

JOURNAL

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Surfing the Net Sarah Stewart

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The BFHI Documents for Aotearoa New Zealand

The New Zealand Baby-Friendly Hospital Initiative documents have been updated to be in-line with the global World Health Organization's International BFHI documents.

The draft documents were sent out for consultation at the end of 2007, and over thirty responses were received. A working party then collated the feedback and the completed documents were launched in Wellington in March this year by Randa Saddeh, a scientist and senior adviser from the Department of Nutrition for Health and Development, at the World Health Organisation in Geneva.

Education requirements for midwifery staff has increased. In line with the global criteria midwives initially need to complete 18 hours of education, which includes breastfeeding for Maori women, plus 3 hours of clinical tuition. Ongoing education now requires one hour of clinical instruction annually and three hours of breastfeeding education.

Medical and ancillary staff are now required to answer several questions about breastfeeding, relative to their role and education received.

The interpretation of step four will extend the current practice of skin-to-skin contact at birth. "Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed." The criteria do not differentiate between mothers who birth vaginally or by caesarean section. Where a general anaesthetic is used the skin-toskin contact will commence when the mother is able to respond. The standard is based on research which shows the importance of this early and continued contact for bonding and a successful breastfeeding outcome.

Baby Friendly Aotearoa New Zealand

Rooming-in (Step Seven) twenty four hours a day, while in hospital, has been tightened. Where an 80% adherence to all other aspects of the Baby Friendly Hospital Initiative is required this step, and Step One (the Breastfeeding Policy), now require a hundred percent compliance. Clinical issues and maternal insistence are exempted under certain circumstances.

The International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions has been strengthened throughout the document and all staff are now required to answer questions regarding the Code.

How a maternity facility applies the principles of the Treaty of Waitangi within its environment, documentation and collaborative relationships have been included in the text.

Recognition is now given to the importance of the supportive feeding practices for the non-breastfeeding baby and mother. Because these babies are more at risk of illness it is important that the mother is given accurate information to ensure her baby receives safely prepared nutrition. Advice given to these mothers regarding sterilization of equipment, preparation and handling of infant formula is now included in the facility assessment.

These new documents will be implemented into facilities over the next few months and assessment, applying the new criteria, will begin towards the end of the year.

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Philosophy of the Journal

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

Provoke discussion of midwifery issues.

Support the development and dissemination of New Zealand and international midwifery research.

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All submissions should be submitted electronically via email to joan.skinner@vuw.ac.nz For queries regarding submission please contact:

> Lesley Dixon PO Box 21 106 Christchurch 8143 Fax 03 377 5662 Telephone 03 377 3732 practice@nzcom.org.nz

Subscriptions and enquiries Subscriptions, NZCOM, PO Box 21-106, Edgeware,

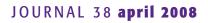
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EDITORIAL

Growing midwifery research in New Zealand

Research is a systematic examination of how

and why we undertake our work, in order to

improve the quality of care provided to the

childbearing women and her family.

It was with some trepidation, but also with some excitement that I have taken over the reins as editor of this Journal. Some trepidation, as it is a big job, and I take over from wonderful midwives who have done so well. As I go back over previous issues of the Journal I am impressed by what has been achieved. So thank you to all those who have developed a journal that we can all be proud of. Your hard work has made my job much easier.

It is an exciting prospect for a number of reasons. Midwifery research in New Zealand is at an exciting stage of development and I believe we are in an excellent position to grow a vibrant and unique model of research, just as we have done for practice,

for policy and for education. I attended the Joan Donley Research Forum last year and was immensely impressed by the presentations. We had established researchers presenting their work, alongside PhD and Masters candidates and midwives from practice. It was also very exciting to see a national collaboration of researchers proposing to undertake some research utilising the

MMPO database and seeking Health Research Council funding. Each time we have a conference or forum, we see an exponential increase in the quality and quantity of New Zealand midwifery research.

I think that it is important to state that research is not only undertaken in universities and it is not just about gaining formal qualifications. The bigger picture of research should involve everyone in the profession. Research is a systematic examination of how and why we undertake our work, in order to improve the quality of care provided to the childbearing women and her family.

So it involves us all. We all need to question what we do, to seek answers to those questions and to translate that new knowledge into practice. This journal is a forum for communicating this and is thus is a powerful tool in growing and developing practice. To this end we have made a small change to the philosophy of the Journal which now includes the aim: 'to support the development and dissemination of New Zealand and international midwifery research'.

This edition of the Journal is a wonderful example of what research can mean and achieve. We can undertake research into the theoretical underpinnings of what we are undertaking and Hope Tupara's exploration of some of the theoretical approaches to decision making and its applicability to midwifery is an example of this. Hope's PhD research is investigating decision making in whanua and she has applied her understanding of the theoretical approaches to decision making in practice.

We welcome Mel Lauti and Dawn Miller to this issue and hope to see more cross-disciplinary research published here. Their research project investigates midwives' and obstetricians' perceptions of their role in relation to family violence. Lorna Davies has produced some of her poetry for us

some of her poetry for us to publish, in the context of other ways of knowing and communicating. It's great to see creativity being explored as a way of growing understanding. Research, in its wider meaning can take many forms and I would welcome contributions that seek creative and intuitive processes. Robin Cronin and Robyn Maude have provided a wonderful example of the translation

of research into practice, which is of course the core of what we are about. They have provided a case study of a woman with obstetric cholestatis and have examined the research in relation to this condition.

We are also very pleased to have another contribution from Sarah Stewart in her 'Surfing the Net' column. This time Sarah is sharing with us some information about how to surf the net more effectively. The tools she has described will help us to do our own research. So in one edition we have examples of key aspects of research: theory, research process, a more traditional research project, a creative project, and translation into practice.

We look forward to more submissions from you and are excited about the possibilities. It is great to have Lesley Dixon to work with. Lesley is providing the secretariat support and we are both keen to see the Journal continue to develop. Please feel free to be in contact with either of us and to use the Journal to share perspectives, to open debate and to grow research.

Joan Skinner

THEORY AND PRACTICE

Facilitating functional decision making in midwifery: lessons from decision theory

Author:

Hope Tupara Ngai Tamanuhiri, Ngai Te Ragnihouhiri, Ngai Tahu PhD Candidate Public Health (Maori) Massey University Casual Employed and Self Employed Midwife Palmerston North

Abstract

Midwives have a professional and ethical responsibility to facilitate and support a woman's decision making without coercion. Communicating information to women is a necessity for a midwife and it can be a challenge when each woman is different and will make decisions from her own perspective. Midwives are in a position to influence women in decision making and this paper considers the decision process from a theoretical perspective, focusing on descriptive decision theory, concerning cognition and information processing, as one approach that midwives might find useful to consider in everyday practice. Four strategies are discussed as a response to knowledge of descriptive theory to do with utilising positive affect, involving whānau/family, modes of thinking and narrative.

Introduction

Supporting decision making is a core issue for midwifery practice. Midwives in New Zealand have an ethical and legal obligation to inform women of their choices and are in a position to influence the decisions that women make, by the way in which they convey this information. This paper takes a theoretical look at decision making, focusing on descriptive theory as one approach that midwives may find helpful. This approach posits four essential strategies that can be used to facilitate sound decision making in the context of cognition and information processing. These are: the utilisation of positive affect, the involvement of whānau/family, an understanding of modes of thinking and the use of narrative or storytelling.

Contextualising Midwives' Obligations to Women in Decision Making

Midwives engagement with women involves a complex interplay of factors. The transfer of clinical information and research evidence is only one of many areas that need to be considered when caring for women during the childbirth process. The ability to support informed decision making required at this time is reliant on the midwife having formed a trusting relationship with each woman. Within this context there are also key regulatory and professional frameworks related to information and decision making, which must be adhered to. These are the Code of Health and Disability Services Consumers' Rights (1996), the Health Practitioners' Competence Assurance Act (2003) and the New Zealand College of Midwives Code of Ethics and Standards of Practice (2005).

Midwives have a professional duty to 'uphold each woman's right to free, informed choice and consent throughout her childbirth experience' (New Zealand College of Midwives (NZCOM), 2005, p 10). This requires that a midwife 'facilitates the decision making process without coercion', 'respects the decisions made by the woman', and clearly states when 'professional judgement is in conflict with the decision or plans of the woman' (NZCOM, 2005, p 14).

The Code of Health and Disability Services Consumers' Rights Regulation 1996 (Health and Disability Commissioner Act, 1994) ensures the right of every woman to effective communication (Right 5), the right to be fully informed (Right 6) and the right to make an informed choice and to give informed consent (Right 7). These rights are fundamental to informed consent (Pearse, 1998), and the onus is on the midwife to create a 'functional partnership' relevant to a woman's decision making (Midwifery Council of New Zealand, 2004, p. 2).

Individualising the Decision Experience

What we do know as midwives is that although these statutory and regulatory requirements apply to all women, each woman is actually very different and inevitably the decisions that she makes will come from her own unique perspective. This need for an individualised approach to midwifery is a cornerstone of culturally safe care, which requires a midwife to respond to each woman on the basis of the woman's own cultural norms and values (New Zealand College of Midwives, 2005). Cultural safety is relevant to the decision experience of women as participation in decision making is a key contributor to a woman's positive birth experience (Lavender and Walkinshaw, 1999). Legislative and ethical frameworks in New Zealand require that all women receiving midwifery care will receive consistent information necessary to make informed decisions. Midwives need to balance this requirement with the need for an individual approach to each woman, remembering that information given should be accurate, and timely (Hibbard & Peters, 2003). Midwives also need to have insight into their

own practice norms and attitudes, or midwifery culture, in order to recognise how they themselves might influence the decision process for women.

The Decision Process

Decision making is the cognitive process leading to the selection of a course of action among variations, and it is only after reaching a choice can women give their consent. Consent is closely associated with autonomy (Draper, 2004). In the context of midwifery assessments like urinalysis, blood pressure monitoring, abdominal palpation and vaginal examination, gaining consent before touching a woman's body, is a manifestation of respect for her autonomy, and giving consent to midwifery intervention is a woman's expression of autonomy (Draper, 2004).

Comparing Options

When women are faced with choices that require them to compare two or more options on information provided (called comparative information), each choice is likely to make similar demands on the decision maker, because the information about each choice is likely to include technical terms and complex ideas, compare options, and require the decision-maker to differentially weight various factors according to individual values, preferences and needs (Hibbard and Peters, 2003). A typical example is choosing appropriate management for 3rd stage of labour, in which case a woman is faced with making a choice between options of active management or taking a physiological approach. Each option is likely to be important, but the information may be unfamiliar. Therefore, a woman has to interpret the information, identify the important factors to integrate into a decision, weight those factors in ways that match her individual needs and values, make trade-offs, and bring all the factors together into a choice. Although these may sound easy enough, they tend to be demanding cognitive tasks (Hibbard and Peters, 2003). The way information is framed and packaged will determine to a large degree what information is actually used in the final choice.

Preference Construction

To understand the complexity of decision making, preference construction is used to cope cognitively with information. This theory posits that when people are faced with a situation that is complex and unknown, they are likely to not have fixed ideas, but will 'think up' or construct an answer for a moment in time (Hibbard & Peters, 2003). The following is a hypothetical scenario about Carli which demonstrates this. Carli is pregnant with her first baby and at 12 weeks gestation she meets a midwife, Bea, for the first time. Carli has an expectation that Bea will do home visits because she has read an information booklet from Bea's practice, which lists home visits as an option. Bea and her colleagues have framed their practice information as if home visiting is an option for women. In reality, they prefer to, and do, conduct antenatal checks at their clinic. On hearing this, Carli responds to Bea's framing of her practice by constructing an answer that conforms to their practice approach. Carli agrees to go to clinic visits, despite the fact this is not consistent with her desire or expectation.

Information and communication form the basis of gaining consent and it is important that information reflects actual practice, and that the potential for mixed messages or miscommunication is reduced. This begins at the first point of contact between a midwife and a woman, when the midwife must negotiate her role and clarify expectations and/or needs.

Time constraints and pressures on midwives, may result in midwives having a lack of discussion with women about their choices in maternity care. One reason might be acute or emergency situations when the midwife prioritises attention to clinical responsibilities. But time constraints may also affect midwives who have a caseload that is so significant, they have little or no time dedicated to informing women about basic midwifery assessments.

Hibbard and Peters (2003) suggest that the simple provision of information alone does not improve decision making. To make informed decisions and navigate the complex maternity system, including research evidence, women, they say, need to have access to accurate and timely information. Though women may have all information deemed relevant by the midwife, it does not necessarily follow that they use the information or that they will consent. (Paterson, 2003).

