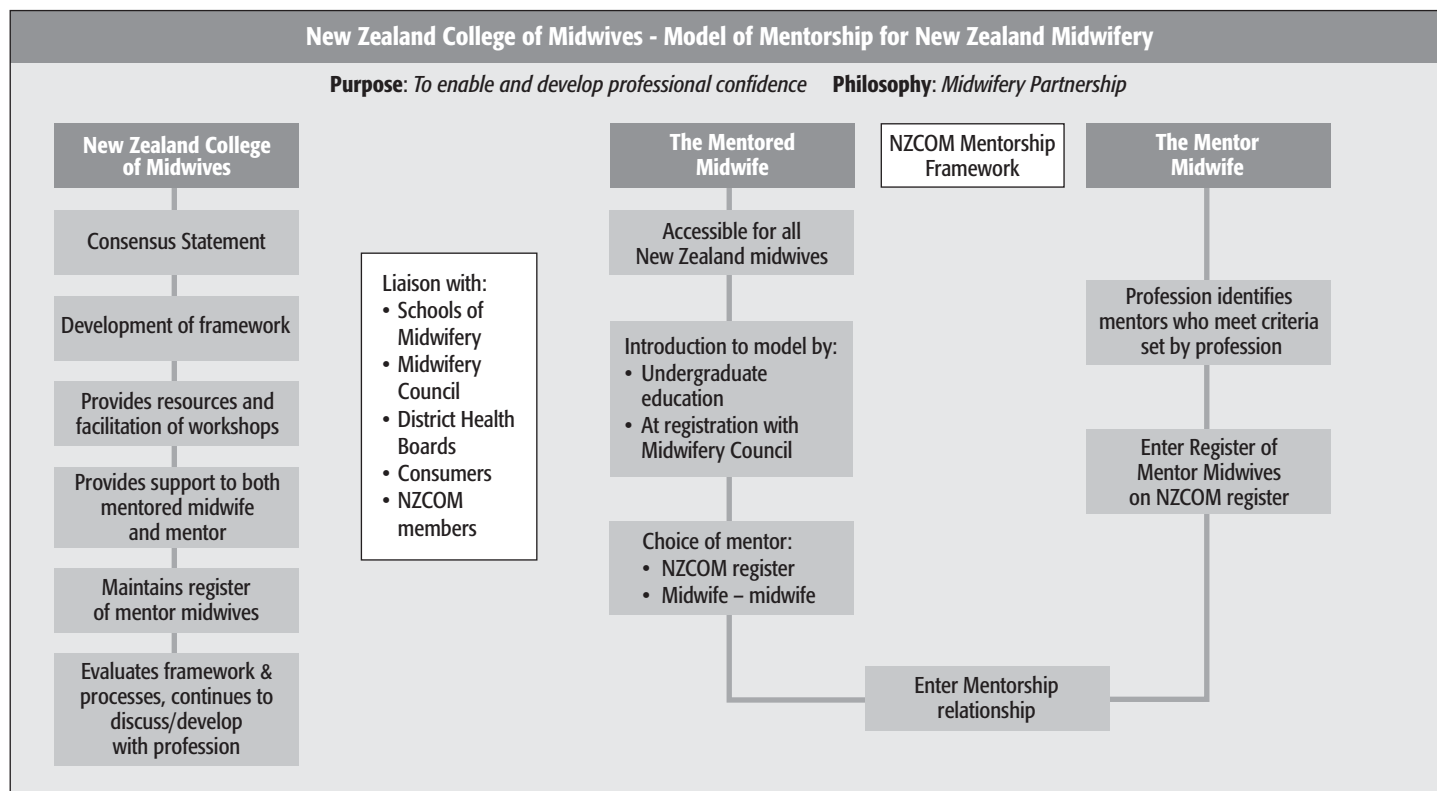
Figure 1. Responsibilities of the mentored midwife (Stewart, 2005, p.15).



Walker, Partick & Hume (2002) describe mentorship from a conceptual basis they describe as centred more on the relationship than any specific structure and in which the strategy is to share intellectual and emotional resources. Darling (1994) defined the mentor's role using fourteen specific parameters which share six common descriptive systems of mentoring: teaching/learning process; reciprocal role; career development relationship; knowledge differential between participants; duration of several years and reciprocity.

