

JOURNAL

Being a delivery suite co-ordinator

Informed consent and midwifery practice
in New Zealand: lessons from the Health
and Disability Commissioner

A review of psychosocial predictors of
outcome in labour and childbirth

The vaginal examination during labour:
Is it of benefit or harm?

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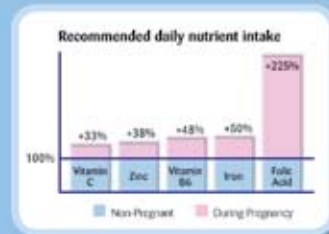
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Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
Provoke discussion of midwifery issues. Support the development and dissemination of New Zealand and international midwifery research.

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The place of research in the quality and safety of midwifery care

Joan Skinner

It is an interesting time for midwives in New Zealand at the moment (isn't it always?) as the Ministry of Health begins to develop and implement a Quality and Safety Programme for Maternity Services. Many of us have recently attended the regional workshops that the Ministry held throughout New Zealand and were able to provide input into what we value and what we are hoping for. It is always great to be keeping an eye out on how we are doing- not only to improve the outcome for the women and the families for whom we care but also to identify what we are doing well, so we can support and promote this. There are lots of ways to do this and the quality and safety programme will hopefully support what we are doing well and improve and integrate the process so we can both be seen to be providing high quality care and to be working on improving it. Another important way we work towards improving the quality and safety of care is to undertake research and to reflect on how we are practising and to share the results of this. The Journal plays an important role in our ability to share our thoughts and findings and thus is a key tool in our 'quality and safety' toolbox. I have been noticing lately how often articles from this journal have been cited by others writing here. It is very gratifying and exciting to

see the growth and dissemination of New Zealand midwifery knowledge, reflecting a real growth in this particular tool for quality.

The growth of the Journal has also necessitated bringing on some more support and I am pleased to be able to tell you that we have now appointed three new sub-editors. Ruth Martis, a midwifery lecturer with Christchurch Polytechnic, Andrea Gilkison midwifery lecturer Auckland University of Technology (AUT) and Jackie Gunn midwifery lecturer and head of school (AUT) have kindly agreed to come on to the Journal team as sub-editors. I welcome them with open arms and thank them for their commitment. Apart from easing my sometimes daunting work load this will also mean that we can focus on really being able to support more of you to get into print to share your research findings and practice reflections. So do feel free to send me your submissions knowing that we will endeavour to get your work 'out there'. I would also like to welcome and acknowledge the work of Rhondda Davies who has made the kind offer of proof reading the Journal before it goes to print. This is always a real challenge so it will be great to have a keen set of eyes to pick up what needs fixing. Thanks to you all.

In this edition of the Journal we have four papers. The first is a piece of midwifery research that looks at the complex and

demanding role of the delivery suite coordinator and how this role is experienced. We also have a practice reflection on the place of the vaginal examination in labour which looks at the careful balancing act we as midwives must undertake as we assess both the benefits and harms of this procedure. We have two articles by non-midwives in this edition. Both have a real interest in aspects of maternity care. One looks at how we as midwives might grow our understanding of how we manage informed consent, a challenging topic. The article examines reports of the Health and Disability Commissioner and helps us learn about what is expected. We also have a review, from a psychologist perspective of the psychosocial factors that are important during the childbirth experience. It is great to see such articles submitted to the journal. As midwives we have a unique characteristic in that we place a high value on the importance of accessing and assessing knowledge from many different perspectives. Along with the knowledge we generate from our own research and reflections, we also value the knowledge we acquire from our own experiences and from those of the women for whom we care. But we also source knowledge from other disciplines such as social science, neuropsychology, epidemiology, bioethics, even architecture, to name just a few. We value and make good use of knowledge diversity. We are in a sense, knowledge synthesisers, able to source and make use of different ways of knowing and understanding. It's great that we are able to acknowledge this role in the Journal, growing our understandings of what is important as we seek to support and extend the quality and safety of the care we provide.

ERRATUM

We would like to apologise for typographical errors made during publication of the paper: Midwives care during the Third Stage of Labour: an analysis of the New Zealand College of Midwives Midwifery Database 2004-2008 by Dixon, L., Fletcher, L., Tracy, S., Guilliland, K., Pairman, S., and Hendry, C. published in the October (2009) edition of the

New Zealand College of Midwives Journal 41 20-26. In the paper Figure 2 was incorrectly formatted and caused errors in the text related to this figure. These errors have been corrected and an updated version of this paper has been placed on the NZCOM website in the Journal publications. Cinahl has also been supplied with a corrected version.

Being a delivery suite co-ordinator

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ABSTRACT

This phenomenological study was conducted to reveal five midwives' experiences of working as coordinator/charge midwives in three tertiary hospital delivery suite settings. The findings reveal the unspoken, taken-for-granted personal experiences of the coordinators. They describe themselves as the 'hub' or the 'pivot' at their workplace. These midwives 'know' the unpredictability of childbirth and the challenge of managing escalating workloads. Their ability to facilitate teamwork and their resilience in the face of seemingly insurmountable obstacles shine through.

However much managers plan staffing and bed ratios, the nature of childbirth – and therefore the intensity of the workload – is unpredictable. Recommendations from this study include consideration of strategic planning by District Health Board's (DHB's) for when the acute clinical needs of women in a delivery suite outweigh the ratio of midwives available to provide care for women. The coordinator midwife needs to be free to utilise her clinical skills 'on the floor' whilst a designated resource person arranges additional staffing cover for the unit.

KEY WORDS:

Midwives, coordinators, clinical skills, teamwork

INTRODUCTION

The tertiary hospital delivery suite coordinator is not only an expert midwife she is also a leader, a broker, a mediator and a peacemaker. Her workplace is one of the focal points within maternity units where midwives, obstetricians, and other staff come together as a team to provide the best care available to mothers and babies. It is in this workplace that the coordinator midwife acts as the 'pivot' or the 'hub' for everyone and everything that happens 'on her watch'. The coordinator offers constancy during the shift, utilising her skills to influence the smooth and safe running of the unit whilst she is in charge.

This paper offers 'a voice' to these experienced midwives through the research findings of a study that explored the meaning of the experiences of hospital delivery suite midwives who work in charge of their shifts. Five coordinator midwives from three North Island tertiary hospital delivery suites were interviewed. The title of 'charge midwife' is used in some hospitals. However to protect anonymity the term 'coordinator' has been used throughout this study.

Readers are introduced to coordinators descriptions of what it feels like being in their leadership roles. One particular story will offer the reader specific insight into the challenges and complexities of the role. While it may appear a startling story of busyness, there were other such stories within the study. Yet still the midwife coordinators were passionate about the role they played and committed to doing their very best to ensure safe practice.

The coordinator is a leader. She is always 'on the floor'; forever present and accessible to everyone. She experiences the daily unpredictability of childbirth as she encounters the "unknownness of the darkness" (Smythe, 2000, p19) of childbirth whilst working both 'with time' and 'against time' as events unfold, sometimes at breathtaking speed. She reveals her 'need to know' what is happening when she is in charge and how she gains that information in order to achieve a 'helicopter view' of

the happenings during her shift so she can anticipate and forward plan (Draycott, Winter, Croft & Barnfield, 2006).

BACKGROUND

There are daily pressures on hospital midwives whose work situations are influenced by the current worldwide shortage of midwives. At the time this study was conducted New Zealand statistics revealed a national midwifery workforce shortage and an increasing national birth rate (Department of Labour, 2006; Ministry of Health, 2006; 2008a; 2008b). The majority of women give birth normally. However the increasing medical, technological and pharmaceutical advances in reproductive health impact on the provision of midwifery care in tertiary hospital settings. Midwives are caring for women requiring increasingly complex care with a small but increasing minority of women becoming critically ill (Billington & Stevenson, 2007). Skinner (2005) writes that "the midwife becomes a mediator between the woman's risk framework, her cultural position and that of the dominant value system, the technological approach" and goes on to observe "the authoritative knowledge stands with obstetrics" (p.273). The coordinator midwives in this study revealed their ability to mediate between lifeworlds and strived to maintain a midwifery focus in their daily work as they worked with colleagues. The challenges of increasing birth numbers and increasing complexity in a tertiary hospital setting, without necessarily an increase in staff numbers, impact on the role of coordinating a delivery suite and create hidden emotional work for coordinators.