A good example of this is found in the work of O'Cathain, Walters, Nicholl, Thomas, and Kirkham, (2002). They conducted a randomised controlled trial in 13 maternity units in Wales, to assess the effect of informed choice leaflets on the exercise of informed choice regarding the use of maternity services. They found that there was no change in the proportion of women who reported that they exercised informed choice. Stapleton, Kirkham & Thomas, (2002) concluded, from the same study, that the potential for leaflets as evidence based decision aids was reduced, because the way in which leaflets were distributed

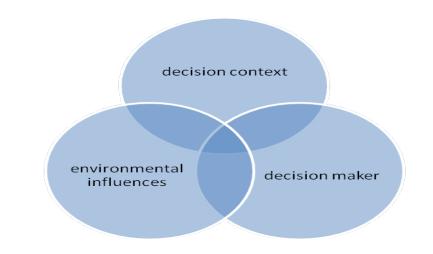


Figure 1: Components of decision making

supported existing normative practice. This ensured informed compliance rather than informed choice.

Various authors have offered different descriptions of factors that affect decision making. Bekker, et al. (1999), for example, propose that there are three major components (Figure 1). These components consist of the context in which the decision is made, the decision maker and environmental influences.

In this model, a woman's own life experiences inform decision making because she will draw on her past experiences to estimate the likelihood of a decision outcome according to options available. Many decisions in childbirth have a clinical context. For example, the decision of a woman to have a blood transfusion or not following a post partum haemorrhage, is likely to be considered against whether she is symptomatic or not and her own feelings about having a transfusion. Midwives can be seen as having an environmental influence on decisions as they are the major providers of maternity services and have a close relationship with women. Other influences include whānau/family, friends, other health professionals and the media.

Carolan and Hodnett (2007) take a slightly different approach and suggest that choices and decisions in childbirth are determined by a woman's knowledge about care models, by the local availability of services and perceptions of risk, both on the part of the woman and of the midwife. A comprehensive knowledge of the maternity system and the major players or practitioners and what they offer, increases a woman's choices and thus she is more able to look for a practice that most closely fits her view of the type of care she needs. This assumes that women understand differences in models or approaches to care. In reality, this 'information is accessed principally by well-educated and well-resourced' women (ibid, 2007, p 142). The Internet for example, is a major source of health information (Brodie et al., 2000) and New Zealand has one of the highest rates of internet access in the world (Statistics New Zealand, 2004). Women who have reduced socio economic resources are less likely to participate in the current information environment, accessed mainly through the internet.

The availability of maternity services in New Zealand is largely determined by the size and needs of the population geographically (Ministry of Health, 2000). Rural services, for example, cater for fewer people, and recruitment and retention of health practitioners to rural areas is problematic due to there being less colleagial support and opportunities for professional development (Health Workforce Advisory Committee, 2001). This in turn, contributes to a reduction in choices for women in rural areas.

Risk is another factor that Carolan and Hodnett believe influences choice. Skinner (2005) commented that midwives are both constrained by and act in resistance to risk. Hansson (2005) describes risk as referring to situations in which a decision is made, from which consequences depend on the outcomes of future events having known probability. However, humans are not exact measurement instruments, and there is an incompatibility in calculating the risk of human behaviour as a mathematical equation on the basis of probability, and applying this to the natural physiological phenomenon of childbirth for which unexpected outcomes can occur. An example of how decisions related to the perception of risk can be effected by context is illustrated in the 2004 study of Mead and Kornbrot.

They found that midwives who worked in maternity units with higher rates of intervention, perceived birth as more risky than their colleagues who worked in units with lower intervention rates. These midwives under-estimated the ability of women to progress normally through their labour and overestimated the advantages of interventions, particularly epidural analgesia. The researchers concluded that workplace culture significantly influences midwives' perception of risk, and that decisions associated with risk perception can often be inaccurate. They commented : 'If midwives' perception of risk is at odds with reality, irrespective of the level of intra-partum intervention, it is likely that the information provided to women will be biased towards labour being presented as more risky than it actually is' (Mead & Kornbrot, 2004, pg 69). The possibility for midwives varying their information to women on the basis of risk perception, gives rise to a question of whether all women do receive the same information within the context of decision making. Insight into decision theory and human information processing can assist midwives understand how they might utilise such knowledge to facilitate their role in the decision process.

Decision Theory

The theoretical approaches to decision theory can be broadly categorised as taking three approaches - normative, prescriptive and descriptive (Bekker et al., 1999). Normative theory describes what people ought to do if they want to be rational decision makers. This approach is dominated by scientific inquiry to illustrate how rational thinking is achieved. Using this approach decisions are seen to be made using mathematical and statistical standards of proof (Bekker et al., 1999). In contrast to the empirical normative approach, rational normative theory emphasises the authority of human reason and conscience (Mautner, 2000). Human beings are motivated by their own desires and goals, and their decisions are infleunced by social phenomena and institutions (Mautner, 2000).

Prescriptive theory assumes that human beings can make poor decisions and therefore proposes that decision aids are necessary to assist the decision process. This is in order to make decisions seem more objective and quantifiable (Nassar, Roberts, Raynes-Greenow, & Barratt, 2007; Wong, Thornton, Gbolade, & Bekker, 2006). Take for example the information leaflets about nuchal translucency scans. If a woman is considering nuchal translucency, she needs information about the technology and the evidence that supports its use in pregnancy. She needs to identify her reason for wanting the scan, the benefits, the clinical risks, any costs and what the actual procedure involves. Whether a nuchal translucency scan goes ahead or not is irrelevant, because a women needs to be satisfied with the outcome of her decision, and an information leaflet can help bridge the knowledge gap while seeming objective.

The descriptive approach to decision making, on the other hand is concerned with cognitive phenomena and how humans actually think and process information. Decision making using this approach is understood to be a sophisticated cognitive activity, sensitive to how complex a task is, the pressure of time, how the task is framed and what reference points are used in order to make the decision (Lichenstein & Slovic, 2006). It is this descriptive approach to decision theory that is emerging as an important discourse in midwifery practice (Raynor, Marshall, & Sullivan, 2005).

Descriptive Decision Theory

An exploration into descriptive theory offers some insights into the relevance of cognition to decision making in childbirth. Known features of human information processing are that humans have a limited span of working memory, they have limited exactness in quantitative measurement, and they have a tendency for error and contradiction (Larichev, 1999; Hansson, 2005). Each of these features has consequences and these are discussed using vignettes to demonstrate their implications for practicing midwives.

Limited Span of the Working Memory

Human capacity to process information is limited and the simple provision of more information does not necessarily improve decision making. The great body of empirical work to date suggests that we are "boundedly rational". In other words, 'although we are capable of great feats of intellect, our intellectual capacity is nonetheless limited' (Hibbard & Peters, 2003, p. 416). Integrating different information and different variables into a decision is a very complex cognitive process, and the complexity of clinical decision making is a well reported phenomenon (Raynor, Marshall, & Sullivan, 2005). Too much information can become an impediment to decision-making and this can lead to attempts to problem solve by reducing cognitive effort (taking mental shortcuts) or 'heuristics'. Tversky & Kahneman's seminal work (1974) on heuristics and biases is the dominant school of thought in considering subjective judgements. Heuristics refers to methods of problem solving by experimentation or 'trial and error' and this means that the task of assessing the probability of a situation is reduced

to an intuitive judgement (Tversky & Kahneman, 1974). For example, in representative heuristics, the chance that a first time mother will have a long labour is based on the degree to which she is representative of other first time mothers.

Bias is another human behaviour, commonly explained as a byproduct of the limitations of processing information, and it is difficult to quantify because it is based on human experience and social perception (Haselton, Nettle, & Andrews, 2005).

Anchoring or focalism, a form of cognitive bias describes the common human tendency to rely too heavily, or "anchor," on one trait or piece of information when making decisions (Tversky & Kahneman, 1974). Take the example of a woman who chooses to artificially feed her baby, stating that it is the best feed for her baby. She conveys this message to her midwife, despite evidence which attempts to dispel those views. Her hypothesis is based, or anchored on her perception that breastfeeding is painful. A consequence of this anchoring is that all incoming information is not considered seriously, and the woman favours her original hypothesis. Unless the midwife is alert to anchoring, taking time to explore the source of the woman's opinion, then the woman may hold to her hypothesis. Her perception of breastfeeding as a painful experience will persist. In addition, the midwife herself needs to recognise her own bias and how she can contribute to a woman's perception of breastfeeding. This can happen through direct or indirect communication. Direct communication includes verbal information sharing and the midwife's own body language, and indirect communication can include such things as entries in midwifery notes.

Limited Exactness in Quantitative Measurement

Tversky (1969) the pioneer of cognitive science, observed that individuals make inconsistent choices even in the absence of changes in their preferences. This reflects the fact that cognitive behaviour is not underpinned by an exact science (Larichev, 1999). Alternative options are eliminated in preference for a single 'dominant' factor that most reflects an individual's preference at any point in time.

Imagine a scenario involving Jay, who is healthy and in her 2nd trimester of pregnancy. Jay has told her midwife that she wants to have her baby at the local hospital rather than in the birth centre, so 'everything is there if something goes wrong'. Jay's view has been influenced by a close friend who had a caesarian section for fetal distress. Jay anticipates that she may need a caesarian and she has neglected to consider information about the risks of caesarian section or the benefits of birth centre care, because 'fetal distress' has become the dominating factor for her. The implication for midwives is the need to identify the dominating factor in order to acknowledge and explore, in this case, Jay's concern.

A Tendency for Human Errors and Contradictions

'To err is human' is a quote that is no less true of humans when processing information. The reasons for human error are numerous and can include such things as weariness and a lack of attention that can result from illness, grief, concentration span or boredom (Hibbard & Peters, 2003). A lack of attention often has a root cause, affecting a person's behaviour and judgement. Imagine a scenario involving Brenda who is 38 weeks pregnant with her first baby. She last saw her midwife at 32 weeks when her baby was lying in a breech position. Brenda has missed several visits from midwife Janet including the last three, and Janet is frustrated by not being able to meet with Brenda to discuss ongoing care. Unbeknown to Janet, Brenda and her partner are having serious relationship problems. She has not had the strength or courage to tell Janet, so she is avoiding meeting her where conversation about her partner might come up.

Continuity of care by one midwife enables the midwife to get to know a woman. The midwife is better able to detect changes in the woman's wellbeing and is better placed to make judgements about the woman's preparedness to receive information. The midwife might also make judgements about what to tell women and at what time. The implication for midwives is the need to identify barriers for women's participation in decision making.

Strategies For Practice

Through knowledge of decision theory and cognitive processes, midwives can be in a stronger position to identify ways to facilitate their role in providing information to women. Two key ideas found within the theoretical approaches are reducing cognitive effort, and making information contextually relevant to individual women. The challenge for midwives is not merely to communicate accurate information to women, but to understand how to present and target that information so that it is usable (Hibbard & Peters, 2003). This next section considers four strategies that might assist midwives facilitate the decision process.

Using Positive Affect

The first of these is the use of positive affect (feelings, emotions). A growing body of research indicates that the use of such positive affect can influence everyday thought processes and do so on a regular basis (Isen, 2001; 1997). For example the presence of positive feelings may cue positive material in memory, making access to such thoughts easier and thus making it more likely that positive material will "come to mind" (Isen, 1997). According to Isen, positively remembered material is organised and accessible, and particularly important in that it has been found to improve both efficiency and thoroughness in decision making.

The implication for midwives is that there is opportunity to draw on positive affect in a way that may enhance a woman's decision experience. For a woman who has already had a baby, for example, this might involve reflection on her experience of labour or parenting, in order to identify positive factors that may help to influence her decision making for her current pregnancy.

Whanau/Family

The word 'woman' promoted by the midwifery profession in New Zealand includes woman's baby/partner/whānau/family the (New Zealand College of Midwives Inc, 2005). Social structures akin to whānau/ family have a significant influence on attitudes to health decisions (Hoddinot & Pill, 1999). For example, role modelling of breastfeeding by family members and the embodied knowledge women gain from observing the practical skill of breastfeeding within their own family, have a more profound positive influence on a woman's decision to breastfeed than theoretical knowledge (Hoddinot & Pill, 1999). Many midwives may have observed how women consult their close relatives, partners or friends at some stage during their childbearing. Decisions are rarely made alone, and the people closest to a woman can be important for relaying the message the midwife wants to promote, and for interpreting the message in a way that is culturally fitting. For example, a whānau/family that has a history of artificially fed babies may find that one woman amongst them decides that breastfeeding is best for her baby. In this case, the midwife may need to target education to the whānau/family, in order to advocate and support an individual woman's choice.

Appealing to Modes of Thinking

Information in decision making appears to be processed using two different modes of

thinking: analytic and experiential (Hibbard & Peters, 2003). The analytic mode is conscious, deliberative, reason-based, verbal and relatively slow, and it is this mode of thinking that we as midwives tend to consider in our attempts to inform choices. The experiential mode is intuitive, automatic, associative and fast. It is based on affective (emotional) feelings, and one of its primary functions is to highlight information important enough to warrant considerations. When information is provided without consideration for emotional meaning, it cannot be given appropriate attention in decision making (Hibbard & Peters, 2003). It is here where midwives can be influential and proactive in influencing socially constructed attitudes to childbirth as it is experiential thinking that gives meaning to relevant information.