Morton-Cooper & Palmer (1993) compare mentor and preceptor relationships and suggest that mentors take a specific interest in assisting an individual practitioner by encouraging personal and professional satisfaction whereas preceptors act as an agent for their employers, to assist employees or students in adjusting to their new role. Structured objectives with clear expected outcomes are used as the basis of the preceptorship relationship, with many being formally assessed to meet the

Figure 2. Conceptual Model of Mentorship



requirements of the organisation. Burke (1994), cited in Bain (1996) describes the preceptor role as having several main functions; providing orientation and support and teaching and sharing of clinical skills. A preceptor is seen as an experienced and competent staff member who serves as a role model, nurturer and educator for the newly hired staff member (Craven & Broyles, 1996).

Supervision is another form of potential support that can be confused with both mentoring and preceptorship. According to O'Donoghue (2004) supervision means the monitoring of, and reporting on, the performance of a health practitioner by a professional peer and is usually based on a hierarchical model.

Themes from postal survey (Stewart, 2005)

Selected themes from the study conducted by Stewart (2005) are discussed in the following section. All data was used in the development of the NZCOM mentoring framework and in the development of mentorship education workshops for midwives.

Formal versus informal

Should the mentorship relationship be formal or informal? The College's consensus statement (see previous quote) implies an informal relationship, while the Midwifery Council of New Zealand appears to recognize a more formal approach in its definition as quoted previously (NZCOM, 2000; MCNZ, 2005, p.42).

According to Ragin, Cotton & Miller (2000), formal mentoring relationships are developed by a third party and the mentor and mentored do not meet prior to the formal mentoring process. While this may work in the business world it does not reflect the midwifery model or the highly personal nature of midwifery work and the involvement of women in their own care.

Stewart (2005) found a difference in opinion as to whether mentoring should be informal or formal. Some respondents felt that there should be time limits and signed contracts for the mentorship relationship, while others thought the relationship should be informal and could not be placed in 'one box'. There was an overriding theme that mentors require some guidance and a semi-formal approach such as guidelines may address some of these concerns but also permit the individual mentored midwife and mentor to create their own relationship.

Support versus Competency Assessor

A significant theme emerged through the study findings (Stewart, 2005), in relation to competency. Some midwives felt the role of the mentor was to 'teach and instruct' the mentored midwives. Although some midwives saw this as 'support', others seemed to imply that the mentor midwife was responsible for the mentored midwife's clinical practice. There is no legal or professional basis for this view and it is the role of the Midwifery Council to oversee processes for assessment of competence.

Interestingly, midwives who were mentored had clear ideas of their responsibilities in the mentorship relationship and all identified that they were accountable for their own practice (Fig. 1).

Kensington (2005) explored the realities of being a new graduate midwife in the first year of practice and found that some respondents felt they had to prove themselves to their peers in relation to clinical skills and use of equipment. Respondents in Stewart's survey (2005, p.15) also stated that they were 'on trial' and 'being tested'.

Financial Remuneration

Financial support for the mentor midwife was an important topic of debate for most of the respondents of the survey. Frequent reference was made to the time commitment and how each mentor midwife approached the mentorship relationship. Mentored midwives felt if they 'paid' their mentor midwife they felt they could contact her at any time. Midwives practising as Lead Maternity Carers (LMC) discussed the financial implications of having to reduce their caseloads to facilitate an effective mentoring relationship.

Rural Practice

Twenty two percent of respondents (n=153/684) practised in rural areas and 2% (n=15/684) practised in remote rural areas (Stewart, 2005). A unique feature of New Zealand midwifery is the role of LMC practice with the geographical

continued over...

Midwives as mentors

isolation of parts of New Zealand and this rural workforce has particular needs (MOH, 2002). While the Ministry of Health recognizes the need to support rural doctors, the support needs of rurally practising midwives is not yet fully appreciated or addressed.

midwifery partnership, recognizing that each mentorship relationship will be different according to the needs of the midwife and thus the framework needs to be flexible.