Midwifery is a caring profession. The partnership philosophy of care, that of being 'with women' lies at the heart of the professional standards for practice for New Zealand midwives (Guilliland & Pairman, 1994; New Zealand College of Midwives Inc, 2005). Hunter (2004) identifies the difficulties for some hospital midwives who adopt a 'with woman' style of practice which can result in an emotional struggle for the midwife. Skinner (2005) questions whether hospital

midwives become focused on “the demands of the institution”, rather than on the woman (p.261). Similarly, Hunter (2005) describes the reality for midwives in her study who worked in a way that ensured the needs of the institution were met by deployment of workers and resources, in order to facilitate the efficient “passage of women and babies through the maternity care system” (p.257). Organisational constraints which impinge on midwifery work are reinforced by Walsh (2007) who identifies factors including the pressures of time, institutional constraints, regulations and bureaucratic power differentials both between professional groups, and also between professionals and women within the hospital system. The coordinator midwife thus holds the tension of preserving a midwifery philosophy of care amidst a system that demands efficiency.

Within this work environment where there is uncertainty and risk, positive relationships and effective communication are vital. Hierarchical issues exist in the delivery suite setting and “any particular decision may be the subject of dispute, negotiation and occasionally pulling of rank” (Lankshear, Ettorre & Mason, 2005, p.374). Isa et al., (2002) offer an example of the responsibility and confidence required when a midwife challenges a consultant’s decision. They explain that “it takes one with a strong sense of confidence in her own practice and decision making ability, and to be absolutely within boundaries of safety. It would take only one mistake to undo years of gain and we are always very aware of that, consequently we must be certain of our decision making” (p.26). As a result, a midwife with less experience and confidence is less likely to voice her opinion (Timmins & McCabe, 2004). The issues of communication that surround decision making during her shift are a daily challenge for the coordinator midwife.

Management of emergency situations is a regular part of a hospital midwife’s professional working life. Thompson (2003) describes the negative impact of emergency situations when “caregivers spend the majority of their focus on the people directly involved and impacted by the incident and fail to pay attention to their own needs” (p.1). There is literature which describes support available for midwives (E.A.P., 2009; Smythe & Young, 2008; Weil, 2008). However, Deery (2005) writes there is minimal research which addresses how to alleviate the burnout and stress which exists within the midwifery profession. Coordinator midwives require resilience to stay working in such an environment.

Midwifery practice encapsulates “skilled knowledge” and “emotional intelligence” (Byrom & Downe, 2008, p.4). The hospital delivery suite is an environment where emotions run high and as Davies (2007) poignantly writes “you bear witness not only to the baby’s emergence but to the emergence of the mother, father and family” (p.45). Amidst all the challenges of working as a coordinator midwife is the huge significance of the experience of birth for each family on her shift.

RESEARCH DESIGN

The findings reported in this article are from a study which used an interpretive phenomenological, hermeneutic approach guided by van Manen (1990). Van Manen writes that phenomenology “attempts to explicate the meanings as we live them in our everyday existence, our lifeworld” (1990, p.11). Phenomenology does not seek to generalise meanings, rather it reveals the life experiences of those interviewed and seeks to articulate the

They were encouraged to tell stories of their everyday experiences. Interviews were initially transcribed then crafted into stories. The original transcriptions and stories were returned to participants which gave them the opportunity to change or delete data. One participant deleted portions of stories which she felt could identify her. All data returned were brought together and themes were revealed by delving deeply into the stories through a process of writing and re writing and “moving dialectically between the part and the whole” (Koch, 1996, p.176). This process is termed “phenomenological reduction” (Caelli, 2001, p.276).

Ethical approval for this study was granted by Auckland University of Technology Ethics Committee in February 2008

FINDINGS

Insights from this study are presented firstly as a series of similes that participants used to capture the nature of the role, and then through a story

WITHIN THIS WORK ENVIRONMENT WHERE THERE IS UNCERTAINTY AND RISK, A POSITIVE RELATIONSHIP AND EFFECTIVE COMMUNICATION ARE VITAL

nature of ‘how it is’ to be. Van Manen charges the researcher to choose a study which requires commitment and interest and this means the researcher inevitably holds pre conceived ideas about the phenomenon. In keeping with his methodology the primary researcher initially had a tape recorded interview with her supervisors, which was transcribed. The primary researcher then analyzed and interpreted her beliefs in order to address and be mindful of her assumptions before she commenced participant interviews. Throughout the study, a reflective journal was maintained by the primary researcher to stay focused and true to the methodology.

Participants from three North Island tertiary hospital delivery suites were recruited using purposive sampling. As phenomenology requires detailed descriptions from a small number of participants, five coordinators who offered a large volume of experiences were interviewed once, with the interviews ranging from 60-90 minutes. Each was assigned a pseudonym.

that reveals the busyness that can arise within the birthing environment.

‘BEING’ A COORDINATOR MIDWIFE IS LIKE:

For the participants in the study being a coordinator midwife is an experience of complexity in a context that is ever changing. New admissions can arrive at any time. Emergencies, threatening the life of mother and baby, happen. There is often not enough staff to meet the demands. It is this uncertain, potentially chaotic set of circumstances that the coordinator is challenged with while managing her shift. The coordinators described in a variety of ways what the experience is like:

Being ‘the Hub’

Being the coordinator feels as though I am the hub and I am in the centre of a circle with the multidisciplinary team who surround me each doing their jobs.

By coordinating I am giving directions and receiving directions. Directions travel in and out of the circle. I am at the interface when directions come into the circle and as a coordinator I send directions out. It is a constant in out interplay of communication with colleagues about a variety of topics ranging from clear instructions to practice directives to positive reinforcement. The coordinator is constantly in the middle of everything that is going on (Irene).

As the coordinator, Irene is pivotal to the smooth and safe running of the delivery suite during her shift. There is a sense of fluidity in her work and of weaving threads together to make things whole. Effective communication skills are the basis of her management style. Her ability to listen and respond appropriately shines through in her descriptions of working with colleagues. She gives and she receives with no sense of a power play conveyed in her interview.

'Being the pivot'

Alice speaks about 'being the pivot':

You try to make the system work and I think you are a very pivotal person in that respect. I was saying the other day "what do I really like about my job?" because I do nothing but moan about it. I like being a pivotal person that things happen around; I get a buzz out of that I suppose.

There is almost a sense of love/hate feelings for her job such are the swings of emotions for Alice. She identifies her work as 'people management' in what is often a stressful environment. At the same time, she is the professional who is central to everything happening in the delivery suite, which is exhilarating and stimulating for her.

'Feeling the peck, peck, peck'

Alice continues:

There's the phone, and then people at you the entire time, peck, peck, peck of being the pivot. Some days it's fine but when you're busy it becomes hard to deal with and gets frustrating especially when it's not necessary.

How Alice reacts to people and situations is critical to the smooth running of the shift and ultimately reflects on safe care for mothers and babies. Her description of being 'pecked' is effective and conjures up an unpleasant sense of being worn down by the persistency of people, each with their own agenda. However there is also a sense that this is an integral part of her role and something she has to manage. It is

how Alice reacts to this persistent pecking and sustains herself that reveals her leadership skills as a coordinator.

'Solving the puzzle'

Sally uses a different analogy for describing her work:

I like coordinating because I enjoy being in control and seeing all the mess come together. I enjoy having a great big puzzle that I can fix and bringing everything together at the end of a shift, then knowing it all came together really well. Where I work, the difficulty is the staffing shortages and when the puzzle just doesn't fit together.

Sally enjoys being in charge, being "in control" and being a decision maker. This is not 'just' a puzzle; rather it is "a great big puzzle". Fixing a puzzle takes resoluteness, patience, determination and persistency. It is only at the end of her shift that she is able to reflect and feel the satisfaction of fixing the puzzle, in the knowledge her achievements directly relate to safe practice for staff and safe delivery of care for clients. These puzzles are not easy and sometimes the pieces are not all there; she does not complain, rather she reflects on the 'difficulty' she faces when the puzzle does not fit. Something that is difficult to fix is not necessarily impossible and that is her enjoyment factor.

Experiencing 'the plop, plop, plop of a good day'

Within the phenomenon of lived space for coordinators, Alice describes how it feels on a good day:

A good day is when you've come away feeling good. When there have been lots of deliveries, they've all been normal, there's been lots of midwife led deliveries around the place and it's all just been straight forward, plop, plop, plop and the midwives are all happy because they've had nice midwifery care. It's not been too busy so everyone's had a chance to sit in the coffee room and have a laugh and a cup of tea which is important. When things have flowed, there have been lots of normal deliveries and nothing bad has happened or if it has, if there has been an emergency, it's been dealt with well; that's a good day.

Everybody needs good days. In tertiary delivery suites every day is unpredictable. Irene spoke about the need to look at the positives and here, Alice describes the positives that help to make her and her staff feel good. Her description of good days is when there is normal birthing with

a sense evoked that babies have just 'fallen out' with ease in her workplace where women often require intervention and assistance for birthing.