To demonstrate the application of modes of thinking in practice, consider the subject of vaginal examination. Any discussion with a woman about vaginal examination assumes that a midwife will carry out this procedure as necessary. The fundamental purpose of a vaginal examination is to gain information about the progress of labour, and it is generally a universally accepted procedure by women and health professionals as one of the main methods of assessment in labour. The intimacy involved in carrying out a vaginal examination is, in a way, a separate issue from the purpose of a vaginal examination by a midwife, and these two interrelated issues will require the midwife appealing both to a woman's analytic and experiential thinking as part of the process of informing her about the procedure. All aspects of midwifery care will involve engaging analytic and experiential thinking.

Narrative

Narratives or stories about someone else's experience can help a decision maker who has never experienced the consequences of some choice and may not be able to predict its impact on their life. Narrative helps move the decision maker closer to the actual experience, and 'may help render even unfamiliar information evaluable, salient, and easily imaginable through the use of concrete descriptors and images'. (Satterfield, Slovic, & Gregory, 2000; Hibbard & Peters, 2003, p. 424). The key ingredient is sharing and talking, and this can happen in a range of forums such as at antenatal classes, on the marae, at church, family gatherings, support groups, through one-on-one or group activities. The implication for midwives is that if a woman is isolated or has little or no contact with other women, she will not be in a position to hear other women's stories to imagine how she would think or feel in the same situation.

Conclusion

New Zealand legislation provides for women, the right to effective communication, and the right to be fully informed and to give their informed consent. Such rights are supported by midwives' professional standards and regulation. Midwives play a key role in giving women information and in supporting the decision process. Knowledge of decision theory and cognitive processes can be useful for midwives in facilitating a woman's decision making. This also requires midwives to have some insight into factors within their own practice context that may inhibit, influence or enhance women's choice. This includes perceptions of risk, time and information overload. Various strategies can be used by midwives to enhance fulfilment of their professional obligations and this paper has discussed four strategies - positive affect, support from whānau/family, utilising modes of thinking and narrative.

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Midwives' and obstetricians' perception of their role in the identification and management of family violence

Authors:

Dr Mel Lauti MBChB BSc BMedSc House Surgeon, Dunedin Hospital Dr Dawn Miller MBChB MRNZCGP PGDipGP Senior Lecturer in Women's Health Dunedin School of Medicine Correspondence to: dawn.miller@otago.ac.nz ABSTRACT

Background

Pregnant women are at risk of family violence. Pregnancy provides a window of opportunity for identification and management of abuse. Practitioners do not adequately identify family violence and abused women tend not to disclose it. This exploratory study aimed to investigate the opinions of midwives and obstetricians, regarding their role in identification and management of family violence.

Method

Focus groups and semi-structured interviews with midwives and obstetricians were conducted, recorded and analysed.

Results

Identification themes included concerns about privacy and confidentiality, the doctors' lack of continuity of patient care, and the role of screening. Management themes included uncertainty regarding management and referral options, the impact of managing family violence on clinicians, and the need for debriefing.

Conclusion

Maternity health professionals in the locale studied have significant issues and difficulties in the identification and management of family violence. These need to be addressed in training programmes and guidelines to improve patient outcomes, and to provide support and safety for clinicians. Further research is required to achieve saturation of themes and explore identified issues, which can then be used to focus on interventions. **Keywords:** midwife, obstetrician, pregnancy, violence, abuse

Introduction

Family violence may begin, carry on or worsen during pregnancy. An international review reported a prevalence of 3.9-8.3% (Gazmararian, Lazorick, Spitz, Ballard, Saltzman & Marks, 1996). Family violence is more common than conditions routinely screened for, such as diabetes and hypertension (Janssen, Holt, Sugg, Emanuel, Critchlow & Henderson, 2003). Family violence during pregnancy is associated with intrauterine growth retardation (Moraes, Amorin & Reichenheim, 2006; Janssen et al, 2003), antepartum haemorrhage and perinatal death (Janssen et al, 2003). Pregnancy provides a window of opportunity for identification of family violence and previous research suggests that asking about family violence is acceptable to most pregnant women (Bacchus, Mezey & Bewley, 2002; Stenson, Saarinen, Heimer & Sidenvall, 2001).

Midwives recognise family violence as an important issue (Mezey, Bacchus, Haworth & Bewley, 2003; Stenson, Sidenwall & Heimer, 2005). The New Zealand College of Midwives (NZCOM) implemented midwifery family violence education in 2002, the same year that the Ministry of Health published FV intervention guidelines (Fanslow, 2002). There is little information on obstetricians' perception of their role in dealing with family violence. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) (2004), have introduced an educational module for Obstetric and Gynaecology trainees, consultants, as well as GPs, on management of adults who have experienced sexual assault.

It is crucial that practitioners feel capable of identifying affected women and providing appropriate care. Currently practitioners are not adequately identifying family violence, and abused women tend not to disclose it (Hegarty & Taft, 2001; Bacchus, Mezey, Bewley & Haworth, 2004). Appropriate training and guidelines are vital, and it is important to include the experience of practitioners working in maternity care in their development. The aim of this exploratory study was to investigate opinions of midwives and obstetricians regarding their role in identification and management of family violence.

Methods

Focus groups and semi-structured interviews were used to investigate the perceptions and experiences of maternity practitioners in the identification and management of pregnant women affected by family violence. All 28 midwives and 11 obstetricians working at Dunedin Public Hospital were invited to attend a focus group discussion, one for obstetricians and one for midwives. Small incentives were offered for participation. Five midwives participated in one focus group and two obstetricians in another. Due to the small number of obstetrician participants, obstetricians who did not attend the focus group were invited to individual semi-structured interviews; three obstetricians did so. Midwives were not invited to have an interview as the number of midwife focus group participants was adequate (Brown, 1999).

All focus group and semi-structured interview discussions were conducted by the authors in the Department of Women's and Children's Health, Dunedin Public Hospital, Dunedin, during November 2002. An interview guide was developed from the results of a literature search for prompting and focusing discussion, and participants were encouraged to raise issues they considered important. The obstetrician focus group and semistructured interviews lasted approximately 30 minutes each, and the midwife focus group lasted approximately 90 minutes. All discussions were audiotaped, transcribed and checked for accuracy by comparing transcripts with tape recordings.

Initial analysis involved independent coding of the transcripts by each investigator, who then met to compare and review their interpretations. Data were organised according to a template coding style. The codes used were broadly categorised as identification or management issues with subcodes as presented in Table 1. Additional categories can emerge and old ones change in this analytical process (Crabtree & Miller, 1999). In this case the template was concordant with the focus group guide areas of enquiry. Findings were combined with consensus into a master file using the software program ATLASTM. There was no automated analysis. Data were connected and corroborated by examining chunks of related text together (Crabtree & Miller, 1999). Ethical approval was granted by the Ethics Committee of the University of Otago, Dunedin, New Zealand.

Table 1. Codes used in content analysis.					
Identification					
Previous experience in identification					
Enquiring about family violence					
Barriers to identification					
Factors facilitating identification					
Screening					
Management					
Reflections about current management practice					
Barriers to management					
Facilitators of management					
Impact on the practitioner					

RESULTS

Demographics

Midwife participants included two hospital midwives, two independent midwives in community-based practice and one hospital midwife who had also worked independently. The five midwives had an average of 9.8 years in midwifery practice, and all but one reported attending courses about family violence. Obstetrician participants included one hospital based consultant obstetrician and four obstetric registrars. Three were female and two were male. On average the five obstetricians had 9.4 years in obstetric practice and three obstetricians reported no previous education about family violence.

Identification of Issues

Experience in identifying pregnant women who were the victims of family violence ranged from *"I don't know that I have seen it"* to *"lots and all the time"*. Both obstetricians and midwives acknowledged that identification of these women was *"nowhere near as much as it should be"* and that their respective professions had a role in the identification of family violence.

The midwives were more experienced in enquiring about family violence, stating "you can't assume anything, you have to ask", whereas an obstetrician made the comment that they "don't go there because it is too difficult". All obstetrician participants perceived midwives as having "a unique opportunity to pick up (FV)...because they are building a close relationship with the patient, ... the trust, ... seeing them more frequently".

The midwives agreed, acknowledging that the relationship they developed with pregnant women could help in identifying family violence victims.

"Often women see us as a friend, a mother figure ... they confide in you more than they would perhaps with friends or relatives." [Midwife]

Both obstetricians and midwives felt that asking about family violence in a direct fashion was most appropriate.

"I would ask directly because you are not going to get an honest answer unless you are honest, you have to be up front." [Obstetrician]

However obstetricians usually learnt of a woman's experience of family violence secondhand, often from the midwife.

Barriers to Identification

Midwives and obstetricians identified lack of time, perceived complexity of family violence issues, uncertainty about management, and privacy and confidentiality issues as potential barriers to identification.

"It is too emotional to deal with, you don't know how to deal with it..., it's time consuming." [Obstetrician] Most obstetricians felt that dealing with 'social issues' like family violence were beyond their scope of practice and enquiring about it could feel like intruding. They described identifying family violence as *"opening a can of worms"* and did not know how to manage it, *"not being able to give a pill to make it better."*

Midwives and obstetricians perceived privacy as a barrier to identification, including privacy in a clinic setting and difficulties separating the partner from the pregnant woman. Privacy could be difficult for midwives visiting women in their homes. For obstetricians the lack of continuity of patient care was identified as a barrier. Obstetricians also commented that disclosure only occurred when the women wished to disclose and that these women were often disempowered, in denial and needed to feel in control of any potential disclosure.

"If the woman feels that if she discloses something that isn't going to stay within her bounds of control, then she won't disclose it. ...the thing she is fighting against is loss of control." [Obstetrician]

Facilitating Identification

Obstetricians commented that abuse victims will often decide for themselves when to disclose -"it's a point that they have to get to themselves" and "was usually precipitated by things like the husband disappearing or a child being badly hurt".

They also stated that "you have to create an environment where disclosure is accepted". This included a good practitioner-patient relationship, continuity of care, adequate time, a confident health professional, privacy and confidentiality. Both obstetricians and midwives discussed the importance of picking up on possible cues, such as a woman's relationship with her partner.

"If a woman has left (her partner) multiple times and returned, that may be one cue...You see them together ..., you get an idea about the tension between the two, or the woman shutting up and the man answering for her." [Obstetrician]

Low self-esteem, history of chronic pain, prior agency involvement and/or a previous history of abuse were also mentioned as cues, as well as physical evidence of abuse. Some obstetricians perceived low socio-economic status, young pregnant women, unplanned pregnancies and drug users as possible risk factors. However other obstetricians and midwives acknowledged family violence is a global issue and could be missed if only particular community groups were considered at risk.

Screening

Obstetricians felt that if a screening programme was introduced they needed to know appropriate

responses to disclosure. Although they felt they would take part in screening, provided there were definite benefits for the abused women, they perceived midwives as being in a better position to screen successfully. They also felt a suitable environment was essential, particularly ensuring privacy. Midwives felt they had a role in screening pregnant women for family violence, but that the initial booking was not the right time. They also expressed concerns about being adequately trained to deal with disclosure.

"At booking... they are going to tell you what you want to hear. ...It is many visits ... before you actually start to hear things." [Midwife]

Screening could pick up on historic abuse, and midwives wondered if this was appropriate.

Management Issues

Not knowing what to do with information once disclosed, where to refer women, and how to access appropriate services were the most commonly expressed concerns by all participants.

"I am not familiar with what the management plan is...I am not well armed with like a flow chart ...of who to go to." [Obstetrician]

Midwives and obstetricians described the management of identified abused women as a team approach involving midwives, GPs, social workers and other agencies, and where they relied heavily on advice of others.

Both midwives and obstetricians considered it important not to pressure women as they would be less likely to seek help.

"You need to gain their trust... Being supportive, listening to what they want to do about it." [Midwife]

However practitioners described frustration when a client would not accept a referral.

"I have got to take ten approaches before a woman would agree to do something about it. I get a bit frustrated with that." [Midwife]

And referral was not always with consent, a potentially difficult situation.

"Explaining that you think their life is in danger, or their children's life is in danger. You promise confidentiality but within certain boundaries... When they leave (the relationship) is one of the most dangerous times so you can precipitate a problem." [Obstetrician]

Midwives and obstetricians voiced concern about documentation after disclosure of abuse, especially when pregnant women keep their maternity records at home, a common practice in New Zealand.

Barriers to Management

Perceived barriers to successful management of abused women, included inadequate training and limited access to resources. Midwives felt that it was difficult for midwifery students to gain practical experience dealing with family violence.