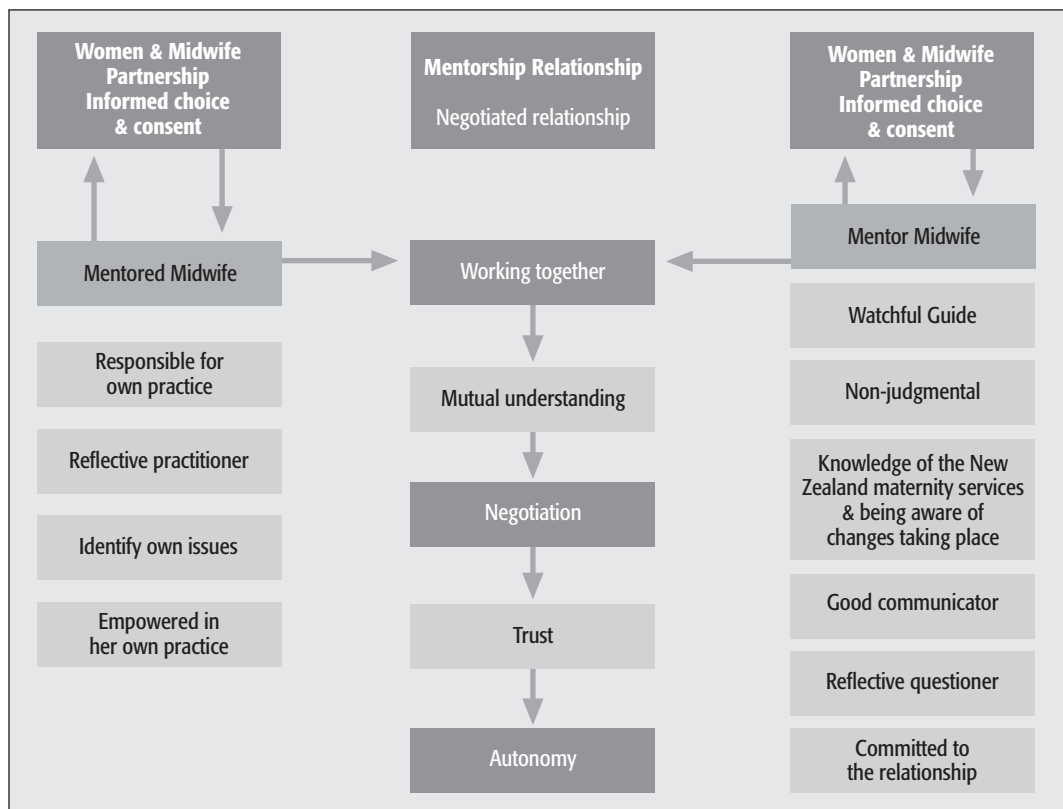
The framework (Figure 3) is based on midwives supporting their peers in a negotiated relationship

both midwives to understand the principles and philosophy of the mentorship framework.

New Zealand midwives have opted to have a semi-structured approach to mentorship and midwives will be encouraged to utilize the College's model and framework. The College, through its National

Office, will provide both midwives with support as relationships between the mentor and the mentored midwife are crucial to the overall success of any mentorship. Therefore at any point of the relationship if either midwife is dissatisfied with the relationship they will be encouraged to discuss their relationship with each other sooner rather than later.

Figure 3. Conceptual Framework for Mentorship



The expected benefits of the mentorship model and framework

Mentoring will be available for all midwives (self-employed and employed) in New Zealand but emphasis will be given to ensuring mentoring for the following groups:

- Newly graduated midwives
- Midwives returning to practice
- Midwives who change practice areas
- Midwives who identify the need for mentoring as part of through their own professional development
- Midwives registering in New Zealand from overseas

Development of a framework for mentoring

Stewart's study (2005) provided an opportunity to explore current understandings of the mentorship concept amongst New Zealand midwives. The findings of this study, along with findings of current literature on mentorship have been used in the development of the mentorship framework for the New Zealand midwifery profession. Workshops were also held with the College's National Committee members and midwives nationally have been consulted on their views. The resulting conceptual model and framework is presented below. Implementation of this model will necessarily involve schools of midwifery and the Midwifery Council. The College will provide workshops to prepare mentors and mentored midwives for their respective roles and a set of guidelines will be developed.

The Conceptual Model and Proposed Framework for Mentorship

Purpose:

The central purpose of the mentorship model is to enable and develop professional confidence. The model is underpinned by the philosophy of

and is therefore seen as an equal relationship with no hierarchical principles. One midwife may have more experience than her peer but each is recognised as having her own identity. The sharing of knowledge will be transparent between the two midwives.