Jane offers a story when she has time to sit and discuss forward planning with a registrar and anaesthetist about the care of a woman with complications with the 'luxury of time to discuss things' and reflects:

It was good because we had a three way discussion about how it was going to be safest for the woman. It was nice to have the time to know that the three of us, each with a different focus could sit down and talk about what could be the best outcome.

The unhurriedness of the shift gave Jane the gift of time to focus on collaborative planning; this was a luxury rather than the norm for her and something to be valued. Like Alice, her 'good day' is also when there is no sense of time constraint, with time 'flowing' rather than 'racing', where midwives and colleagues have time for each other, where there is nurturing, caring, teamwork and fluidity in the day and an absence of undue tension.

In the Eye of the Storm

Coordinators know they are working in a high risk environment with the unexpected often revealing itself with no warning. Storms are unavoidable parts of life experiences to which we each react differently. Irene remarks:

It makes me think about a movie I once saw about a storm. Part of me always remains in the centre of the storm even though there may be times when I am weaving in and out of the storm with everybody around me moving too.

Irene's analogy fits well as she describes partly being centred in 'the storm' but in reality, never still as she multi tasks and moves in time to the rhythm of the happenings of the unit and the colleagues she works with. Smythe and Norton (2007) write "thinking leaders live a back-and-forthing, drawn to lead and pulled back to follow, to being with and then to being alone, prompted to act and cautioned to wait" (p.76). Irene has no control over what 'is' or what 'may be', rather she is a player in life's events as they unfold in her workplace.

A PARTICULAR SHIFT

All of the experiences described above come together as parts of the whole in Jane's story. Her story was chosen because it reveals her

level of multi tasking, her skill base and the 'knowing' she utilised to manage the challenges that confronted her that shift. Midwives know the unpredictability of childbirth. Just as they experience quiet shifts, so they experience relentlessly unexpectedly busy shifts which stretch them to their limits. This is the nature of tertiary hospital childbirth. This is a dramatic story, a day remembered because it was so busy and so taxing, similar to those described by other participants. It is included not to argue "this is how it always is" but rather as a reminder that this is how it can be. It is offered to encourage thinking as to the kind of strategies that could be put in place to address such situations:

On Sunday it was a twelve hour night shift, staff sickness on the antenatal floor, post natal was busy, and delivery suite staff had sickness. There were two off sick, so it's the situation of how many inpatients have they got in the ward and who I can pinch to cover. I had four midwives plus a registered nurse on delivery suite which was a luxury. But, we ended up with all admissions being previous caesars (sic) with their midwives not accompanying them.

I ended up coordinating, three midwives 'specialising' women in labour, one on synto (sic), one with an epidural and one with synto and an epidural, and I cared for a twenty nine weeker with placenta praevia.

So I had a patient load as well as coordinating and ensuring safe staffing for the night for the block. Once it was sorted out you start thinking 'I hope nothing comes in overnight because I don't have anybody else to give'. Then of course an LMC [Lead Maternity Carer] wanted to hand over at around 4am for an epidural for her client. I didn't have anyone and had to say "you are going to have to explore other choices for your client because an epidural is not a choice".

Then my client started to bleed, with the complete praevia at 29 weeks. Is she going to come unstuck, bleed and then deliver? Where is the best place for her to be delivered? So I am working through these scenarios with the registrar and anaesthetist as to what is safe for the woman.

By 6am just when we thought we had got through the night quite well one woman had to go for a Caesar(sic) which was okay because she already had a midwife and our RN[Registered Nurse] would scrub. But at the same time, the woman who couldn't have the epidural started pushing and continued for quite some time. An LMC rang to say she had a lady coming in who was going quite fast. The woman was fully dilated and pushing on the doorstep when

she arrived, so I cared for her because the LMC hadn't arrived.

Amongst this I was worried about my placenta praevia client who was bleeding. I hadn't checked on her or the baby's wellbeing because I was busy with the lady who was trying to push her baby out. None of the other three midwives had had a break all night because I had my own patient load and I couldn't relieve them. They were entitled to breaks but didn't get them.

By 6.30 am everything fell apart. The registrar had completed the caesar, the LMC's client who had been pushing needed assistance and I agreed so the registrar went in there and ventoused that baby. Unfortunately there was no paediatric support for an instrumental delivery so that was me again. Fortunately I had asked the anaesthetist to stay around. Just as well because the baby came out rather flat and took a couple of minutes to pick up, so we got the newborn unit down to assist. Just as I had the nurse practitioner from the newborn unit and the anaesthetist helping me with that baby, the LMC had arrived for her client who was fully dilated and pushing by that stage. She double belled from her room so I left the anaesthetist and NNP [Neonatal Nurse Practitioner] with the baby, and jumped into that room. The woman had quite a major tear, so she was rushed straight down to theatre. Then the day staff arrived and said "We're ready for a handover, do you think you could come?" "Yeah, sure I'll find time".

When I have enough staff to cope with everything I enjoy coordinating. The times I don't enjoy it is when you know there is absolutely nothing, nothing, nothing left and if one more thing comes through the door it would tip you over the edge. I just hate those times because I'm really frightened that something awful is going to happen because there is no one, absolutely no one to care for the woman.

Jane's story reveals the busyness and the complexities of coordinating on delivery suite. Her decision making and her prioritisation is based on her knowledge and experience. Her first task when she starts her shift is to know the staffing situation of the entire unit and the skill mix. Despite the busyness of the unit she has the added challenge of having to provide midwifery care for a woman in a high risk situation.

Jane's decision making reveals her 'knowing' that there is huge uncertainty with women in labour and that she always needs to be prepared to manage the unexpected. She knows what might happen, she will never know everything that could happen, however Jane reveals in her story that she is continually thinking ahead.

The LMC has the right to hand over care just as her client has the right to an epidural but neither are realities on this shift. Jane knows this and has to manage this reality the best way she can in trying circumstances. Jane knows the consequences of torrential haemorrhage with a placenta praevia and reveals her team approach to forward planning the 'what if's'. She knows she has no option but to care for the woman who has arrived on delivery suite in the second stage of labour and is actively pushing. She knows she should be checking on her own client but staffing shortages make this impossible. She knows no one has had breaks all night which impacts on safe practice but there is nothing she can do about this. The pace remains frenetic. It is her knowledge base, based on her experience as a coordinator, which helps her anticipate potential problems. She is ready to resuscitate the baby who has birthed by ventouse, she recognises the need for assistance from the newborn unit and she responds to the postpartum haemorrhage situation by transferring the woman to theatre at speed.

Jane is working in the midst of great complexity. She knows her limitations and reveals her fears of the 'what ifs' of her job. She has no control over the unexpected; all she can do is respond and utilise her knowledge to make the situation as safe as possible under the circumstances. Heidegger (1927/1962) writes of thrownness, where one is thrown into a world where one must respond, with all the understanding of how the situation could get even worse, and all the anticipation of possibilities still unrevealed. One struggles to manage the unknown, especially when there are no extra resources to employ. When one is stretched beyond capacity one deals with what 'is', responding to the most urgent, yet always knowing an unsafe situation may be unfolding with no one there to see.

Coordinator midwives are all too familiar with the unsafe situations they and their colleagues can find themselves in. It is nobody's fault. Nobody could have predicted such a busy shift with so many at risk situations. Everybody does their very best, often under stress and exhaustion. On most occasions enough safety is maintained to get through, but the fear remains. Yet, there is always the potential that the coordinator finds herself in a situation stretched beyond what she knows is safe care. Such is the nature of the work.

The midwives in this study were all very aware of the huge responsibility they carried, and their commitment to the birthing women. Irene sums up her sense of 'being' a coordinator midwife where despite the busyness of the delivery suite environment, her focus remains on the woman 'who has to carry the canvas of her experiences'. She sums up her pivotal role when she remarks:

I am not 'just' a midwife. I am a midwife and that is my expertise.....my midwifery is inside me and if I don't bring it out it will be invisible; I practise by example.

Being a midwife is about supporting women and families to have safe, empowering birthing experiences. However frenetically busy or luxuriously quiet the delivery suite may be, the strength of these coordinator midwives lies in their commitment to work with their midwifery, medical, and nursing colleagues to achieve that aim.

DISCUSSION

This study reveals the ability of the five delivery suite coordinators to work alongside people, to work ahead of time and to project themselves into worlds of unknown possibilities over which they may have little or no control. There exists an underlying level of excitement, adrenaline rush, 'buzz' and sense of achievement in their experiences and how they manage their shifts.

These women have the fortitude to manage 'what is', their emotions of stress and angst disguised as they maintain a professional demeanour. They return to work shift after shift with extraordinary commitment to a job which poses immeasurable challenges. They are seen to be 'doing', 'directing' and 'facilitating' to get things done, always with the safety of the woman and baby paramount. They seem to have the ability to cherish the good times when all goes well yet also be anticipatory of situations which offer no forewarning.