"If you have got a family at risk you are inclined to not take the student down because the dynamics change. If you are trying to build up a relationship with that family, so you can deal with the issues, you don't want a third party there, so they (the student) don't see it." [Midwife]

Facilitators of Management

Obstetricians thought training about resources, referral agencies, communication skills for dealing with disclosure, and medico-legal issues were important.

"Referral options, but also how to deal with disclosure (of FV)...If you start being angry with them, making them feel worse, making their low self esteem even worse....It is incredibly important that you get training in it." [Obstetrician]

"the legal side ... when can you intervene? Is it your duty to intervene or are you not responsible for doing something now?" [Obstetrician]

Obstetricians perceived midwives and social workers as invaluable to successful management as they have time, resources and can work beyond the hospital. Midwives felt that having a good knowledge about available referral agencies, their role and accessibility would facilitate management of abused women. Practice guidelines on family violence were helpful though some participants were unsure whether they would result in better outcomes.

"having guidelines and algorithms that show what to do are beneficial. As long as people understand that it is not a rule. This is a guideline to help you, not that you must do this in that situation." [Obstetrician]

Impact on the Practitioner

Midwives described serious boundary issues dealing with victims of family violence.

"I was called at midnight and asked to pick up someone who was standing on the footpath with her suitcases, her three kids and her TV." [Midwife]

"You say, 'All you can do is call the police', and they don't want to do that because in the morning it will be alright. 'He's going to say sorry But in the meantime, can you come and get me? ...Can you do this? Can you do that?' " [Midwife] Although the midwives knew it was not their role to intervene in these instances, their genuine concern for women and their children forced them to take action. Midwives could become involved in the power imbalance in an abusive relationship.

"The partners terribly resent your presence sometime. The woman looks to you and the attention is taken away from him. Often you are giving good, positive answers to the woman...You are boosting up her self esteem and he wants her kept right down where he has got the control so he starts resenting you coming." [Midwife]

Several midwives reported threatening behaviour, both indirectly and directly, towards them from a woman's abusive partner.

"I put myself between the partner and the door...I made sure I was strategically placed so I could leave the house in a hurry." [Midwife]

"What do you do when that violence gets turned towards you?... I have heard through the woman that they (the abusive partner) are out to get me. ... my husband took me out of town for the day because I was such a nervous wreck that this person was going to find me...I have also had fairly strong sexual connotations from partners ... That makes you very uncomfortable at times because he is always around." [Midwife]

Being exposed to violent situations could also produce an adverse response.

"As I visited them over the time, that control was horrendous. I wanted to smash his head in." [Midwife]

Obstetricians, however, made no similar comments. In fact, one obstetrician experienced in dealing with family violence, stated that they had never felt at risk when dealing with violent relationships.

"I have felt the danger between them, but have never felt it directed to me." [Obstetrician]

Both obstetricians and midwives expressed the need for debriefing after dealing with challenging cases of family violence.

" It is...an emotional situation... I think we are very poor at debriefing...You need to debrief, ... to talk to someone." [Obstetrician]

One obstetrician talked about a mentoring programme with a senior colleague, particularly valuable if the practitioner could choose their own mentor. The midwives had no formal regular peer support but said they "offloaded to each other" and kept a personal journal as a form of reflective practice.

Discussion

The midwives thought they were in a good position to identify family violence. However many obstetricians felt that family violence was beyond their scope of practice and enquiring about it could feel like intruding. This is concerning when family violence is an internationally recognised health issue and has been associated with poor maternal and fetal outcomes (Moraes et al, 2006; Janssen et al, 2003; Webster, Chandler & Battistutta, 1996).

Lack of time, lack of privacy in clinics and lack of continuity of patient care were perceived as barriers to identification by the obstetricians in this study and midwives in this and previous studies (Bacchus et al, 2002; Mezey et al, 2003). Hospital-based obstetricians usually see patients for a one-off clinic visit, whereas midwives see women regularly, often including home visits, highlighting the different patient-practitioner relationships and opportunities for identification. This may be different for obstetricians practising in the private sector and future studies should include these practitioners. However participant obstetricians were keen to work with midwives in identification and support of women who were victims of abuse.

Both midwives and obstetricians had difficulties supporting disclosure without actively directing the victim of abuse to seek help. General practitioners have described this difficult path, dealing with the victims of family violence, as 'walking a tightrope' (Miller & Jaye, 2007). Perceiving particular individuals or groups to be at high risk may mean abused women who are not associated with those groups are more likely to remain unidentified. In a previous study of primary care physicians, 39% stated that they were less likely to consider the possibility of family violence in their differential diagnosis when patients were from a similar social group to themselves (Sugg & Inui, 1992).

Participant midwives felt they had a role in screening for family violence, which is consistent with previous literature (Jones & Bonner, 2002; Bacchus et al, 2002). In the study by Bacchus et al (2002), most pregnant women felt midwives were the most appropriate health professionals to enquire about family violence because of their ongoing and trusting relationship. Obstetricians and midwives in our study agreed. Participant midwives of this study felt the initial booking appointment was not the best time for screening. This was contradictory to previous work where midwives described finding it easier to ask screening questions to new clients (Jones & Bonner, 2002). However Bacchus et al (2002) showed an increased rate of disclosure with advancing pregnancy. This suggests the potential

benefits of promoting repeated enquiry about abuse in screening programmes to maximise identification rates.

The documentation issues that concerned participants in this study have been previously described (Taft, 2002). There is a need for alternative forms of documentation whereby a woman's disclosure of abuse can be suitably recorded, without putting her at risk of further violence.

An issue about screening described in this study and seemingly no other, is that family violence screening may identify women's historic abuse. The emphasis of family violence identification has been on current abuse, but identification of historic abuse may also be important and relevant, especially if there are unresolved issues. Furthermore there is an association between family violence and major depression (Leung, Kung, Lam, Leung & Ho, 2002), a risk factor for postnatal depression (Eberhard-Gran, Eskild, Tambs, Samuelsen & Opjordsmoen, 2002). Guidelines and training need to suitably prepare clinicians should current or historic abuse be identified .

Despite participant concerns about screening, recent work has documented the benefits associated with antenatal screening for family violence in obstetric care. In one study screening 159 women, 10.7% disclosed family violence and 23.5% of the women who disclosed, wanted or accepted further assistance from midwives (Jones & Bonner, 2002). However a systematic review of studies on screening for family violence in any healthcare setting concluded that currently there is a lack of evidence of benefit in screening for family violence (Ramsay, Richardson, Carter, Davidson & Feder, 2002).

An important barrier to helping abused pregnant women is that practitioners feel inadequately informed about managing disclosure, where to refer and how to access appropriate services. Midwives and GPs have expressed these concerns in previous studies (Mezey et al, 2003; Miller & Jaye, 2007). The NZCOM has introduced guidelines and training programmes which should improve knowledge, practise, confidence and motivation for midwives dealing with family violence. RANZCOG currently has a teaching module on sexual assault only. Guidelines and training should include information on referral issues and options available, as well as communication skills for dealing with disclosure, and medicolegal issues related to violence and abuse. To be effective, training needs to be ongoing (Protheroe, Green & Spiby, 2004; Berman, Barlow & Koziol-McLain, 2005). Both obstetricians and midwives acknowledged the importance of working with other agencies supporting women who were victims of abuse. The multidisciplinary approach is the cornerstone of practice guidelines and discussed in other studies (Bacchus et al, 2002; Mezey et al, 2003).

Midwives described entanglement in the power imbalance and violence in a woman's abusive relationship. This was consistent with previous reports where midwives expressed fears of being assaulted after screening women for abuse (Mezey et al, 2003). Midwives also described requests from abused women which exceed the boundaries of midwifery practice and may indicate a gap in services for these women. Training should prepare midwives to deal with potential violence and boundary issues. GPs' fear of violent patients, or the patient's partner has been described in other studies (Miller & Jaye, 2007; Brown, Lent & Sas, 1993).

Debriefing after managing emotionally difficult cases was considered beneficial by both midwives and obstetricians in reducing adverse impact. Practitioners need to feel safe and supported in their practice with adequate support networks readily accessible. Practitioner safety and debriefing measures should be included in guidelines, training and practice.

This was a qualitative exploratory study which sampled for information-richness to determine whether issues existed in maternity practice regarding the identification and management of victims of family violence. This study contributes to discussion on this important topic. Its findings were not intended to be generalisable, but do indicate that there are important issues that need to be addressed. This study was limited by small participant numbers, and by using both focus groups and semi-structured interviews in information gathering. However the data obtained from all discussions were meaningful. Small participant numbers could reduce informationrichness and some themes may not have been identified. To ensure saturation of themes, further qualitative studies on the role of New Zealand midwives and obstetricians dealing with family violence in both public and private sectors are required. A nationwide survey could then be undertaken. These findings would be very helpful in the development of research on interventions to improve identification and management of family violence in maternity care.

Conclusion

Midwives and obstetricians in the locale studied have concerns about their role in the identification and management of family violence in maternity care. Many of this study's results were consistent with previous literature, but themes such as dealing with historical abuse were documented for the first time. The limitations of this exploratory study do not diminish the significance of the emergent themes. The important issues identified suggest the need for further research on the role of obstetricians and midwives in identification and management of family violence. Research findings should be used in the continuing development of training programmes and guidelines provided by the NZCOM and RANZCOG, to assist maternity practitioners dealing with family violence in a way that is effective and practical rather than just ideal and theoretical, whilst keeping practitioners safe.

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Lauti, M., Miller, D. (2008) Midwives and obstetrician's perceptions of their role in the identification and management of family violence. New Zealand College of Midwives Journal, 38, 12-16 Book Review Caesarean Just Another Way of Birth?

Mander, R. (2007) London: Routledge ISBN: 978-0-415-40136-4

Reviewer: Sue Marshall RN, RM, Post Grad.Cert Health Science DHB Midwife, Hawkes Bay.

The incidence of caesarean section is increasing within the Western world with rates in some private hospitals in Brazil approaching 98% (Nuttall, 2000, as cited in Mander, 2007). Women are increasingly requesting this significant intervention to surgically "birth" their babies. Some obstetricians are not only meeting this demand but also advocating for it (Mander, 2007). There appears to be growing concern about the spiraling costs to health care, the short and long-term effects in morbidity and women's altered perception and expectations of childbirth in the 21st century.

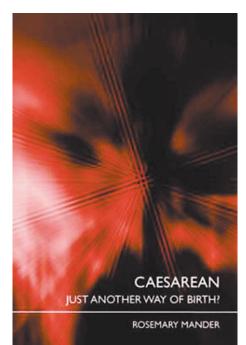
Rosemary Mander, Professor of Midwifery at the University of Edinburgh, Scotland, established researcher and practising midwife has written on this extensively investigated topic. In her 170page exploration of these issues in the detailed text "Caesarean Just Another Way of Birth", she discusses in a comprehensive way the diverse and contrary views on all aspects of caesarean with the aim of exposing the wide ranging effects and implications, to stimulate "a constructive dialogue between all of the interested parties", (Mander, 2007, p1).

The book is divided into nine chapters. These include the historical background to the procedure, research questions, surgical issues, and the international position including a comparison between countries, dynamics of decisionmaking, immediate and long-term implications of caesarean and the significance of trial of labour and vaginal birth after caesarean. The book concludes with a chapter commenting on the status of caesarean, long-term developmental views, medicalisation and women, and risk.

Mander's extensive knowledge of the subject, along with the expertise and experience of others and the outcomes from a range of research papers, make this a valuable current book. It is interesting and informative, with discussion about the influences and impact of caesarean that are not widely explored in other texts. Examples of these are the opening paragraphs in Chapter Four, and concluding paragraphs in the last chapter. The former describes the role of the World Health Organization and the events leading to the optimal caesarean section rate being determined by this organization. The process to reach this well-known rate of 15% was dubious and Mander challenges the role of the World Health Organization as, appearing to be maintaining world medicalisation rather than safeguarding world health. Mander also explores the idea that there are threats imposed by unnecessary caesareans on women and these threats are perceived as oppressive of women when caesarean is used to "maintain a sexually appealing body" (Mander, 2007, p.177). This can be a violation of the women's bodily integrity and a comparison is made with the practice of routine episiotomy throughout Western maternity centres in the mid to late twentieth century.

"Caesarean Just Another Way of Birth", written in a strongly academic style, is at times lengthy and complex and this can be irritating when a more direct statement would seem appropriate.

While recommended by the publisher to be of particular interest to the childbearing woman and the health care provider, in the reviewer's opinion this book is clearly more suited to the midwifery or medical student, and midwives practising in all settings, as well as medical and obstetric providers of maternity care. Although written by a British researcher it is still entirely relevant to the New Zealand context as a useful book to lead discussion and debate about caesarean section.