The mentorship framework will be supported by the following documents:

- Competencies for Entry to the Register of Midwives (Midwifery Council of New Zealand, 2004)
- Standards of Midwifery Practice (New Zealand College of Midwives, 2005b)
- Code of Ethics (New Zealand College of Midwives, 2005b)

The negotiated relationship

Midwives willing to act as mentors will volunteer for the role and the mentored midwife will choose her mentor so that both enter the relationship willingly. This is crucial to the relationship and creates an environment of trust for the mentored midwife as each relationship will be different and unique in nature. The negotiated relationship requires

Figures 3 and 4 identify the roles of both the mentored midwife and the mentor midwife and their responsibilities in the mentorship relationship. Midwives who wish to act as mentor midwives will be encouraged to do so as part of their own professional development. These diagrams also identify that a mentorship relationship develops over time and requires commitment from both parties to develop a strong mentoring relationship.

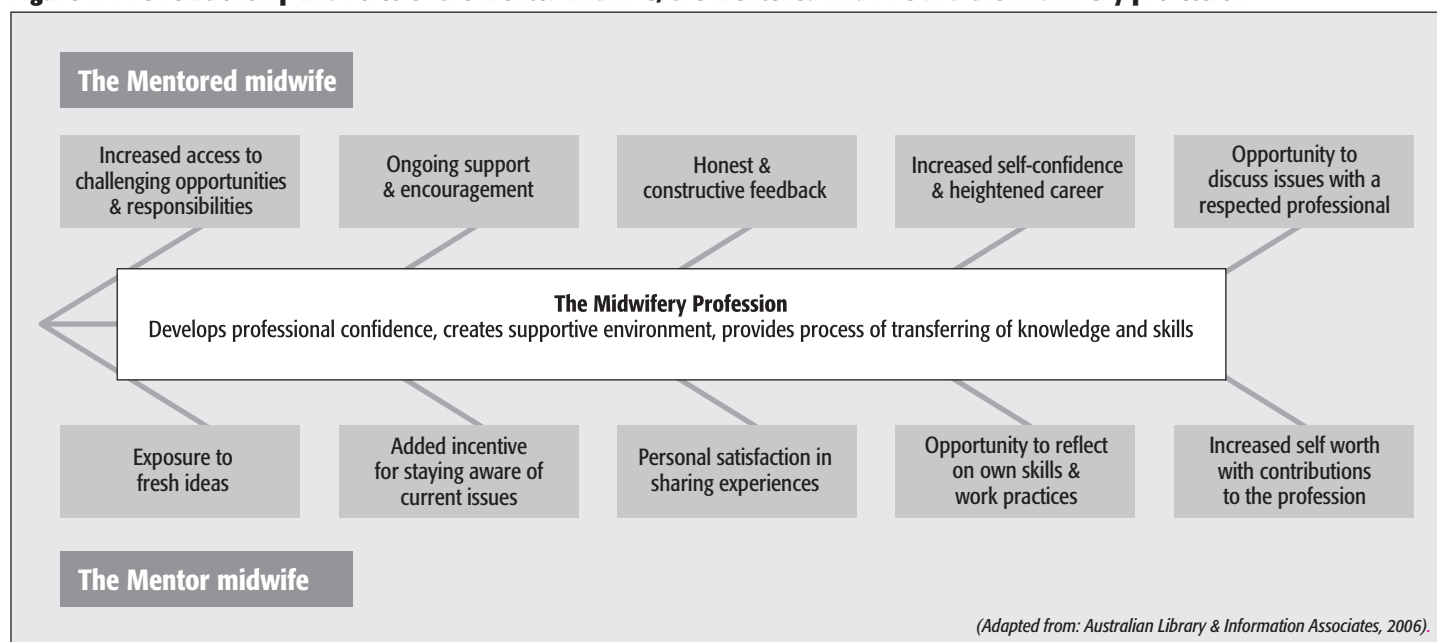
It is envisaged that midwives will be identified as a mentor midwife in a number of ways:

- Nominating themselves to be a mentor midwife, this may occur at Midwifery Standards Review (MSR) as a professional development opportunity;
- By approaching the College directly; or
- Be identified by peers as an ideal mentor midwife.