The challenges for coordinators include staffing shortages and skill mix anomalies in their workplaces. Further, the nature of childbirth means that however prepared they may be, there is always the potential for the unexpected to present itself and for them to be stretched to their limits or beyond; this is the nature of being a coordinator.

Within this study, coordinators offered little insight into how they manage the relentlessness of working under such conditions and more questions than answers emerge. Is their work sustainable long term? Do coordinator midwives possess resilient personalities? What and who are their support systems? Do they need or want professional support as a result of their experiences?

RECOMMENDATIONS AND CONCLUSION

Experiences of coordinator midwives working in tertiary hospital delivery suite settings have not been previously studied. This study reveals the pivotal role coordinators play when faced with a rising national birth rate, a high

technology work environment, increasing complexity of provision of care required by women with co-morbidities, staffing shortages, skill mix challenges, managing 'what is' and the unpredictability of 'what may be'.

It is the unpredictable nature of the delivery suite workload that presents challenge. Even the most competent practitioners cannot maintain safe care in situations when there is not enough staff to 'be there' in every situation that demands close watchful attention. There is no way of predicting workload in terms of numbers or complexity for any given shift. Coordinators need a mechanism whereby they can send a message that extra midwives are needed 'now' to someone not responsible for the ongoing clinical management of the unit, yet able to make that 'happen'. The unpredictability of workload needs to be addressed with strategies that are immediately responsive to meet the required standards of safe care.

Finally, research is required on the resilience of coordinator midwives, the skills required to undertake the role, the support needed to maintain it and the sustainability of their role long term. Consideration of access to professional support for coordinators is required as part of coordinator midwives' employment contracts.

Being a midwife is the springboard from which these women leap. Van Manen (1990) writes that it is our sense of purpose in life which sustains us. It is my hope that this study offers coordinator midwives 'a voice' and will lead to an increased awareness and understanding of their work experiences which in turn will foster strategies to maintain safe staffing levels, ensure staff development, appropriate remuneration and give attention to coordinators' personal wellbeing. A profoundly rich 'heart and soul' of midwifery and a true intent to offer the best and safest of care to mothers and babies shone throughout this study in spite of the numerous and often daunting challenges the coordinators encountered.

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Informed consent and midwifery practice in New Zealand: lessons from the Health and Disability Commissioner

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ABSTRACT

Informed consent appears to be a challenging and sometimes problematic area of practice for midwives. It is not always clear, for example, what amount of information is required to be supplied to women to ensure fully informed consent. Similarly it is unclear whether midwives can provide unbiased information, and what midwives' communication responsibilities are when other health care providers become involved in care and treatment decisions. This paper examines the Code of Health and Disability Services Consumers Rights and selected Commissioner's opinions which consider potential breaches of the Code in relation to informed consent. Case analysis demonstrates how the principles relating to informed consent are applied in the midwifery context, and examines how the Commissioner's opinions can offer practical guidance to midwives.

KEY WORDS:

Informed consent, autonomy, midwifery, Code of Health and Disability Services Consumers' Rights.

INTRODUCTION

This paper examines how New Zealand's Code of Health and Disability Services Consumers'

Rights (the Code) may guide midwives in the challenging area of informed consent. Firstly, a search of the literature highlights potential barriers to informed consent in midwifery practice. A background to the Code is then provided and the Rights relating to informed consent are considered. This includes an examination of selected cases which show how the Health and Disability Commissioner (the Commissioner) applies the principles relating to informed consent to possible breaches of the Code in the midwifery context and how the Commissioner's opinions might inform practice. This paper concludes by evaluating what can be learnt from the Commissioner's investigations.

AUTONOMY AND INFORMED CONSENT

In the current consumer focussed health care environment, there is an ethical obligation for midwives to facilitate the autonomous choices of mothers. As Mill famously declared in 1861, autonomy is the right of individuals to self-determination 'over himself, over his own body and mind, the individual is sovereign' (Mill, 1972, p. 78). For a choice to be autonomous, it must be intentional, made with understanding, without controlling influences and be made voluntarily (Beauchamp & Childress, 2001, p. 59). This highly prized ethical principle finds expression through the competencies for entry to the Register of Midwives. It is also embedded in the New Zealand College of Midwives (NZCOM) Code of Ethics, and is given legal weight through the Code of Rights. Registered midwives must respect and support the needs of women to be self determining, provide up to date information and support women's informed decision making (Competencies 1.7 and 1.10, Midwifery Council for New Zealand [N.D]). Midwives must accept the right of women to control their pregnancy and

birthing and must uphold a woman's right to free, informed choice and consent throughout her childbirth experience, while accepting that women are responsible for the decisions they make (NZ College of Midwives, N.D.). While all ten rights in the Code relate to facilitating a client's autonomous decision, Rights 5, 6 and 7 specifically address effective communication, access to information and informed consent.

BARRIERS TO INFORMED CONSENT IN MIDWIFERY PRACTICE

Despite this emphasis on women's autonomous decision making rights in professional guidelines and in the law, the proportion of midwifery complaints investigated by the Commissioner - which relate directly to informed consent - suggest that this area of practice may be one of the most problematic. While the number of complaints was very low overall, of the 41 opinions published by the Commissioner relating to complaints about midwifery practice received after 2000, 21 investigated potential breaches of the rights relating to informed consent (www.hdc.org.nz as at 26.8.09). The 2008 Midwifery Council report also highlights a lack of informed consent and communication with clients as two of the themes from the 35 complaints they received that year about professional conduct (Midwifery Council of New Zealand, 2008, p. 25).

A search of the international midwifery literature highlights the difficulties in this area of practice. Skirton & Barr (2007) conducted a systematic review of the literature on antenatal screening and informed choice in the United Kingdom. Their main finding was that there was a danger that parents and professionals regarded screening tests as routine and therefore not requiring a decision. Additionally,

midwives were not always sufficiently prepared in terms of their knowledge, skills or attitudes to offer screening in ways that facilitated informed choice for parents. More recently Skirton and Barr (2009) surveyed both parents and midwives and found that although parents wished to have information about screening at an early stage, many parents did not perceive their second trimester scan as a method of antenatal screening. Also, midwives lacked accurate knowledge about screening and the conditions for which it is offered.

In his discussion about the roles of midwives and obstetricians in informed consent in the modern era, Longmore (2004) questioned the value of antenatal education, suggesting that 'informed compliance' may be a more realistic outcome than informed choice or informed consent because of the way information is promoted. He challenged whether the information given in prenatal education is non-biased. Using the example of the risks of pelvic injury from vaginal delivery, he asked: "Are women ever informed of these risks?" (Longmore, 2004, p. 7). Longmore raised other important issues about when information is delivered and who is responsible for giving information to enable informed consent. He asks if medical professionals can assume that women already have information from other sources (i.e. through antenatal education) and whether fully informed consent is possible when a woman is in labour.

When investigating the influences on decision making about induction of labour in New Zealand, Austin & Benn (2006) echo concerns about the lack of consensus on what constitutes informed consent. This seems justified given their research findings. In their New Zealand study they interviewed 74 Lead Maternity Carers (LMCs) and 79 women in the birthing suite prior to an induction of labour and found that the women had limited knowledge about the negative effects of induction and that their participation in decisions to induce labour was minimal. They also found disparities in the reasons cited for induction between women, the LMC and consultant obstetricians. Fears of litigation, and even the hospital booking system were influential when decisions were being made to induce labour. These findings raise significant questions about poor communication, professional anxiety and hospital systems as barriers to informed consent.

Other writers add to this list of issues. In considering the challenges for midwives in New Zealand Stewart (2006) identified the following factors that may influence informed consent: contradictory clinical guidelines; the

midwife's bias; fear of litigation; and the power imbalance between patients and midwives. She urged midwives to take into account the quality of the evidence on which they base their practice. Patronising approaches to women (Kitzinger, 2006), the language and terminology used to transmit information (Hunter, 2006) and midwives' perception of risk (Tupara, 2008) have all been implicated in undermining women's autonomous birthing choices. In addition, commonly used methods for sharing information and promoting informed choices, such as leaflets, birth plans and education classes have been identified in the literature as insufficient (Deave & Johnson, 2008; Lothian, 2008; Kitzinger, 2006; Longmore, 2004; Schott, 2003; O'Cathain, Walters, Nicholl, Thomas and Kirkham, 2002; Bradley & Schira, 1995).