WAYS OF KNOWING

Rhyme and Reason - The use and value of poetry in midwifery practice and education

Author:

Lorna Davies RM, BSc(Hons) MA PGCEA Senior Lecturer in Midwifery Christchurch Polytechnic Institute of Technology Correspondence to: lornamidwife@hotmail.com

Introduction

We frequently speak of midwifery as a 'holistic' occupation. The use of the word holistic implies a belief that the whole is greater than the sum of its parts, and assumes an interrelationship among those parts. In other words, we do not view the childbearing woman from a reductionist, biomedical perspective, as simply a physical entity. We understand her to be a complex being, influenced by the psychological, emotional, spiritual, social and cultural aspects of her life, all of which may impact on her physical health and well being, and vice versa.

In order to help the woman to meet her unique needs in this period, we need to work with her with an open heart and an open mind (Anderson & Davies, 2004). We seem to understand that the clinical skills which have historically been given primacy, need to be further augmented with communication and interpersonal skills; emotional and spiritual literacy; team skills; problem-solving; lateral thinking; flexibility and adaptability. These are skills that we now recognise as being essential in developing the critically thinking, solution focused midwife, required to provide care for women in the 21st century (Davies, 2007). By encouraging the development of creative expression in midwifery education, we may begin to draw upon these alternative skills and the arts may provide a vehicle for this.

However, Midgely (2001) argues that art remains a kind of luxury within the scientifically disposed health care curriculum. She states: "It seems that science supplies all of the facts out of which we build the house of our beliefs. Only after this house is built can we- if we like- sit down inside it, turn on the CD player and listen to some Mozart or read some poetry." (p 28).

She goes on to suggest that the notion that science is a separate domain, which is irrelevant to the arts,

has produced what she describes as a "strange kind of apartheid" (p.28). The word apartheid conveys a sense of ideological strength and oppression. Is this what has happened in health education generally, including midwifery education? Have we created a situation where science takes such precedence that we are producing 'one-sided' practitioners who are unable to fully function in a holistic sense? As an educator, I believe that we have to create midwifery curricula that offer

students the opportunity to become truly holistic practitioners by including learning and teaching methods and strategies that address the need to 'nurture the soul'.

In this article, I intend to discuss the merits of using poetry as a tool that may be utilized in order to help to achieve this. I have been using poetry as a form of journaling for

many years and I will use some of my own poetry to demonstrate how this may be achieved.

Poetry as a Tool for Personal and Professional Development

By encouraging the development

of creative expression in midwifery

education, we may begin to draw upon

these alternative skills and the arts may

provide a vehicle for this.

Poetry can offer the opportunity to explore familiar territory from new and sometimes unique perspectives, perhaps reawakening our awareness and appreciation. It can help to convey to others the essence of the experience of midwifery (Jackson & Sullivan, 1999). It may help to enhance communication and care skills, by offering the practitioner insight into how other

people feel about things, thereby encouraging an empathetic approach (Anderson, 2007). At a

time when documentation skills are being challenged, the writing and reading of poetry may help to refine writing skills and precision. A further benefit, is that because poetry can help us to perceive things in a more abstract way, it has the potential

to assist in the development of decision making skills, especially in ambiguous situations. Essentially, it can help to develop the skills of critical thinking (Jackson & Sullivan, 1999).

Reflection

Poetry can offer the opportunity to explore

familiar territory from new and sometimes

unique perspectives, perhaps reawakening

our awareness and appreciation.

As a tool for reflection, poetry has several benefits. Both the writing and reading of poetry may enable us to explore emotional issues and reflect upon them. The writing of poetry may offer us a unique way to develop our thoughts and ideas (Aull, 2005). 'Composting' is a theory developed by Natalie Goldberg in her classic book "Writing Down the Bones". She suggests that putting down our feelings in

poetic form allows us to create a storehouse of ideas and experiences that can and are being 'composted' for later use. This allows us to 'journey' through our poetry and to use reflection as an evolving process, that may adapt and change over a period of time. Poetry can equally help to pragmatically explore practice-based issues.

Reflection from a Personal Perspective

I would like to share a small number of poems that I have written during my journey to date as a midwife. I have used my poetry primarily as a tool for personal reflection, although I have occasionally used them to trigger discussion in teaching sessions. The literary quality of the poetry is not important. These are probably technically quite naïve, but they allow me a way of exploring issues in a way that is not always achievable in other forms.

The poem *The Quickening* was written some years ago. As a member of a Women's Health Group, I was involved in voluntary pregnancy testing. One day whilst performing a test for a woman, I suddenly became aware of feeling quite voyeuristic and I was prompted to reflect on this which resulted in this poem.

The Quickening

We gossip idly between visits from the women of our local community Waiting for the door to open tentatively. Latex gloves, like spectral hands, sit patiently waiting Lined up with the vial, the crystal ball of the pregnancy testing kit Boldly posed to determine the course of the future for the next punter.

We can't begin to guess what the morning holds in store It may be a happy and heartening moment Or a devastating and painful experience. We just never know which way it is going to go Wanted baby, unwanted baby, yes baby, no baby, maybe baby.

They produce a variety of vessels of both the surgical and kitchen variety Filled with precious amber coloured fluid. They remind me of relic traders in the middle ages The pots and containers handled with reverence and care An almanac of possibility held within their contents.

It is humbling to consider the fateful significance of this small room The buzz of the Saturday morning market Can be heard from three floors below Yet the world stands still momentarily as the testing begins No breathing, no heartbeat, no new life this time.

I feel something of a haruspex as I pack away the kit at the end of the session A Roman augur predicting what lies ahead By inspecting the entrails of sacrificed animals A latter day soothsayer with my little kit of divine prophecy Without any knowledge of the outcome of my uttered divination.

Is it really right that I can take on the role of Eros so easily?

A messenger that shuttles between the divine and human realms Sometimes harbinger of doom, sometimes angel of mercy Science has provided me with wings, but what of the flesh and blood of this discovery. The secret knowledge of a life to come, the joy of quickening.

The second poem, 'Sweet Dreams' was written following my attendance at a stillbirth. I was invited to attend the funeral and on a beautiful spring day I watched the immensely strong young parents release a balloon for each of the immediate members of the family. Each balloon represented their love and thoughts for the baby. I suddenly found the words that had eluded me, and I was able to share this poem with the couple, who keep a copy in their memory box.

Sweet Dreams

Blue and white balloons bob together, like dolphins in a sea of blue, Now released, unwilling to separate each representing the hopes and dreams of those who love you Each an individual entity but collectively stronger and more fathomable.

In a clear blue space they cluster together, resolutely Whilst we stand like spectators at an air show They refuse steadfastly to go alone, climbing steadily towards the heavens, until they disappear And though hopes of what should have been may go with them The dreams of what may have been will never die.

The Valsalva Rap is an illustration that poetry can be great fun and yet still convey an important message. Last year I wrote a critique of a research study on coached versus uncoached maternal pushing. I opened the critique by introducing the concept of the 'mantra of the second stage' that is often performed by health professionals in the presence of a woman in second stage. This, in conjunction with my teenage son's preoccupation with all things 'rap', encouraged me to write this tongue in cheek ditty to challenge a frequently encountered practice based on little more than custom and tradition.

The Valsalva Rap

Just hop on the bed and we'll listen to baby dear We'll just pop your waters to help speed things up dear

Put your chin on your chest and push - push Keep it coming, keep it coming and push – push

Don't be a martyr to the pain dear There are no medals and nothing to gain dear

Deep breath, chin down and push – push Keep it coming, keep it coming and push – push

We'll just put a clip on the little one's head dear Baby's heart beat is dropping and we need to get him out dear

Aim down to my fingers and push – push Keep it coming, keep it coming and push – push

Just a little cut to help to get the baby out dear The doctor will give you a helping hand dear

Breathe down into your bottom and push - push Keep it coming, keep it coming and push – push

The Valsalva Rap is where its at dear We've always done it and it works for us dear

Bear down right now and push - push Keep it coming keep it coming and push – push Keep it coming keep it coming and push – push Keep it coming keep it coming and push – push Keep it coming keep it coming and push – push

The use of poetry as I have already stated can be used for personal and professional development. Why shouldn't midwives be encouraged to take to their Midwifery Standards Review, a portfolio that contains some of their thoughts in poetic form?

Poetry in Parent Education

Women and their partners may value the introduction of poetry into antenatal or preparation for parenting classes. Before dismissing it as being far too arcane an idea, just 'google' birth poetry and take a look at what women are doing with poetry around birth on any number of websites. During an assessment for an education for parenting course some years ago, I witnessed a student midwife introduce a brief relaxation exercise to seven or eight couples in late pregnancy, whilst they rested in chairs. At the end of the exercise she read a poem entitled *Thirty-Six Weeks* which explored the feelings of a woman in the latter weeks of pregnancy towards her baby who was also preparing for birth. The poem prompted a discussion about how the women felt about their pregnancies and approaching parenthood. In a very simple way, the group had been offered an opportunity to examine their feelings and emotions (Wickham & Davies, 2005). What other activity could promote this sort of discussion in parent education?

Poetry as Therapy

Perhaps we should be further encouraging the introduction of Poets in Residence into maternity settings to help to promote this sort of activity. Foureur, Bush, Duke, & Walton (2007) have reported on the introduction of a poetin-residence at a hospital in Wellington. The project was established with the hope of gaining insight into how nurses and midwives contribute to health outcomes. The authors concluded that the project was a success inasmuch as it resulted in positive feedback from the participants. They also recommended that the provision of poetry workshops for health care workers may help the avoidance of workplace stress and enhance interpersonal and inter-professional communication. It may be that women could also benefit from working with a poet-in-residence, particularly those who are experiencing problems. Poetry may help them to work through some of these problems. Interestingly, the word 'therapy' is derived from the Greek 'to, heal through dance, drama, poetry and drama' (Anderson, 2007).

Poetry in Midwifery Education

I understand that many of the schools of midwifery in New Zealand are using poetry in a variety of forms. For example, using a poem as a catalyst for the discussion of difficult subjects such as postnatal depression, or to view the experience of pregnancy from a woman's perspective. This is exciting and encouraging, but I believe that we have only scratched the surface with regard to employing the use of poetry within a pedagogical context and there is scope for a much greater inclusion, in particular in relation to reflection.

Conclusion

There is currently a great deal of discussion and debate about challenging the medicalisation of childbirth and encouraging a more holistic approach to practice. However, if this is to be any more than just rhetoric, we must place greater value, and give more space and time to exploring alternative ways of expression, thinking and being (Anderson, and Davies 2004). Poetry, in conjunction with other forms of creative expression may offer us a useful tool in the endeavour to create a greater sense of equilibrium between the arts and the sciences in midwifery education and practice. As Blaise Pascal (a 16th century French mathematician, philosopher and physicist) so rightly conjectured,

"We know the truth not only by the reason, but also by the heart"

Science may be able to give us the reasons why, but the arts may give us a raison d'etre.

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PRACTICE ISSUES

Third trimester itch: Obstetric Cholestasis a serious condition of pregnancy

Authors:

Robin Cronin BA IBCLC RM RCompN LMC Midwfe Tauranga Correspondence to: robincronin@xtra.co.nz

Robyn Maude PhD candidate MA (Midwifery) RM RN Lecturer Graduate School of Nursing, Midwifery and Health Victoria University Wellington Correspondence to: Robyn.Maude@vuw.ac.nz

Introduction

Obstetric cholestasis, also known as intrahepatic cholestasis of pregnancy, is a relatively uncommon liver disorder that classically presents in the third trimester (Royal College of Obstetricians and Gynecologists [RCOG], 2006). The main concern with obstetric cholestasis is a risk of prematurity and sudden intrauterine fetal death in previously healthy fetuses (RCOG, 2006). In this article we have used a fictionalized case report, with changes made to protect confidentiality, based on a scenario from practice to provide an overviewofobstetriccholestasis, the investigations, diagnosis, risks and management options for this condition.

Pathophysiology

Obstetric cholestasis is the most common liver disease which is unique to pregnancy (McDonald 1999). The incidence is estimated as 0.7% of pregnancies in a multiethnic population (Abedin, Weaver, & Egginton, 1999). Around 448 pregnant women per year in New Zealand would be expected to contract this disease. Ch'ng, Morgan, Hainsworth and Kingham (2002) consider that this figure may be an underrepresentation of the problem due to failure of diagnosis.

Nichols (2005) describes the pathogenesis of obstetric cholestasis as the slowing of the normal flow of bile in the maternal liver, causing an increase of bile acids in the blood. This leads to damage of the liver cell membrane and consequential rise in liver enzymes in the maternal blood. There is also an increased transfer of bile acids from the mother to her fetus. Its causes are not well understood, but generally agreed to be multifactorial, with genetic, environmental and hormonal components (Lammert, Marschall, & Matern, 2003). Risk factors include a family history of obstetric cholestasis, gallstones, previous obstetric cholestasis, multiple pregnancy, older maternal age and Chilean or Scandinavian ethnicity (Bruce & Watson, 2007).