Mentor midwives will need to meet certain criteria prior to being placed on the College's mentoring register. These criteria need further development but at present they require the mentor midwife to:

- Be a member of the New Zealand College of Midwives

Figure 4. The relationship and roles of the mentor midwife, the mentored midwife and the midwifery profession



- Have attend a NZCOM mentorship education workshop
- Have completed at least two MSR for LMC midwives and/or one MSR for employed midwives

In line with the competencies for practice midwives should have sound knowledge of the New Zealand maternity services, be culturally safe, be confident in their own practice and be engaged in the recertification programme set out by Midwifery Council (2005).

It is expected that midwives wishing to develop a mentorship arrangement will approach their chosen mentor midwife. New graduate midwives will most likely have approached a mentor midwife by the end of their pre-registration education as students will be introduced to the mentorship model and framework during their midwifery programme. Newly registered midwives from New Zealand and overseas will be introduced to the mentorship model and framework by the Midwifery Council upon registration. Midwives who wish to be mentored during their career will be encouraged to approach a midwife directly or utilise the College's register to search for a mentor midwife.

The College, as leader of the profession, has a commitment to ensuring that the mentoring structure in New Zealand achieves its aim of *enabling and developing professional confidence*. Therefore, the New Zealand College of Midwives will evaluate the framework and processes via an anonymous audit after the first year of implementation. The framework will be reviewed and modified in conjunction with the audit findings and after consultation with the profession.

Conclusion

The development and implementation of this mentoring model and framework will evolve, but acceptance by the profession of mentoring as a normal expectation of practitioners is crucial to its success. New Zealand midwifery is poised to embrace mentoring as a fundamental part of midwifery practice and out of this process a uniquely New Zealand model of mentoring will grow. The College looks forward to feedback on the conceptual model and framework.

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Gray, E. (2006). *Midwives as mentors*. *New Zealand College of Midwives Journal*, 34, 24-27.

Women's sexual health

(3rd edition)

G. Andrew (2005)

London: Balliere Tindall ISBN 0-7070-2762-6

Reviewer: Mary-Clare Reilly.

Case Loading Midwife employed by a Primary Health Organisation.

Interests: Women's Health in developing countries, Gestational Diabetes Mellitus

This text recognises the complex content of its topic. As an example, I enjoyed the review of ethical theories and the subsequent scenarios. While set in the United Kingdom, these involve students, patient rights, national health frameworks and litigation; all of which could apply to our practice context here in New Zealand. These scenarios would lift very easily into a teaching programme or discussion groups.

Two other aspects of the book struck me as very useful. The first was the clearly outlined ideas for personal and professional development. With the advent of competency-based practicing certificates and the need to have recognised strategies to achieve this, these lists are excellent prompts. The

second aspect, highlight points for teaching, allows a type of resource check list for providers be they individuals or organisations. The text remembers other resources such as websites, National Health Development agencies, self help groups and alternative therapies. Midwives who have a working knowledge of their resources at both local and national level are well placed to facilitate and validate information available to consumers.

I enjoyed the text and would recommend it to other practitioners in this field. It makes an excellent addition to any practitioner's resources whether they are providing care, information or undertaking their own studies.

Birthing autonomy: women's experiences of planning home births

N.P. Edwards (2005)

London : Routledge ISBN 0-415-35409-9

Reviewer: Rosemary Mander MSc PhD RGN SCM MTD

Professor of Midwifery, School of Health and Social Science, University of Edinburgh

It may be that attention to detail is an admirable trait in some circumstances. At other times, though, the big picture is what we need in order to really get things into a proper perspective. This book by Nadine Edwards manages to achieve both of these seemingly disparate aims. What is more, she achieves them in a surprisingly reader-friendly way. Drawing on her ground-breaking research into women's experiences of planning home birth, she presents us with the meaning of home birth to the woman and to women. To do this she situates planning to give birth at home as the marginalised activity it is in Scotland where the research was undertaken. The fact that the data were collected in Scotland certainly does not make the book any less relevant to other settings. It may actually serve to point up the more significant issues.

The marginalisation of home birth is examined from the viewpoint of the women involved as members of society – hence the big picture. She also relates her work to the research evidence on the safety of the woman giving birth in her own home, thus providing the attention to detail. In this way the significance of home birth emerges in terms of its personal, social and political meanings. Thus, she advances the debate way beyond the usual safety issues which are invariably rehearsed when home birth is discussed in the UK. To do this

she leads her reader into uncovering the discrepant knowledges on which the various adversaries base their cases (Coslett, 1994).