There is a paradox that while midwives fear of litigation has been cited as a barrier to informed consent (Stewart, 2006 and Austin & Benn, 2006), problems with inadequate informed consent can themselves become the focus for complaint or litigation. An added tension for midwives is that they have a dual professional responsibility to both the mother and the unborn child. The law in relation to the status of an unborn child in New Zealand has been described as "unpredictable" (Peart, 2006, p. 464), although a fetus does not "generally become a person in the eyes of the law until it is born alive" (ibid., p. 452). This is contentious and further discussion is available elsewhere (see Peart, 2006). A significant body of research demonstrates that women who participate in decision making experience greater satisfaction, reduced labour and postpartum adjustment (Martin, 2008). Although it may be controversial to suggest that women should always have *complete* autonomy over their birthing experiences (see for example Douche's 2009 paper which, using a poststructuralist lens, examines the construction of a 'natural caesarean' where women may elect caesarean regardless of need), in New Zealand, they have legislated rights to effective communication, to be fully informed and to make informed choices.

BACKGROUND TO THE HDC CODE OF RIGHTS

It is now over 20 years since the Cartwright Report investigated poor research practices for women with cervical cancer at National Women's Hospital in Auckland (Cartwright, 1988). The Report highlighted violations of fundamental patients' rights, concluding that clinical freedom, peer supervision and a lack of

RIGHT 1	Right to be Treated with Respect
RIGHT 2	Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation
RIGHT 3	Right to Dignity and Independence
RIGHT 4	Right to Services of an Appropriate Standard
RIGHT 5	Right to Effective Communication
RIGHT 6	Right to be Fully Informed
RIGHT 7	Right to Make an Informed Choice and Give Informed Consent
RIGHT 8	Right to Support
RIGHT 9	Rights in Respect of Teaching or Research
RIGHT 10	Right to Complain

Figure 1: The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

[www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-(full)).

informed consent contributed to poor ethical practices and a failure to deliver acceptable treatment (ibid.). In response to the Report, the Health and Disability Commissioner Act 1994 (the Act) was passed. The Act was also necessary because New Zealand's unique "no fault" accident compensation scheme (ACC) leaves health and disability service users with restricted recourse to the courts and there was no formal complaints mechanism for consumers (Dew & Roorda, 2001). The Act's / Code's purpose is to promote and protect the rights of all health and disability service consumers ensuring fair, simple, and speedy complaint resolution when consumers' rights are infringed (The Health and Disability Commissioner Act, 2004).

The Code was developed by the Commissioner and enacted in 1996. Unlike the Health Practitioners' Competence Assurance Act, which applies only to registered health professionals, the Code applies to "any person or organisation providing, or holding themselves out as providing, a health service to the public or a section of the public whether that service is paid for or not." (www.hdc.org.nz/theact/theact-the-code). It confers ten rights on all consumers of health and disability services in New Zealand and places corresponding obligations on providers of those services (Figure 1).

The Commissioner's role is to investigate any complaint or action that is, or appears to be, in breach of the Code (Section 14 (1) (e) of the Act). Providers of health services are not in breach if they have "taken reasonable actions in

the circumstances” to give effect to the rights and comply with the duties set down in the Code (The HDC Code of Health and Disability Services Consumers’ Rights Regulation 1996). The standard of proof for a finding of a breach of the Code has been described as the balance of probabilities i.e., the Commissioner “must be of the opinion that it is more likely than not that any action that was the subject matter of the investigation was in breach of the Code’ (01HDC02996, p. 36)”.

At first glance the rights themselves appear to offer little help to midwives on the standard required to give them effect. However, closer examination of each right relating to informed consent and relevant cases does provide guidance. As evidence of the Commissioner’s educative role (see Section 14 (1) (c) of the Act), many of the opinions are publicly available on the HDC website (www.hdc.org.nz) and offer learning opportunities regarding the interpretation of informed consent in New Zealand.

RIGHT 5 RIGHT TO EFFECTIVE COMMUNICATION

Right five requires midwives to communicate in a language and manner which their clients can understand and to provide an environment which fosters open, honest and effective communication (see Figure 2). In Case 07HDC14036 the Commissioner investigated a complaint about the appropriateness and adequacy of the care provided to a woman in the later stages of her pregnancy by two midwives and of the information and communication provided by one.

In brief, Mrs A had an uneventful pregnancy. However, 10 days before the estimated due date she was assessed by a locum midwife (Mrs E) who found that Mrs A was in early labour, but the midwife did not check the fetal heart. The next day Mrs A came to hospital, the fetal heart

could not be heard and it was established that the baby had died. Mrs A then elected to proceed with a natural delivery. Part of the complaint Mrs A made concerned communication problems with her LMC midwife (Mrs D), finding her to be idiosyncratic with little rapport and that she was ‘overly focussed on her own problems’. On several occasions during antenatal checks the midwife, Mrs D, communicated these to her patient (including how her uncle had just died and that she had a bad leg) and during one consultation she took five phone calls. Mrs D was present during Mrs A’s labour and birth, during which she made inappropriate, light hearted comments; for example that blood tests would show how much wine Mrs A had been drinking. Mrs D was also unable to communicate under pressure and became very emotional and distressed, crying at times during the delivery and afterwards became overwhelmed. Mrs D did not believe her actions to be unprofessional, ‘but caring and human’, though she did accept that she was not effective in her communications with Mrs A or her family.

Independent midwifery advice to the Commissioner suggested that Mrs D would have been facing her own very difficult situation because this was the first intrauterine death she had managed. However, the advisor emphasised that in these situations the focus should remain entirely with the mother. The Commissioner agreed. He found that Mrs D mishandled her communications to the extent that the family lost confidence in her ability to manage the birth and that while midwives may show their emotion, the midwife’s primary focus should be on the needs of the mother. Mrs D’s behaviour constituted a breach of Right 5 (2) by failing to take reasonable steps to provide an environment that enabled effective communication. Mrs D was required to apologise to the parents and reflect on the way her communication style was perceived.

Even though this case was investigated through the lens of Rights 5 (the right to effective communication) and 4 (the right to services of an appropriate standard), it also considered important issues about the ultimate responsibility for the woman’s care as well as the negotiation and transfer of care between LMCs and hospital staff. Problems which may arise in the event of poor communication between mother, LMCs, and specialists have been well documented (Haines, 2009) and may impact on informed consent. The importance of involving the woman, the LMC and the specialist in three way discussions when unexpected events occur was highlighted by the Commissioner.

Case 01HDC05774 offers further guidance regarding the relevance of communication between clinicians in relation to informed consent. Mrs B was found to have received inadequate care when in her 39th week of pregnancy she showed signs of meconium stained liquor. The LMC (Mrs A) had involved a specialist, but difficulties arose around whether the specialist had communicated effectively with the woman about her birth, for example, why he elected to continue with a vaginal delivery and not proceed to a caesarian section. Mrs B said that she was kept ‘completely in the dark about what was happening over the course of her labour’. In considering the midwife’s place in informing the patient about the specialist’s advice, the Commissioner’s advice is unambiguous.

In circumstances where a midwife has consulted a specialist because of his or her expert ability to assess the risks and benefits associated with available options, I do not consider that the midwife has a legal obligation to explain the respective risks and benefits of the options to the consumer or her family... (B)ecause the midwife is not the expert in making that assessment (which is why she seeks specialist advice) and because ultimately it is a medical, not a midwifery decision, I consider that the midwife should not be held accountable in law for a failure to explain the relative risks and benefits.

HDC Case 01HDC05774, P. 10.

However the Commissioner did also emphasise midwives’ responsibility in discussing the involvement of other health professionals and their respective roles with patients. He highlights the LMC’s role in facilitating ongoing 3-way discussions about the management of the labour and the various risks and benefits of recommended options. Further, the Commissioner found that the midwife had an ongoing obligation to ‘take reasonable steps to ensure that she (Mrs B) felt informed and empowered’, ensuring that she was ‘kept in the loop by being a conduit of information from the various health professionals’. In not doing this, the Commissioner found the midwife breached Right 5 by not effectively communicating with her patient or keeping her well informed throughout her labour. This case demonstrates that while the specialist has legal obligations to inform and involve women in clinical decisions, this does not absolve midwives of their ongoing communication responsibilities to ensure that women are sufficiently informed and involved in decisions about all aspects of their care and management.

1	Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
2	Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Figure 2: Right 5, the Right to effective communication

[www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-(full)).

RIGHT 6 RIGHT TO BE FULLY INFORMED

The Code of Rights has been applauded as some of the most enlightened consumer focussed legislation of its kind internationally (Skegg, 1999). In this spirit, the standard of information required to give effect to Right 6 is that which a 'reasonable consumer, in that consumer's circumstances, would expect to receive' (Figure 3). In *Rogers v Whittaker* (Australia, 1992) the 'reasonable patient' standard was used to establish the information a consumer could expect to receive in order to give informed consent to medical treatment. "A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk,

in the circumstances (Skegg, 2006, p.213). Commissioner's decisions demonstrate how the standard has been applied in midwifery cases.