Symptoms and Biochemistry

Diagnosis is suggested if a woman in the third trimester of pregnancy develops itching without a rash and at least one biochemical liver abnormality (Walker, Nelson-Piercy, & Williamson, 2002). Exclusion of other causes of itching and liver disorders is necessary for the diagnosis (RCOG, 2006). The itching is described as intense, beginning on the hands and feet, later spreading to the limbs and body in an ascending pattern, but without skin rashes (Nichols, 2005). Itching is prior to or in tandem with raised serum bile acids and accompanied or followed by other abnormal liver function tests (LFTs), most commonly raised alanine transferase (ALT) and aspartate aminotransferase (AST) (Walker et al., 2002).

Serum bile acids (SBA) are the most sensitive marker of biochemical liver abnormality, "the biochemical hallmark" (Nichols, 2005, p. 220) but it usually takes several days to get a result. However, according to Walker et al. (2002), most biochemical liver abnormalities are diagnostic in the presence of itching and with the exclusion of other liver disorders. ALT and AST are elevated in 60% of cases of obstetric cholestasis (Milkiewicz, Elias, Williamson & Weaver, 2002) and are usually two to three times normal levels (Walker et al., 2002). There may however, be up to a ten fold increase (Popli, Roberts, & Mills, 2006). Alkaline phosphatase (ALP) may be elevated up to four times normal levels (Popli et al., 2006). Milkiewicz et al (2002) also found gamma glutamyl transpeptidale (GGT) raised in 30% of their patients with obstetric cholestasis. Nichols (2005) describes diagnosis as complicated by lack of uniform criteria. The only consistency in the studies she reviewed was a steady increase in bilirubin, ALP, ALT, AST and SBAs.

Other associated symptoms, according to McDonald (1999), include jaundice, with a 20 to 25% incidence one to four weeks after the onset of itch. Urinary tract infection is also found in 50% of women diagnosed. McDonald (1999) also lists possible gastrointestinal symptoms, such as malaise, nausea, loss of appetite, mild upper right quadrant abdominal pain and pale bowel motions (steatorrhoea). The decreased absorption of fat soluble vitamins leads to abnormal prothrombin time and increased risk of postpartum haemorrhage (PPH). Some women have a history of cholesterol gallstones (Milkiewicz et al., 2002).

Diseases that can be easily excluded via blood tests and scanning, include Hepatitis A, B, C

and E plus Cytomegalovirus, HIV, Epstein Barr, Herpes Simplex, Toxoplasmosis, Pre-eclampsia and HELLP, autoimmune liver diseases, gallstones, acute fatty liver, diabetes, primary biliary cirrhosis and sepsis (McDonald, 1999). Occasionally these conditions may co-exist with obstetric cholestasis and confuse the diagnosis.

While the condition of obstetric cholestasis is distressing for the mother, with intense itching and sleep deprivation, there are no serious shortterm health risks. However women do suffer psychological, social and physical distress with the severe itching and sleep disturbances (Bruce & Watson, 2007). The main concern is for fetal risk of spontaneous and iatrogenic prematurity, fetal compromise and especially sudden intrauterine death (Milkiewicz et al., 2002). Despite many studies of fetal assessment and maternal medications, RCOG (2006), advise that "there is no evidence that any specific treatment improves maternal symptoms or fetal outcomes" (p5). Lack of possible advice about specific treatment is the reason why active management by induction of labour or/and caesarean section at 37 to 38 weeks is advised in order to avoid the risk of late stillbirth. This is common practice in most maternity units.

Case Report

Kelly (not her real name), was a 39 year old woman of European descent, with two children, and in her third pregnancy. She presented on a cold winter's day for her routine Lead Maternity Carer (LMC) midwifery assessment at 33 weeks gestation, with generalized itching which had developed over the last two weeks. The itching had started on the palms of her hands and soles of her feet, but had spread up her legs, down her arms and over her body. She reported that the itching was disrupting her sleep. On examination, there was no sign of a rash or any sign of jaundice. Her urinalysis was clear, fundal height equal to dates, good fetal movements were present and she was normotensive. Although she had no history of viral illnesses, abdominal discomfort, and gallbladder or liver diseases and was not on any medications apart from iron tablets, she reported some malaise, nausea, and loss of appetite. There was no history of steatorrhoea. Initial antenatal blood tests, high vaginal swab, midstream urine and 28 week full blood count, polycose screen and midstream urine had been normal.

Kelly had two normal births previously. However the second birth was complicated by a large PPH requiring four units of blood.

Table 1						
	Non Pregnant	Normal Pregnant	Obstetric Cholestatis	Kelly	Local Lab Values	
Itch Gestation Onset			30.2 (Range 20-35)(ii)	30-31 wks		
ALT (IU/L)	1 - 40 (i)	1 - 30 (i)	100 +/- 127 (ii)	131	0 - 45	
AST (IU/L)	1 - 30 (i)	1 - 21 (i)	85 +/- 126 (ii)	66	0 - 40	
ALP (U/L)	25 - 100 (i)	125 - 250 (i)	825 +/- 380 (ii)	167	40 - 100	
Bilirubin (umol/L)	2 - 20 (iii)	3-14 (iv)	20 - 25% jaundiced (v)	11	2 – 20	
Serum Bile Acids/ Bile Salts (umol/L)	3.2 +/- 2.9 (ii)	6.7 +/- 3.6 (ii)	36 +/- 32.8 (ii)	22 at 35 wks NB: No test at 38 wks	0 -15	
GGT (IU/L)	18 +/- 5 (ii)	15 +/- 7 (ii)	47 +/- 36 (ii)	20	0 - 50	

Table 1: Laboratory values – Obstetric cholestasis i Tran (2005) ii Reyes et al (2006) iii Local Laboratory Values (2007)iv Popli, Roberts and Mills (2006) v Nichols (2005)

- Data shown as mean +/- SD (Reyes et al, 2006)
- Markers of liver function are reduced during pregnancy due to expansion of extracellular fluid with exception of Alkaline phosphatase (ALP) which is elevated from ALP of placental origin (Tran, 2005).
- Serum bile acids (SBAs) are the "the biochemical hallmark" (Nichols, 2005, p.220) of obstetric cholestasis but take up to one week for test results in New Zealand.
- Rises in Alanine transferase (ALT) and aspartate aminotransferase (AST) increase in 60% of cases of obstetric cholestasis (Milkiewicz, Elias, Williamson & Weaver, 2002) and are usually two to three times normal levels (Walker, Nelson-Piercy & Williamson, 2002) but may be up to ten fold increase (Popli, Roberts & Mills, 2006).
- ALP may be elevated up to four times normal levels (Popli, Roberts & Mills, 2006).
- "Although a wide variety of cut-off points have been used for defining abnormal LFTs and bile salts, pregnancy specific ranges should be applied " (RCOG, 2006, p.2).

She did have some itching near the end of her second pregnancy. Her family history did not include liver disease, but Kelly was born five weeks premature and her grandmother had an unexplained stillbirth at term. It was explained to Kelly that an uncommon liver problem called obstetric cholestasis causes itching in pregnancy and if untreated may be hazardous for unborn babies. It could be diagnosed with blood tests. LFTs, full blood count and midstream urine were requested.

Kelly's LFTs came back with raised ALP, ALT and AST, but with a normal full blood count. Her midstream urine showed an asymptomatic infection, which was treated with the suggested antibiotic. A discussion with the duty obstetric registrar concluded that Kelly may have obstetric cholestasis. Further blood tests including screening for viral infections, clotting studies, kidney function tests, full blood count and SBAs were requested. In addition, a pregnancy and maternal liver scan were booked.

Further tests showed that Kelly's SBAs were raised along with a steady rise in ALP, ALT and AST. Her liver scan showed no sign of liver or gallbladder disease. Her APPT and Prothrombin time were normal as was her full blood count. Viral tests for Hepatitis A, B, C and E plus Cytomegalovirus, HIV, Epstein Barr, Herpes Simplex and Toxoplasmosis were negative. The pregnancy scan showed a healthy fetus on 70th centile, with normal liquor, dopplers and biophysical profile (BPP). Exclusion of other possible causes of liver dysfunction combined with itching in the absence of a rash confirmed the diagnosis of obstetric cholestasis. Kelly and her partner were given explanations and patient information pamphlets, which were downloaded from the internet from the RCOG (2006) website and British Liver Trust (2007), along with copies of her blood test results and scan reports. Ideas to manage the itching were discussed, including a low fat diet, good water intake, skin lotions and keeping cool. Kelly and her partner were advised of the importance of monitoring Kelly for symptoms of liver damage and of assessing her baby's wellbeing, because of the risk of sudden fetal demise after 37 weeks. An appointment was made for Kelly to see a duty obstetric specialist within the week.

The duty obstetric specialist appointment at 34 weeks was a disappointment. Kelly was seen by a junior registrar who advised that itching is common in pregnancy and her LFTs and

SBAs were not really significant compared to the local laboratory non-pregnant level. This was surprising advice considering Kelly's LFTs and SBAs results (table 1). Kelly said she felt embarrassed during the consultation especially as her partner asked her if she was disappointed that she was fine! Meanwhile she was increasingly distressed by the itching, even resorting to the extent of using a hard bristled brush up and down her legs.

At Kelly's 35 weeks assessment, her pregnancy remained unremarkable, with clear urinalysis, her fundal height was equal to dates, she had good fetal movements and was normotensive. However, Kelly's itch had increased, so it was highly likely that her SBAs and other LFTs were becoming more abnormal. The tests were repeated and came back showing further rise in LFTs including SBAs. Another urgent duty obstetric specialist appointment was made for Kelly.

Kelly was under strict instructions to advise me if there was any reduction in fetal movements, or of other concerns. She was given a script for oral vitamin K 10mg daily as she was worried about PPH and had read the information pamphlets cautioning that obstetric cholestasis can reduce absorption of vitamin K, leading to PPH (RCOG, 2006). Her previous large PPH was still fresh in her mind. She has graphic memories of her haemorrhage and the drama of the situation as it unfolded, and also of a personal sense of helplessness.

At the appointment with the duty obstetric specialist at 36 weeks, Kelly refused to see the registrar and insisted on a consultation with the specialist. He listened to Kelly, checked her blood test results and perused the copy of RCOG (2006) obstetric cholestasis 'Green Top' guidelines that had been downloaded from the RCOG website and stapled to Kelly's LMC referral. He agreed that Kelly had a diagnosis of obstetric cholestasis and booked an induction of labour at 38 weeks. He recommended a low fat diet, liver cleansing herbal preparation and stress reduction. Sleeping medication, antihistamine phenergan and skin lotions were offered. A cardiotocograph (CTG) was performed on the day of the consultation, but the specialist did not order any other fetal surveillance because he explained to Kelly that there is no specific fetal monitoring that can reliably foretell fetal outcome in obstetric cholestasis.

Kelly was pleased to have a confirmed diagnosis. She explored the information on herbs via the obstetric cholestasis patient information websites

and made an informed decision not to try them. Her diet was already low in fat. She had used a variety of skin lotions including calamine, hydrocortisone and aqueous cream. However she felt they only provided very short term relief and that ice packs, cold showers and scratching were more useful. She tried sleeping medication and the antihistamine phenergan, but did not enjoy the drowsiness associated with the medication, especially as it did not improve the itch. Being told to reduce her levels of stress was not helpful, in the presence of a persistent and untreatable itch, and news that the condition may be fatal for the baby. Kelly had conflicting feelings about the effects of her condition and her baby, alternating between resentment and guilt.

Despite being advised of the lack of evidence of any benefit from fetal monitoring, Kelly was keeping a kick chart and requested twice weekly CTGs and a further scan for her own reassurance. The scan confirmed good fetal growth and liquor volume with normal BPP. By the time Kelly's induction date arrived, she was scratching constantly. The blood tests taken on the day before the induction showed a further increase in LFTs. Kelly was induced with prostaglandin gel and went into labour a few hours after the second dose. Light meconium was noted in the liquor, but the fetal heart remained reassuring throughout. Kelly coped well, with entonox for pain relief, and a healthy baby girl was born normally. She had an Apgar score of 8 and 10 and weighed 3630 gms. To reduce the risk of haemorrhagic disease of the newborn, the baby was given an intramuscular injection of vitamin K. Mindful of her history of PPH, Kelly's third stage was actively managed with IV syntocinon and a postpartum syntocinon infusion. Her blood loss was within normal limits. Kelly successfully breastfed her baby.

The follow-up LFTs at two weeks postpartum were normal and Kelly reported resolution of itching within two days following birth. She was given copies of all her maternity information. Contraception was discussed and Kelly was cautioned about the chance of developing obstetric cholestasis symptoms with the oestrogen containing contraceptive pill, due to the hormonal effect on the liver. The 40 to 90% risk of obstetric cholestasis recurring in another pregnancy was also impressed upon Kelly. She was adamant that she would not be able to cope with the physical and emotional discomfort of such severe itching in another pregnancy, as it totally consumed her life and soul for the last weeks of her pregnancy. She consequently requested a tubal ligation.