While the discussion is scholarly and well-informed, it is presented in an entirely accessible style. The referencing, though, is unfortunately somewhat less than reader-friendly; it comprises a three stage system to, presumably, make the text easier for the reader who is unaccustomed to well-referenced material.

When referring to the research basis of this book as ground-breaking, I am certainly not overstating the case. It was a remarkable feat. This was partly through the inspired use of a post-modernist feminist perspective. For the data collection, Edwards was able to locate thirty women who were planning to give birth at home. She interviewed each woman on four occasions as the woman's pregnancy developed and as her baby grew. Simply locating this group of women in Scotland was a great achievement, but to be able to establish a trusting relationship through this challenging time for the woman speaks volumes. This trust was developed when the women were being harried, hassled and harassed by any number of others.

This authoritative research project, though, was successful in providing a voice for women who, for any number of reasons, might not speak up. It was undertaken in a country where women may not be encouraged to say their piece. Or if they do speak up they might not be listened to. The role of research in giving a voice to such people should not be under-estimated. It may be a salutary experience for some midwives to be able to hear what these women are saying.

The corollary of Edwards' book is that it is now necessary to hear the voice of the midwife. This voice needs to be heard unencumbered by certain colleagues' dogmas. In view of the research evidence, how does the midwife respond? The response may be about the quintessentially distinctive function of the midwife being to attend the woman giving birth at home. It may be argued that the midwife needs to recognise that, using business jargon, home birth is the midwife's USP – her unique selling point. I might even go as far as to suggest that home birth might constitute the midwife's shibboleth, that is, a test of her genuine midwifery credentials.

In search of the midwife's voice I recently undertook a research project in two countries, which are in many ways comparable with Scotland (Mander, 2005). This project shows, through the New Zealand experience, the inestimably great impact of the woman consumer on the maternity system in general. And also on the attitudes to home birth in particular. On the other hand, my data from Finland clearly show the extent to which midwives there would benefit from the support of women consumers.

In this way the adage which I learned from my New Zealand informants is shown yet again to hold true:

'Women need midwives need women'.

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Pregnancy – a guide to healthy pregnancy in New Zealand

A. Noseworthy and J. Rousseau (2006)

Auckland: Random House ISBN 1-86941-750-X

Reviewer: Julie Richards

Self employed midwife and midwifery educator, Christchurch.

I want to acknowledge Ann Noseworthy and Jacques Rousseau for writing this book, as it recognises the uniqueness of the New Zealand maternity system and the need for women to understand what is being offered in order to make choices regarding their maternity care.

This book outlines what to expect from a Lead Maternity Carer (LMC), LMC options and what

each professional group can offer. Following this is a general presentation of what to anticipate during pregnancy, labour, birth and the postnatal period, which comprises most of the book's content. As this book is an A5 size of 140 pages, the range and depth of information is constrained and may not satisfy some women's needs.

The format is clear with effective techniques to highlight important information such as bullet points, shaded boxes and exclamation marks. Useful resources are identified throughout the book with a further resource section at the back, including a glossary of terms used.



Although this book provides considerable information the value of this information is limited by the lack of referenced evidence. This is highlighted in the section on immunisation where the authors' personal opinion is clearly stated. Considering the dynamic nature of informed consent and the complexities of the decisions parents are required to make, it is no longer appropriate to state information without the support of evidenced based research.

Due to this text's simplicity its value may lie in being read in conjunction with a detailed, evidence based book.

Postnatal moods: emotional changes following birth

G. White (2005)

Auckland: Random House ISBN 1-86941-751-8

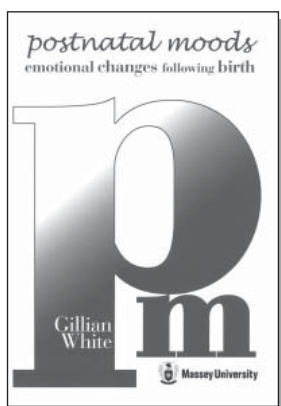
Reviewer: Barbara Churcher

Midwife, Trainee Psychotherapist (Gestalt)

In her book, Gillian White attends to the emotions around the work of parenting. Beginning with conception, White covers the ground very thoroughly, moving well into the postnatal period. She examines the roles of all who may become involved, describing the impact of events and attitudes. It is an ambitious project.