In case 06HDC08238, the Commissioner decided that a woman having a home birth for her first baby was not provided with vital information regarding the slow progress of her labour. Inadequate information prevented her from being involved in important decisions about her care. Specifically, the midwife did not inform the woman that the baby's head had not descended and that birth was therefore not imminent. Thus the midwife breached Right 6 of the Code. The Commissioner also noted that the parents did not seem to be involved in decision making, and, referring to Standard One of the New Zealand College of Midwives

The Commissioner was sympathetic to the realities of the 'flow of information' when labour becomes complicated and clinical decisions are made quickly (p. 48). The obstetric registrar was entitled to expect that a certain amount of information would be given antenatally 'when the environment was more conducive to discussion'. This was done, including the giving of the Ministry of Health booklet. It was agreed that the anaesthetist did explain the risks and side effects of an epidural prior to its insertion. The Commissioner re-emphasised that comprehensive written information about pain relief options should be provided to pregnant women 'well in advance of their expected delivery date' to supplement discussions with the LMC. The Commissioner found 'with some reservations' that the LMC did provide adequate information about pain relief and labour options and therefore did not breach the Code (p. 43).

RIGHT 7 - RIGHT TO MAKE AN INFORMED CHOICE AND GIVE INFORMED CONSENT

The majority of Commissioner's published opinions involving informed consent and midwifery relate to right 6¹ and right 5². Potential breaches of Right 7 have been investigated in relation to obstetricians (see for example case 06HDC12769 which investigated the actions of an obstetrician in managing a ventouse-assisted birth). This is in keeping with the Commissioner's guidance considered so far; that for midwives it does not seem to be the actual gaining of informed consent which is problematic. In the case of medical interventions, this is the responsibility of the specialist. Instead, it is keeping women *fully informed* of all aspects of their ongoing care and management and creating an environment for optimal communication which is a key concern for midwives in relation to informed consent.

Johnson & Keenan, (2010) describe consent not as a single act, but as "a process involving communication between consumer and practitioner in which the practitioner openly and honestly provides full information in an environment, and in a manner, in which the consumer can understand it" (p.88). This process oriented approach to consent has been demonstrated throughout the cases considered here. So while the midwife is not necessarily directly responsible for the actual gaining of consent for specific medical interventions, they have a crucial role in ensuring that there are ongoing processes of communication and information sharing which allow women to

1. 19 cases of those available on the website received after 2000.

2. 2 cases of those available on the website received after 2000.

1	Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including- a) An explanation of his or her condition; and b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and c) Advice of the estimated time within which the services will be provided; and d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and e) Any other information required by legal, professional, ethical, and other relevant standards; and f) The results of tests; and g) The results of procedures.
2	Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
3	Every consumer has the right to honest and accurate answers to questions relating to services, including questions about- a) The identity and qualifications of the provider; and b) The recommendation of the provider; and c) How to obtain an opinion from another provider; and d) The results of the research.
4	Every consumer has the right to receive, on request, a written summary of information provided.

Figure 3: Right 6, the Right to be fully informed

[www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-(full)).

would be likely to attach significance to it" ((1992), cited Kennedy and Grubb, 2000. p. 497). The Code provides additional guidance as to the types and amount of information that a reasonable consumer might expect to receive to ensure they are fully informed (see Figure 3, sections 1. a – g). For example, an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option (1.b.), and the results of tests (1.f.) and procedures (1.g). Despite this guidance, however, it has been acknowledged that when investigating potential breaches of Right 6, the Commissioner has considerable discretion to decide the level of information that a reasonable consumer can expect to receive

Handbook for Practice 2002, stated that 'it is important that a lead maternity carer fully involve the woman in all aspects of her labour and delivery' (06HDC08238, p. 27).

Case 06HDC02099 provides valuable advice about giving information to women about labour and pain relief, particularly epidurals. The case is complex, concerning many different aspects of care received by a couple during the birth of their baby who had dual wrapped nuchal cord and shoulder dystocia. The complainants believed that they were not provided with the necessary information to make informed choices, particularly about pain management options and the risks and benefits of an epidural.

be fully informed and make their own choices throughout their pregnancy and birth.

A key component in this process is documentation by the midwife of discussions and information sharing, including how women wish to proceed with birthing and treatment options. Case HDC05HDC18619 is complex, concerning the care a woman received from a midwife antenatally and during the birth of her baby who was stillborn. It is considered here because of the multiple concerns raised about the midwives' documentation, which was so poor that difficulties arose for the Commissioner to establish exactly what occurred. For example, there was no record that agreement had been reached between the midwife and the mother about how to proceed with the pregnancy and birth, and no documented plan of care. Also, there was evidence that documentation had been amended or added to retrospectively. By doing this, and failing to comprehensively document the woman's care, the Commissioner found that the midwife had failed to comply with her professional obligations. Additionally, the Commissioner made clear the expectations of midwives in documenting all aspects of the informed consent process. "The documentation of a mother's care must be illustrative of clear and specific planning between the mother and midwife of the pregnancy, birth and other associated issues" (05HDC18619, p. 40).

CONCLUSION

The evidence considered in this paper suggests that informed consent is a challenging area of practice for midwives. The Commissioner has emphasised the non-punitive approach of the complaints process with the emphasis instead on learning from complaints (Paterson, 2008). New Zealand's unique consumer focussed legislation and the cases in which complaints have been investigated offer significant guidance for health care practitioners. Having considered a raft of potential barriers and misunderstandings about the expected standards of midwives in relation to informed consent, the Code, and its application in Commissioner's opinions, teach midwives about many aspects of the informed consent process and their obligations in relation to each of the relevant rights. Communication is crucial, particularly when other health professionals join the midwife in the treatment and delivery of care. The reasonable consumer standard provides a guide to the type and amount of information that mother's can expect. Informed consent is not simply permission to proceed with a single aspect of treatment, but an on-going process of communication and information sharing by their midwife so women can make choices about all aspects of their care and management, even when other health professionals are involved.

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A review of psychosocial predictors of outcome in labour and childbirth

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ABSTRACT:

In the following review we synthesise research on psychosocial factors that influence the outcome of labour and childbirth. The review covers psychological factors that have been shown to be important for the actual childbirth experience, namely pain, fear, control, anxiety, confidence and self-efficacy. The review also examines predictors of positive outcomes following birth including social support, expectations, preparation, and continuous support. This body of research informs debate on healthcare system reforms in the future and provides direction for areas of research in the intersection of midwifery practice and psychological theory.

KEY WORDS:

Birth, labour, social support, expectancies, preparation.

INTRODUCTION

This review is an overview of important psychological factors which influence outcomes of pregnancy and childbirth. The authors summarise recent and important research which is intended to provide an overview for midwives. It is our contention that despite significant medical advances (e.g. pain relief), psychological factors play a major part in a woman's experiences at this time. Importantly for midwives these factors are all potentially modifiable so through increased knowledge, advances in service can be made. New Zealand is well suited for integrating these practices due to the system of midwifery lead maternity care. Some factors in this review, such as the benefits of continuous support, will be well known and others may be new. Therefore practitioners can support ideas and practices already held and possibly integrate new approaches.

Note on method: Key terms were used in searches on Google Scholar, Ovid and Medline; reference lists and subsequent citations of identified articles were also examined. Articles included in the review were either latest knowledge or important works, with the intention of providing a broad overview to inform practitioners and highlight future research directions.

SATISFACTION WITH THE BIRTHING EXPERIENCE

Giving birth is a landmark experience in any woman's life. One of the factors that either inhibit or facilitate a woman's efforts to develop a sense of herself as a capable mother is her degree of satisfaction with the experience of giving birth to her child (Klaus, 1998; van Teijlingen et al., 2003). Many aspects of the birthing process can influence satisfaction and confidence in a woman's ability to care for her baby. These aspects include experiencing confidence without fear, feeling control over her labour and birthing process, managing pain well, meeting birth expectations, being

alert and able to interact immediately with her infant, characteristics of care provided and psychosocial factors (Common Knowledge Trust, 2001; Klaus, 1998; Koniak-Griffin, 1993; Rubin, 1984; van Teijlingen et al., 2003). If her birthing experience is positive, a woman is more likely to develop a positive, interactive and reciprocal relationship with her child (Rubin, 1984). On the other hand, research has established that a negative birthing experience can affect a mother's early interaction with her infant (Koniak-Griffin, 1993; Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004) and hence the development of her maternal identity (Nelson, 2004; Rubin, 1984).

A recent study conducted in Scotland found that most women reported high satisfaction with their birth experience (van Teijlingen et al., 2003). Of over 1,000 women, 80% reported that they were "very satisfied" with the birth experience. Although this positive response is typical of satisfaction surveys (Swain-Campbell, Surgenor, & Snell, 2001), some interesting conclusions could still be drawn. Van Teijlingen et al. (2003) found that women who saw only one or two health professionals during pregnancy were more satisfied with their care than women who saw a number of different professionals. They added a cautionary note that consumers in general tend to favour the status quo over innovations, so these types of surveys should be treated with that in mind.