Discussion

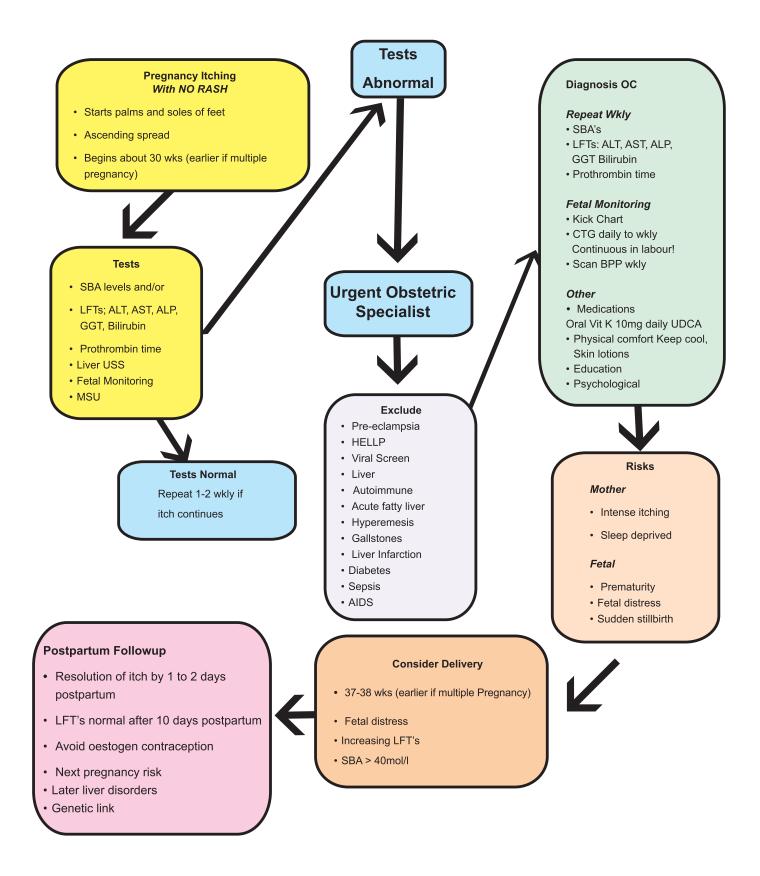
Kelly's case had many characteristic features of obstetric cholestasis, including the development of itching without a rash and at least one biochemical liver abnormality in the third trimester of pregnancy, as described by Walker et al (2002). Her itching was intense and distressing. It began on her hands and feet, later spreading to the limbs and body in an ascending pattern, without any skin rash. Her itching was in tandem with raised SBAs and accompanied by other abnormal LFTs of raised bilirubin, ALP, ALT and AST.

Kelly had some malaise, nausea, and loss of appetite. She also had a typical urinary tract infection at the time of diagnosis of obstetric cholestasis (McDonald, 1999). Her symptoms occurred in winter, and this fits with known seasonal variation which may have a relationship to diet, and in particular, inadequate selenium intake (Lammert, Marschall, Glantz, & Matern, 2000). She experienced itching near the end of her second pregnancy with an unexpected PPH requiring four units of blood. Unfortunately her LFTs were not examined at this time so a retrospective diagnosis of obstetric cholestasis, with possible associated clotting disorder, was not possible.

Kelly was vague about her family ethnic origins, but thought they may have come from somewhere in the UK. So it was unknown whether she shared a genetic predisposition, as described by Beuers and Pusl (2006), as coming from the 'hot spots' of Chile and Bolivia (with risks increased by 5 to 15%) or Scandinavia and the Baltic States (with risks increased by 1 to 2 %). However Kelly's unexplained prematurity, and her grandmother's stillbirth, could indicate a genetic link. It is considered that around 16% of obstetric cholestasis cases are familial and several recent studies show a genetic predisposition (Nichols, 2005). One theory being investigated by Beuers and Pusl (2006) is that 'leaky gut' may predispose some women to obstetric cholestasis, with the suggestion of a genetic factor affecting both intestinal and liver function.

According to RCOG (2006) the current stillbirth rate for women with obstetric cholestasis is comparable to the general population in the UK, falling from a high of 107 stillbirths per 1000 obstetric cholestasis affected pregnancies in the earliest reported study in 1976, to more recent studies post-1980 showing 9.1 stillbirths per 1000 pregnancies. Obstetric cholestasis was unknown until the 1950s (Lammert et al., 2000) and as Williamson et al., (2004) indicate, recent active management of the condition

Figure 1: Obstetric Cholestasis Flow Chart



with fetal surveillance and timed early delivery before 38 weeks, is likely to be the reason for these improved outcomes. They advise that in singleton pregnancies affected by obstetric cholestasis, stillbirth is most likely to occur from 37 weeks gestation, although this may be earlier in multiple pregnancies. Equally, they caution about fetal risks from early delivery, and advise these risks need to be balanced with the risks of stillbirth.

It is uncertain how obstetric cholestasis causes the increased fetal risk of spontaneous and iatrogenic prematurity, fetal compromise and intrauterine death (Milkiewicz et al., 2002). However, it is thought to be related to SBA levels causing an increase in myometrial contractivity of the uterus, with stillborn infants showing signs of acute anoxia and meconium stained liquor. Meconium stained liquor is thought to be caused by the raised SBA levels in the fetus having a peristaltic effect on the fetal bowel, as described by Nichols (2005). Another theory is there may be a vasoconstrictive effect of high levels of SBA on placental veins added to a possible meconium induced vasoconstriction of the umbilical vein (Bruce & Watson, 2007).

It has been proposed that obstetric cholestasis may be divided into mild obstetric cholestasis and severe obstetric cholestasis. This is defined as SBAs being under or over 40 micromol/L and is related to the probability of fetal complications which increase by 1-2% per additional micromole/L (Glantz, Marschall, & Mattsson, 2004). Kelly's SBA levels rose from 11 micromol/L at 33 weeks to 22 micromol/L at 35 weeks, which would put her in the mild obstetric cholestasis category. However Kelly did not have her bile acid levels repeated at 38 weeks, although there is little doubt these would have been increased, as in the previous two weeks her AST, ALT, bilirubin and ALP had all increased significantly.

In the New Zealand 'Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines),' obstetric cholestasis is coded as a Level 3. Level 3 code states "The Lead Maternity Carer must recommend to the woman that the responsibility for her care be transferred to a specialist, given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition" (Ministry of Health, 2007). However the contrast between Kelly's two obstetric specialist consultations highlights the difficulty in diagnosis of obstetric cholestasis. Popli et al., (2006) suggest this may be due to lack of consensus of the criteria for diagnosis. They caution that while it is generally agreed that abnormal liver function tests are indicative of obstetric cholestasis, there is no uniform agreement, and diagnosis is only made by exclusion of other causes of hepato-biliary dysfunction.

Knowing that Kelly's baby was at risk of acute lethal anoxia (Nichols, 2005), which could not be predicted or prevented by fetal monitoring (RCOG, 2006), caused high stress for Kelly until she was admitted for induction of labour at 38 weeks. Kelly was counselled about of the lack of evidence of any benefit from fetal monitoring. However, after reading obstetric cholestasis patient information, she made her own decision to keep a kick chart and requested twice weekly CTGs and a further scan. She explained that *"I can't sit back and do nothing and I need the reassurance that my baby is still alive and well, at least during the time on the CTG."*

Management and Treatment Options

General comfort measures suggested by Nichols (2005) and conveyed to Kelly, included a low fat diet, good water intake, 'liver strengthening' herbal remedies such as milk thistle and dandelion, skin lotions, keeping cool with ice packs, cotton clothing, cool baths and a reduction in stress. Topical emollients are known to be safe (RCOG, 2006), but as Kelly found, they only provide temporary relief of itching. Kelly did not like the effect of night sedation medications, such as antihistamines, suggested by RCOG (2006). Burrows, Clavisi and Burrows (2001) report that antihistamines, while providing night sedation are not effective at alleviating itching. However she was happy to take oral vitamin K 10mg daily orally to reduce risk of PPH and fetal haemorrhage (RCOG, 2006)

Medications that may have reduced Kelly's symptoms include ursodoexycholic acid (UDCA). This is an oral medication and the dosage is 600 mg up to 1 gm/daily (Bruce & Watson, 2007). Kelly's obstetric specialists declined to prescribe UDCA for her, as she came under the mild cholestasis category, and UDCA only has provisional consent under section 23 of the New Zealand Medicines Act. Some studies showed improved fetal outcome with UDCA, although others are inconclusive (Saleh & Abdo, 2007). However, it is the most widely used medication in the United Kingdom to treat obstetric cholestasis (RCOG, 2006). Saleh and Abdo (2007) consider UDCA to be the best available therapy to alleviate pruritis and to lower maternal and fetal SBAs. Furthermore it has no adverse side effects reported, except occasional mild diarrhoea (Milkiewicz et al., 2002).

Burrows et al. (2001) describe further medications to treat obstetric cholestasis, alone or in combination with ursodoexycholic acid, such as S adenosyl methionine (SAMe). However since SAMe is usually given twice daily as an intravenous infusion, and does not appear to be any more effective than ursodoexycholic acid, it has fallen out of favour. Other treatments that have fallen out of favour include Cholestyramine, which may improve symptoms of itching in some women but is unpleasant to ingest and may exacerbate vitamin K deficiency. Activated charcoal and guar gum have unpleasant gastrointestinal side effects, are ineffective and no longer in use.

Recent research has suggested that dexamethasone may be useful when obstetric cholestasis is unresponsive to UDCA, especially in women of Asian and South American origin (Diac et al., 2006). However according to Saleh and Abdo (2007), dexamethasone is less effective than UDCA at reducing SBAs and not effective in alleviation of pruritis or reduction of ALT. RCOG (2006) warns that repeated courses of dexamethasone used for fetal lung maturation have potential fetal and neonatal neurological effects, and should not be used as the initial treatment of choice for obstetric cholestasis.

To have a diagnosis of obstetric cholestasis, postnatal testing for LFTs should be deferred for at least ten days postpartum, as levels may increase in this time (David, Kotecha & Girling, 2000). However, all symptoms usually disappear within one to two days after delivery (Milkiewicz et al., 2002) and biochemistry must have returned to normal within a few weeks after birth, for the definitive diagnosis of obstetric cholestasis to be made (Walker et al., 2002). This was the case with Kelly.

Kelly successfully breastfed her baby girl and was reassured that there were no contraindications to breastfeeding with obstetric cholestasis (RCOG, 2006). Kelly was informed that the risk of obstetric cholestasis manifesting in another pregnancy were as high as 40 to 60 % (Nichols, 2005) and up to 90% (Williamson et al., 2004). Her choice of a tubal ligation for permanent contraception resolved the potential of developing obstetric cholestasis symptoms with the oestrogen containing contraceptive pill (RCOG, 2006). Kelly was cautioned that women who have had obstetric cholestasis were more likely to be later diagnosed with hepatitis C, non-alcoholic cirrhosis, gallstones, cholecystitis and non-alcoholic pancreatitis (Ropponen, Sund, Riikonen, Ylikorkala, & Aittomaki, 2006) and regular health checks with her general practitioner were suggested.

Implications for midwifery practice

The aim of discussing this case is to increase midwives awareness of obstetric cholestasis. Knowledge of symptoms and tests will provide the information required to assist in accurate diagnosis. This will enable timely referrals to an obstetric specialist and will facilitate appropriate management of women with obstetric cholestasis in order to decrease the risk of adverse outcomes for mother and baby. To this end, we have developed a flow chart that will inform midwives assessment, investigation and decision-making about obstetric cholestasis (Figure 1). Midwives, especially those who provide continuity of care, have the huge advantage of an ongoing partnership relationship with the woman and the opportunity to provide her and her family with information, support and follow-through care.

Conclusion

Obstetric cholestasis is a serious condition of the third trimester of pregnancy, and carries a risk of prematurity and sudden intrauterine fetal death in previously healthy fetuses. Obstetric cholestasis affects the woman's psychological, social and physical well-being, through the distress of intense itching and associated sleep deprivation. Lammert et al., (2003) advise "Despite the potential for adverse maternal and fetal/neonatal outcomes, cholestasis of pregnancy is often neglected and treated expectantly" (p.123). Investigations for obstetric cholestasis should be considered if a woman in the third trimester of pregnancy, develops itching without a rash and has at least one biochemical liver abnormality. However, diagnosis can be difficult, and includes exclusion of other causes of itching and liver disorders.

It is important that midwives realize that they, in partnership with women, have the power to prevent adverse outcomes, even in situations when difficulties in diagnosis may affect management of obstetric cholestasis. The obstetric cholestasis flow chart (Figure 1) will support midwives' confidence in this area. Midwives are the main providers of primary maternity care in New Zealand and are the gatekeepers for access to diagnosis and referral for treatment for pregnant women who develop this condition. If midwives don't listen then who will?