The book is a chronological journey from conception to the first months of adjustment for new parents. Each chapter may, however, stand alone as an exploration of a particular area of interest. The book is well laid out, and is very well indexed.

I was particularly taken by the attention paid to fathers. They are not just alluded to in this book: Their experience is explored, explained, and celebrated. White reflects on the mixed messages men receive as they prepare for their new role, on the adjustments they must make as new dads, and of the impact on them when things go wrong, such as the onset of postnatal depression in the new mother.



I was impressed also by the inclusion of a chapter on happiness. The discussion in this section asks the reader to reflect on what meaning is attached to happiness and how we go about attaining it. Here also White gives quite an in-depth explanation of the brain and neurotransmitter functions, and this provides a basis for further exploration of physiological function later in the book.

The book travels a generally smooth course but every now and then I was brought up short by something which didn't make sense in the context in which it was found, or appeared unhelpful and distracting. This seemed odd in a book which is generally deeply explorative and explanatory of difficult physiology, and which is written by a woman who is herself a researcher. To me it seemed that such moments grew largely out of White's determined and admirable support of parents under all circumstances. An example appeared in a section entitled "What psychological changes take place?", when White suddenly announces that current dietary research regarding early pregnancy "is often unreliable and inconsistent"

and goes on to blame the media for "unfair" pressure on pregnant women. I believe that women need to know there is some very clear literature and experience that tell us what is inadvisable for them to ingest at this time.

I was also perplexed by White's claim: "There is a popular belief that breast-feeding is best for the baby – rather it's breastmilk that's best for the baby; breast-feeding is the means by which the milk is stimulated and delivered." As a midwife with a strong interest in breastfeeding and psychotherapy, I believe that breastfeeding IS as important as the breastmilk, and that one of the problems with formula feeding is that it is often given over to several people and sometimes even (aargh!) to the baby itself; thus this wonderful time of close contact, involving all of the baby's senses, and therefore so important for the building of psychic structures which will serve throughout life, is minimised.

The work on Postnatal Depression, Post Traumatic Stress Disorder, and Psychosis, is largely excellent. However the recommended therapies in the chapter on Postnatal Depression suggest it is not necessary to delve into the past and of course, it often isn't. But Tina, who so generously shared her own story, did need to put some pieces of the past together, and some women will need to do deep work. I was disappointed to find psychotherapists absent from White's list of "professional friends".

This book is a brave attempt to cover a large area. Much of it is helpful and it will prove an enjoyable read for many.

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Contact us for dates and enrolment forms or for more information about any of our programmes or courses.

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Contacts:

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sally@tekotago.ac.nz
021735547

Deborah Davis

Principal lecturer
ddavis@tekotago.ac.nz
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- stimulate discussion on donor milk banking in New Zealand
- update perspectives on relactation and adoptive breastfeeding
- explore brain development, attunement, learning to love, and infant sleep patterns
- encourage initiatives to enhance Baby Friendly Maternity and Neonatal Units
- facilitate networking between lactation professionals, breastfeeding counsellors, and other supporters of breastfeeding.

Speakers include Nancy Wight and Paula Meier (USA); Sue Cox, Ros Escott and Karleen Gribble (Australia); Lauren Porter (USA/NZ); Cheryl Benn and Carol Bartle (NZ).

For further information: www.lacton.org.nz or contact jodi@mianz.co.nz



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The International Day of the Midwife - 5 May 2006

The world needs midwives, now more than ever.

"The world recognises that without you, there can be no safe motherhood"

(Khama Rogo, World Bank, former co-chair, Partnership for Safe Motherhood and Newborn Health. Address to 2000 midwives at the ICM 28th Triennial Congress, Brisbane, Australia, July 2005)

May 5 is the day to celebrate midwifery worldwide to remind ourselves and everybody else of the universal importance of midwives work and what midwives stand for

NZCOM is collating a record of events throughout New Zealand for media release and reporting in the June Issue of Midwifery News. Please email information about your event to projects@nzcom.org.nz or phone Lesley MacLennan at NZCOM National Office 03 377 2732



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BFHI Workshops 2006

The New Zealand Breastfeeding Authority are running three BFHI Workshops in May 2006.