In another study researchers used focus groups and in-depth interviews to examine experiences of giving birth in Ireland (Cronin, 2003). Issues identified included the importance of support from lay networks, healthcare personnel, and support services; the experiences of hospital routines and systems of care during birth, including support for breastfeeding; motherhood, the child-mother relationship, and coping strategies; along with other psychological issues such as loneliness, frustration, and depression.

FEAR OF THINGS GOING WRONG – HANDING OVER CONTROL

Along with the greater medical knowledge of birth has come an increasing focus on what may go wrong during the pregnancy and birth. Bradley (1996) argued that increasing medicalisation takes away from the family that intimate joy of welcoming a new member, and places added pressures on those who monitor the process of giving birth. The following experience of a New Zealand midwife typifies these concerns: “In 2000 ... I spent hours talking normal birth to women and suddenly I was faced with a 74% normal delivery rate in my practice” (Vincent, 2008). She argued that a co-dependency is created, with pregnant and birthing women becoming overly dependent on their Lead Maternity Carer. This assertion is supported by Miller (2003), who expressed a concern about women readily and willingly handing over control of their birthing processes to the professionals caring for them when they did not understand how to cope during labour and birth. Miller (2003) argued that this reliance on expert knowledge and opinion can lead to a culture of dependency on the maternity care provider, which results in birthing women experiencing a loss of control over the birth process.

Feeling in control during labour and birth was defined by Hodnett and Simmons-Tropea (1987) as a sense of mastery over both the internal manifestations of the birthing process as well as related environmental factors. This is achieved through confidence in one's ability to make choices that are actively responsive in managing one's birthing process. This includes feeling able to handle contractions and direct personal behaviours appropriately along with making reasoned choices regarding medical interventions (Green, 1999).

Women's experiences of childbirth were examined using a phenomenological approach in an in-depth interview study in the United Kingdom (UK) (Gibbins & Thomson, 2001). Eight women were asked about their birthing experience and how this compared to their initial expectations. Being in control of their labour and birth processes was the major theme identified. Being in control meant different things to different women. For some it involved being a part of the decision making process together with the healthcare personnel, while for others it was wider ranging, involving control over the labour process itself, and control over their own emotions and behaviour (ibid.).

Confidence in her ability to cope seems to be a major factor in how a woman approaches,

manages, and feels satisfaction with labour and birth (Goodman, Mackey, & Tavakoli, 2004). A woman who experiences a sense of personal control throughout the birthing experience, in particular the ability to manage contraction pain, will be more likely to express a higher level of satisfaction. Indeed, Campero, Garcia, Diaz, Ortiz, Reynoso, and Langer (1998) claim that control is the “key component in a satisfactory labor process” (p. 397). Thus handing over personal control of her birthing process may have unwanted psychosocial consequences for the mother, her infant and the family as a whole (Bradley, 1996; Lothian, 2008).

FEAR AND ANXIETY

Women have expectations of what the birthing experience will be like, and these expectations affect how they anticipate and approach the birth of their children (Gibbins & Thomson, 2001). Vincent (2008) described how, in her experience as a midwife, many New Zealand women feel fearful and unable to cope with both the prospect and the actuality of giving birth. Using the Pregnancy Related Anxiety Questionnaire among over 200 Dutch women Huizink, Mulder, de Medina, Visser, and Buitelaar (2004) found support for the argument that pregnancy anxiety is an entity that is distinct from general anxiety. They found that it is stimulated by a fear of not knowing what to expect, or what to do about what eventuates. This theory is supported by the findings of a study of 74 Swedish women during labour by Alehagen, Wijma, and Wijma (2001). Using the Delivery Fear Scale (DFS) Alehagen et al. (2001) found that fear, particularly through the early stages of labour, was more predominant in first-time mothers who have yet to experience giving birth. Alehagen et al. (2001) observed that facing a feared situation caused the release of stress hormones which could affect how the labour progressed, and this could result in longer labours that caused the woman to become exhausted. Gunning (2008) concurred that increased stress hormonal levels in the mother's bloodstream could reduce the supply of blood available to the baby; she concluded that studies have shown severe stress during childbirth is toxic to both the baby and the mother, although she introduced the possibility that moderate levels of worries may be helpful by stimulating active preparation to labour.

PAIN AND PAIN MANAGEMENT

Childbirth is likely to be one of the most painful things a woman will ever experience (Lally, Murtagh, Macphail & Thomson, 2008). Pain is one of the important factors that puts a woman at risk of having a negative birth

experience, although is not nearly as significant as the effect of support (Waldenstrom et al., 2004). While there are many options for pain relief during labour and delivery there are also psychological factors which moderate the need for pain relief. One of the most well supported findings is that continuous one-to-one support will reduce a woman's need for analgesia (Hodnett et al., 2005). There is a wealth of data suggesting that a woman's relationship with her midwife will moderate her experience of pain (see Lundgren & Dahlberg, 2002). While complete blocking of pain is possible, using epidural analgesia, there are some distinct disadvantages (O'Sullivan, 2009) making it a second-line treatment. Huizink et al. (2004) suggested that fear worsens the perception of the pain experienced during labour and birth and that this increased sensitivity to pain increases the fear, thus creating a spiralling increase in the pain experienced. Previous birth experiences can also increase both pain and fear (NilssonNilson & Lundgren, 2009). In a study examining epidural analgesia it was found that fear and pain levels were highly correlated (Alegnan et al., 2005), leading to the assumption that reduction in either will decrease the other. It has also been found that women often enter labour with unrealistic expectations of levels of pain. Thus being unprepared for degree of pain when it comes leads to loss of control, engagement, and lower satisfaction with the birth experience (Lally et al., 2008). Such findings give support to Vincent's (2008) claim that, in her experience as a New Zealand midwife, lack of labour management skills can result in an increased perception of the pain during labour.

CONFIDENCE AND SELF-EFFICACY

According to Bandura (1977) social and self-regulatory skills, and self-belief in personal ability are the necessary components of controlled behaviour. This sense of control is referred to as self-efficacy, encompassing the sense that the individual can control her or his motivation, have control over her or his environment and, as a result, have control over her or his behaviour and associated outcomes. When self-efficacy is low instruction alone will not motivate people to take control of their behaviours in particular situations. Bandura (1977) also emphasised the necessity of developing relevant behavioural skills acquired sufficiently early as to enable the individual to internalise them so that she or he is capable of self-motivation to exert personal control in any given event.

Being able to translate an understanding of a particular situation into the appropriate

application of relevant skills is necessary if one is to exert control over one's behaviour in a demanding situation such as childbirth. Another factor, that Bandura (1977) advocated as essential to maintaining a sense of personal control in situations where the individual feels vulnerable, is being able to connect with or strengthen social support when required. Manning and Wright (1983) examined how 52 American women's thoughts about labour and birth affected their actual experience of the event. They found that a questionnaire measure of self-efficacy was a better predictor of pain management without medication than any other variable tested. In their review of literature on childbirth preparation and pain, anxiety and stress reduction, Beck and Siegel (1980) concluded that confidence that comes from effective preparation has positive effects on how women cope during labour and birth. When a woman is confident that she can cope with the process of giving birth, her ability to reduce her perception of the pain of contractions is strengthened (Manning & Wright, 1983) and her birth satisfaction is enhanced.

OUTCOME EXPECTATIONS

In a recent review Lally et al. (2008) reported that women often enter childbirth with unrealistic expectations. When outcome matches a woman's expectations of how her labour and birth will progress, her satisfaction with her birth experience is enhanced (Manning & Wright, 1983). Self-efficacy and outcome expectancy were closely correlated in Manning and Wright's study and they argue that these perceptions are difficult to differentiate. Both were factors that contributed to a sense of mastery important for birth satisfaction. In their national survey of the birth experiences of over 2,500 Swedish women, Waldenstrom et al. (2004) found that 6.8% of their participants had endured a traumatic negative birth experience. They claim that many more women endure birthing processes that are less than satisfactory. They found that unexpected medical interventions such as induction, augmentation, emergency caesarean delivery and the necessity of placing the newly born infant in intensive care were all risk factors that saw women perceive their birthing processes as negative birth experiences. Indeed, 34% of 122 Swedish women who had undergone an emergency caesarean section described a traumatic experience in a survey of their birth stories (Tham, Christensson, & Ryding, 2007). Taken together these studies suggest that education about childbirth options and possibilities might enhance women's experience by providing more broad expectancies.