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SURFING THE NET

Author:

Sarah Stewart PhD candidate, University of Queensland, Australia

Senior Lecturer, School of Midwifery, Otago Polytechnic

Contact for correspondence: http://sarah-stewart.blogspot.com sarahs@tekotago.ac.nz

Definitions

Before I start this column, here are a couple of definitions of terms you will see me use a lot from now on:

Web 2.0

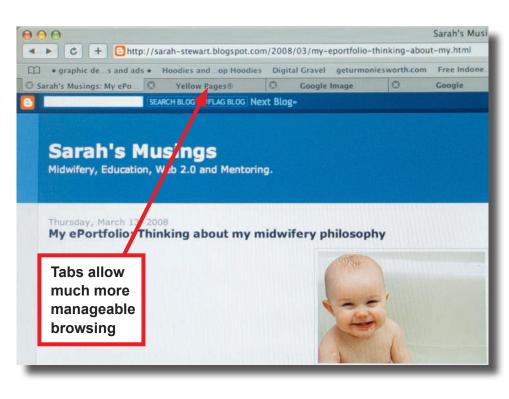
This is not a place, resource or web site but rather a principle or way of doing things using online tools. In other words, I am talking about anything that facilitates open sharing and publication of information and resources, and contributes to collaboration (O'Reilly, 2005). For example, a few years ago I had a web site. I paid a fortune to a web designer to host the web site and change the content. There was no way that the reader could interact with the site other than to email me. Contrast that to my blog (http:// sarah-stewart.blogspot.com) which would be classified as a Web 2.0 tool. It is free, very easy to use and allows me to have complete control over the content. It enables me to interact with other people in that I can link my posts to other blogs and web sites, and readers can network with me and other readers.

Social-networking

A social-networking service or resource is something that facilitates networking for communities of people who share the same interests. The services that immediately come to mind are Facebook (http://www.facebook.com) and MySpace (http://www.facebook.com). New Zealand midwives may be a little more familiar with TradeMe (http://www.trademe.co.nz) which primarily is an auction site but also has a strong community based around it.

Learning, not the tools

A number of things have recently made me stop and think about the way I write this column, or rather what I write about. People who know me, know that I am passionate about the opportunities the Internet and social networking provides for learning and development. There is nothing I love more than to be able to pass on my experience of the latest Web 2.0 tools such as blogs and wikis (Stewart, 2007). But despite evidence that health professionals are becoming more competent and knowledgeable with computer skills (Hegney et al, 2007), it has been my personal experience that there is a lack of understanding of basic online tools and resources amongst many people. Indeed, this has become a strong theme amongst teachers and academics who study the Internet (Martin, 2008). So, rather than harping on about fancy websites that probably will be of no use at all, it is 'back to basics' for this edition's column keeping in mind that it's not about the tools but about the learning (Helfant, 2008).



Firefox

(http://www.mozilla.com/en-US/firefox)

The first thing to think about is what Internet browser to use, such as Internet Explorer and Netscape. Your browser is the door to the Internet. How easy it is to walk through the door will depend on the functions of the browser. The vast majority of the geeks I have spoken to over the years have recommended Firefox. Firefox can be downloaded free of charge from the web site above. I much prefer Firefox to Internet Explorer because it is quicker and easier to navigate the Internet because it uses tabbed browsing so you can open lots of pages at the same time in just one window. For those who are a little adventurous, Firefox provides lots of extra little programs (Addons) you can add, which enhances the experience of using the Internet such as Stumbleupon (http://www.stumbleupon.com) which is a 'my favorites' or bookmarking service.

The joys of Google

To many, 'Google' is purely the name for an Internet search engine. As soon as you want to know about a topic, you go and 'google' it. But Google is much more than that - it is a service that offers you a number of options that helps you organize your life. Have a look above the Google Search button and you will find a list of all the tools that Google offers.

iGoogle (http://www.google.com/ig)

To get the best out of Google, I would suggest you first get a Google homepage. iGoogle is like base camp at the bottom of Mount Everest where you have all the tools and resources to manage the expedition up the mountain. iGoogle can be customized to include all your favorite gadgets such as gmail, date and time, weather, news headlines, alerts and so.

Gmail (http://mail.google.com)

The next thing is to get a Gmail account although you may ask what the point is in having yet another email account. The reason is that it fits in with the other Google applications and makes your whole Internet management system run seamlessly. Gmail also has an instant chat facility like Windows Messenger, so you do not have to open up yet another program for instant messaging. I find it runs really well and has an excellent spam filter. My only complaint is I cannot seem to organize my inbox into a folder system but that may be because I haven't read the 'help' section properly.



Google Reader (http://www.google.

The other tool I could not do without is Google Reader, which is a RSS (Really Simple Syndication) feed. In other words, by joining up to Google reader I can monitor all the latest updates of my favorite websites and blogs. So every time the BBC updates its web site (http:// news.bbc.co.uk) with a new news item, I get a notification in Google Reader. That saves me going to the BBC web site all the time to check what is in the headlines. To find out more, have a look at the video 'RSS in Plain English' by CommonCraft on YouTube

(http://www.youtube.com).

Google Alerts (http://www.google.com/ alerts)

Google Alerts is an alert service that emails you whenever a subject that you wish to monitor is

found in a Google search. The alert is customized according to what topic you want to find, where you want to find information and how often you want to receive the emails. I have several alerts that search blogs for topics pertaining to 'midwifery', 'midwife' and 'midwifery education' which are sent to me every day. This allows me to see what is being written in blogs about midwifery, which in turns increases my learning opportunities.

These are just a few features of Google that I find useful. Also check out Google Documents, Google Scholar and Calendar.

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LETTER TO THE EDITOR

The NZ experiences of a UK-trained midwife Suggestions for supporting and promoting safe practice for immigrant midwives

Since arriving in NZ last year to an employed LMC role, I've had a very busy time, one full of changes and challenges: familiarizing myself with a new job and midwifery model, meeting DHB requirements, completing huge learning packages for the midwifery council, organizing re-certification evidence and meeting the study requirements, preparing for MSR, and the plethora of tasks associated with settling myself and young family into a new country. It has been overwhelming at times and I have often wondered why I've thrown myself so far out of my comfort zone.

Of course, I chose to come here, mainly out of respect for the NZ midwifery profession. So many aspects of the maternity system are really positive, particularly for the families who receive midwifery care. Midwifery colleagues are extremely knowledgeable and supportive and the high standards of the study sessions have surpassed my expectations. I am becoming accustomed to this system, though it is a very different model to one that I had been trained for and worked in.

I am surprised and sad to have found one recurrent and very negative theme which has persisted throughout: inadequate professional support. When combined with limited clinical mentorship (I'm not a new graduate, but this is a very different kind of midwifery), the NZ midwifery service has been an unnecessarily scary place. I have found myself missing the supportive UK system of 'Statutory Midwifery Supervision'.

From the very beginning, throughout the application process for registration with the Midwifery Council, guidance was absent. There were no suggestions, for example, on what constituted evidence for meeting the criteria for the competencies. My chief advisor then was an employment agency (many thanks Heidi from Tonix!).

I picked up my caseload within a week of arrival, and have since relied on the goodwill and support of my colleagues to steer me through the midwifery model maze. Initially the DHB requirements were a priority, as were re-certification study days. Support and guidance for preparing for Midwifery Standards Review has been at best, ad hoc, though undoubtedly a brand new concept for any midwife from outside NZ. Equally mystifying even now (and clearly not only to midwives new to NZ), is a full understanding of how to demonstrate the re-certification competencies.

A greater comprehension of the NZ midwifery model came with the Council's learning packages that overseas midwives are required to complete within 18 months of beginning to practice. These incorporate pharmacology and prescribing, the NZ maternity system, the legal framework, cultural safety and the Waitangi Treaty. They took hours and hours to complete but were wholly necessary to provide exactly the kind of background knowledge needed to practice safely within the wider midwifery culture. Yet I was already practising within that context. I feel fortunate now, that my early lack of knowledge about the maternity system, including the legal framework, did not land me in deep water.

The following suggestions would have made my integration into the NZ midwifery system more satisfactory from all counts:

- An information pack incorporating some of the information in the 'Legal, Professional and Cultural Environment for New Zealand Midwives' learning package before leaving my country of origin.
- The allocation of a personal support person within the Council (or appointed to that role from within DHBs) to provide guidance through the process of meeting the Council's requirements for registration and general advice about practising as a midwife in NZ (including MSR).
- For employed midwives, a recognized and structured induction period during which individual requirements are established with a mentor, a personal plan tailored and evaluated, and time allocated for private study to complete the 'Legal, Professional and Cultural Environment for New Zealand Midwives' learning package before starting to practice.
- A 'settling in' period of time before MSR requirements are applied (with support and monitoring by the mentor during this time).
- Recognition of limited neonatal examination skills. I have never been trained to undertake full neonatal examinations, yet I am expected to embrace it as part of my role without having been assessed to be competent.

NZ has high expectations of its midwives. Those who haven't trained here or who are new to its maternity model may well find themselves in a system very different to the one they left. The absence of professional support in the early months leaves them vulnerable, both clinically and legally, and has the unwitting potential to contribute to sub-optimal care.

Insufficient national midwife numbers over the last few years have meant that immigrant midwives have been actively sought and now make up a significant part of the workforce.

The NZ midwifery system has focused on the provision of a high quality service for the childbearing women of this country. If it is to continue relying on midwives from outside NZ to safely deliver this level of service, it must find ways of supporting them to comprehend and internalize its unique model of care.

Silke Powell Caseload Midwife for the Nelson Marlborough DHB

Response from Midwifery Council

Thank you for the opportunity to respond to Silke Powell's letter in which she describes her experience as an overseas qualified midwife coming to practise in New Zealand.

The Midwifery Council acknowledges that coming to a new country and maternity service with different regulatory processes is challenging for midwives. Council believes that professional support is crucial. To that end overseas qualified midwives are required to indicate where they are working when they apply for their practising certificate so we can ensure they have support either through DHB or group practice until the further education designed to familiarise them with midwifery in New Zealand has been completed. Council does not believe that support should be dictated, rather applied to individual need.

Council acknowledges that midwives who have arrived in recent years are coming into a new environment in terms of recertification and that there are varying levels of familiarity with and understanding of the Recertification Programme amongst all midwives in New Zealand. Council expects that by the end of the next three year cycle it will be part of every midwife's professional expectations.

Council appreciates Silke Powell's feedback that the education requirements for overseas midwives are useful. While some midwives do access these courses from the UK before they arrive, that is an individual choice rather than a stipulation made by Council. Council wishes to facilitate midwives coming to New Zealand without setting too many barriers. We acknowledge also her feedback about lack of training in neonate examination; similar feedback has also been received from elsewhere.

Council is considering how it may work with DHBs to more fully understand Council's registration processes and to enable DHBs to provide more effective support to overseas midwives in their employment. We are also reviewing the pre-registration information given to overseas qualified midwives to make sure it is as clear as it can be.

Council is also undertaking collaborative research with Christchurch Polytechnic and Institute of Technology looking at the experiences of midwives from the United Kingdom as they enter practise in New Zealand. Council anticipates that it may make changes to policy and/or process as a result once this research is completed.

Yours sincerely, Susan Yorke, Registrar, Midwifery Council susan@midwiferycouncil.org.nz



Guidelines for Contributors to the New Zealand College of Midwives Journals

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

Articles should be written with double spacing and a left margin of 3 cm. Authors should use section headings and label any diagrams or tables which are included. Diagrams, tables or photographs should be supplied as computer generated items. The word count for the article should be stated. Articles should be supplied as an electronic copy in a WORD document or RTF file. All articles should have an abstract of 100 words maximum.

In addition, authors are requested to provide the following details on a separate file which is not sent to the reviewers. Name, occupation (current area of practice/expertise), qualifications, address for correspondence during the review process including day time phone number, contact details such as email address which can be published if the journal accepts the article. Where the article is co-authored, these details should be provided for all authors. ALL authors of the article should state in an accompanying letter that they wish to submit it for publication.

Submission

Articles should be submitted electronically via email to joan.skinner@vuw.ac.nz

Content

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 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 and Finn, 2001)" can be used. Where there are more than 6 authors then "et al." can be used throughout.

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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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Contacts for the Editor:

NZCOM Journal Editor: Dr Joan Skinner Senior Lecturer Graduate School of Nursing, Midwifery and Health Victoria University of Wellington PO Box 600 Wellington Email: joan.skinner@vuw.ac.nz Phone: 64-04-4636654

Reference

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

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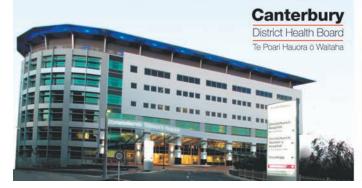
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