Hamilton	May 2nd & 3rd
Christchurch	May 16th & 17th
Auckland	May 18th & 19th

If you wish to enroll in a workshop please contact the NZBA on info@nzba.co.nz or 03 3572072



The NZCOM journal is published in April and October each year. It focuses on midwifery issues and has a readership of midwives and other people involved in pregnancy and childbearing, both in New Zealand and overseas. The journal welcomes original articles which have not previously been published in any form. In general, articles should be between 500-4000 words.

Format

Please ensure that the following requirements are followed.

- Four copies of article supplied – typed on A4 paper with doublespacing **OR**
- Article supplied as WORD document or RTF file
- Word count included
- Abstract of 100 words maximum included
- 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.

Ethics

Any article which reports a piece of research needs to note the processes undertaken for ethical approval.

References

Authors are responsible for providing accurate and complete references. The journal uses the American Psychological Association (APA) format. Some details of this format are available on the APA website at www.apastyle.org. The 5th edition of the APA *Publication Manual* was published in 2001. In the

JOURNAL guidelines for contributors

text, authors' names are followed by the date of publication such as “Bain (1999) noted” or “this was an issue in Irish midwifery practice (Mary, 2000)”. Where there are three or more authors, all the names should appear in the first citation such as “(Stoddart, Mews, Neill & Finn, 2001)” and then the abbreviation “(Stoddart et al., 2000)” can be used. Where there are more than 6 authors then “et al.” can be used throughout.

The reference list at the end of the article should contain a complete alphabetical list of all citations in the article. It is the responsibility of the author to ensure that the reference list is complete. A comprehensive range of examples are provided on the APA website. Two examples are included here.

Journal article

Pairman, S. (1999). Partnership revisited: Towards a midwifery theory. *New Zealand College of Midwives Journal*, 21 (4), 6-12.

Book

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

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Review process

External review is undertaken by two reviewers who have expertise relevant to the article content. In addition, two members of the Editorial Board act as reviewers and collate feedback from the two external reviewers. The process of review is outlined in the October 2001 issue.

Other items for publication

Items other than articles are welcomed for publication. These include:

- Exemplars/ stories of practice for the practice wisdom column
- Book reviews
- Abstracts of Masters or doctoral theses
- Letters to the editor

The expectation regarding publication of any of these items is that they preserve confidentiality where necessary (e.g. in exemplars) and seek any necessary copyright permission of quoted materials (see earlier section on copyright). Items other than articles are not generally sent out for a review. Instead the Editorial Board reserve the right to make a final decision regarding inclusion in a journal issue. Such decisions take into account the length of the journal and the nature of other articles.

Acceptance

On acceptance of an article or other item for publication authors will be requested to submit the material with any necessary amendments by a specified date as either a Word document or a RTF file for a PC. Articles which are accepted and published become the copyright of the journal. In the future this may include placing articles as part of an on-line publication of the journal. As part of the electronic process of printing the journal, the Editorial board reserves the right to modify any article which is accepted with regard to formatting and layout.

Contacts for the Editorial Board:

- Alison Stewart, Convenor of the Editorial Board, alisons@tekotago.ac.nz
- Deb Davis, Receiving Member of the Editorial Board c/o School of Midwifery, Otago Polytechnic, Private Bag 1910, Dunedin.

Reference

American Psychological Association. (2001). *Publication manual of the American Psychological Association* (5th ed.). Washington, DC: American Psychological Association.

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⁷A.E. Czeizel, et al. Preterm birth reduction after Clotrimazole treatment during pregnancy, EU J Obstyn and Reproductive Biology 116 (2004) 157-163, 2004.

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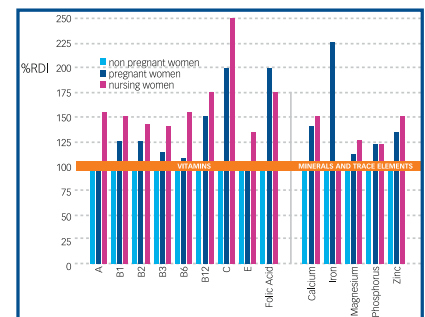
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1. Aztec Pharmacy data MAT 1/06, 2. IMS data MAT 12/04, 3. Czeizel et al, Prevention of the first occurrence of neural-tube defects by periconceptional vitamin supplementation, New England Journal of Medicine (NEJM), 1992



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