DEPRESSION

Negative birthing experiences, particularly unexpected caesarean sections, may inhibit the healing process and may be a factor contributing to postpartum depression (DiMatteo et al., 1996; Garel et al., 1990). Ip and Martin (2008) found that the level of confidence a woman felt as she entered her labour was predictive of postpartum depression among 120 Hong Kong Chinese mothers. Postpartum depression inhibits or even halts the development of a sense of being a capable and effective mother (Cutrona & Troutman, 1986). In a meta-synthesis of studies on postpartum depression, Beck (2002) noted that up to 13% of women who give birth will experience postpartum depression at some stage during their child's first year. An already challenging role transition for the new mother is greatly exacerbated by postpartum depression, and there are serious psychosocial consequences for a mother and her child (Field, 1998).

PREPARATION AND TRAINING FOR CHILDBIRTH

Because the possible consequences of negative birth experiences can be severe for mothers, children and families as a whole, it is imperative that interventions, that will improve how women anticipate and experience birth, are developed to supplement the existing antenatal education facilities currently available and to support midwives in their core role. The goal of the New Zealand developed programme The Pink Kit (Common Knowledge Trust, 2004) is to help the pregnant woman understand what is happening to her body and, as a result of using the programme, to teach herself birthing skills relevant to her own body shape and needs. With this specific training it is believed she will be more likely to have the knowledge to work with her baby's efforts to be born.

Vincent (2008) described how the skill level of the birthing women in New Zealand is generally low, resulting in increased pressure on the healthcare personnel during the birthing process. She described how she, and many of her fellow midwives, would like to see the skills of women giving birth improved to the point where they choose to take control of their own processes, relying on professional assistance only when medical difficulties are experienced.

The authors of *The Pink Kit* (Common Knowledge Trust, 2004) argue that the labour is generally shorter and complications are fewer when the woman is skilled and able to deliver vaginally. A review by

Klaus (1998) supports this, given that the attachment process may be assisted by the release of the hormone oxytocin into the systems of both mother and child, which is stimulated for both during breastfeeding and skin-to-skin contact. Klaus (1998) also noted that allowing the infant to remain with the mother reduces the indications of distress displayed by the infant. Mothers able to interact positively with their infants immediately after birth have been found to be more positive about their infants and to feel more confident in handling their infants at six weeks postpartum. Bradley (1996) argued that using natural birth processes when giving birth makes the experience joyful for both parents and a day of celebration for all concerned. In contrast, recent studies have suggested that a pregnant woman's levels of social support and other relationship variables are more important for her birth experience than childbirth education (e.g., Hodnett, 2002; Waldenstrom et al., 2004).

SOCIAL SUPPORT

Waldenstrom et al. (2004) reported that some of the most important risk factors for negative birth experiences were social factors. These factors may be seen as beyond the control of care providers and include relationship issues with partner and family.

Using self-report data from over 2,000 Canadian women at a mean gestation of 24 weeks, Glazier, Elgar, Goel, and Holzapfel (2004), found that good social support had positive consequences for both the birthing process and later. British women have said that positive support from both midwives and partners (which included caring, information giving and recognition that the woman could be actively involved in decision making) assisted them in maintaining a sense of personal control throughout their birthing processes (Gibbins & Thomson, 2001). This was supported by Halldorsdottir and Karlsdottir (1996) who found that Icelandic women expressed a strong need for understanding and caring from those who were a part of their birth experience. This social support enabled them to feel a sense of security they considered important for a positive birth experience.

CONTINUOUS SUPPORT

Having someone available to offer continuous emotional, informational and physical support from the onset of labour until after the delivery, and knowing that this support will continue

beyond the actual birth, significantly reduces tension and assists women to retain a sense of being in control of their birthing processes (Vincent, 2008).

Research suggests that there are various tools available which decrease the trauma experienced in labour. One of these tools is continuous support of the birthing mother throughout her labour and the birth of her child (Hodnott, 2002; Hodnott, Gates, Hofmeyr & Sakala, 2005). It had been the tradition that women assist women during their labours and birthing throughout history, until the increasing medicalisation of birth saw more and more women giving birth in hospitals rather than the family home (Sauls, 2002). Campbell, Lake, Falk, and Backstrand (2006) found that an intervention group of nearly 300 American birthing mothers who were allowed to select a known woman (such as a close friend or relative) to provide continuous support during the birth had significantly shorter labours and higher Apgar scores [the simple and reliable method of assessing a newborn baby's health that checks appearance, pulse, grimace, activity and respiration] than a control group of nearly 300 mothers who were provided with routine maternity care. Bruggemann, Parpinelli, Osis, Cecatti, and Neto (2007) established that provision of such support also greatly increased Brazilian women's satisfaction with their birthing experience. Such a tool also reduced the need for medical interventions during the birthing process (Bruggemann et al., 2007). Rosen (2004) reviewed eight previous randomised controlled trials which consistently supported these findings, and she suggested that "continuous labor support offers multiple benefits for mothers and infants" (p. 24).

CONCLUSION

The international research we have reviewed suggests that the support women receive prior to and during childbirth is important for the outcomes for mothers and their babies. Continuous one-on-one support, such as that offered by midwives in New Zealand is optimum. This type of support is related to lower pain, fear and anxiety and greater feelings of satisfaction with the labour and birth. As the New Zealand maternity service continues to evolve, these factors need to be kept in mind for the well-being of our future generations. Mothers, their partners, their families and maternity care providers are all key stakeholders in this evolution and their views need to be sought in further studies of methods of facilitating the optimal birth experience in New Zealand.

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The vaginal examination during labour: Is it of benefit or harm?

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ABSTRACT:

Giving birth is an important life event and care practices that occur during labour and birth can have a lasting influence on the mother and the family (Beech & Phipps, 2004). The use of regular, routine vaginal examination to assess the progress of labour is one such care practice. There are two ways of viewing the vaginal examination during labour. The first regards the vaginal examination as a physically invasive intervention which can have adverse psychological consequences (Kitzinger, 2005). The second sees vaginal examination as an essential clinical assessment tool that provides the most exact measure of labour progress (Enkin et al., 2000). This paper explores these two viewpoints in more detail and discusses the benefits versus the harms of undertaking a vaginal examination during labour. Midwives use a variety of skills and observations to assess labour progress. The vaginal examination is an important clinical assessment tool that should be used carefully when there is a need for more information to help understand labour and whether it is established and progressing, taking into account both the potential harms and benefits.

KEY WORDS:

Vaginal examination, intervention, physiological labour, labour progress, assessment tool, midwives, partogram.

INTRODUCTION

For most women childbirth is a time of transitions and major life changes. Giving birth is a dramatic life event which has a profound influence on a woman and can create both positive and negative emotions (Beech & Phipps, 2004; Edwards, 2005). Birth is a physiological process that can be shaped and influenced by societal expectations, culture and emotions and is seldom just 'a biological act' (Davis-Floyd & Sargent, 1997). During pregnancy and birth women will come into contact and have care provided by midwives and/or the medical profession. Care that is provided during labour has the potential to influence the labour and has an impact on the woman's feelings about her labour and birth (Beech & Phipps, 2004). Midwifery has a philosophy which seeks to sustain the health of the woman and baby throughout the childbirth process and provide holistic care which considers the social context and personal identity of the woman (Lane, 2006). Within this philosophy is the need to promote and facilitate the physiological processes of birth (NZCOM, 2008) and to keep clinical intervention during the birth process to a minimum (NICE, 2007).

DEFINING INTERVENTION

Generally when we consider clinical interventions we discuss practices such as artificial rupture of the membranes (ARM), intravenous syntocinon to accelerate labour, epidural anaesthesia, instrumental and caesarean births (Tracy, 2006). In many countries the rates of these types of intervention are increasing, whilst the rate of normal birth is decreasing (Tracy, Sullivan, Wang, Black, & Tracy, 2007). Interventions of various kinds have become a routine part of intrapartum care with only a small number

of women achieving birth with minimal intervention (Tracy, 2006; Waldenstrom, 2007). Whilst there is general agreement that ARM, augmentation of labour and instrumental births are clinical interventions, there are many other acts or care practices that could also be considered an intervention (Kitzinger, 2005). The New Penguin English Dictionary defines intervention as the act of intervening, and to intervene is to come in or between things so as to hinder or modify them (Allen, 2000). If we consider a physiological birth to be one in which the woman is able to labour and give birth in her own space and time, with no interference to her physiological rhythms, then any care practice that hinders or modifies this could be considered to be an intervention (Kitzinger, 2005). This would suggest that many actions undertaken by a midwife during labour could also be considered an intervention. One such care practice is the vaginal examination which can be undertaken frequently and routinely during labour (Cheyne, Dowding, & Hundley, 2006). In order to undertake a vaginal examination (also known as an internal) the midwife must break the woman's concentration and interfere with the rhythm of her labour. She must ask the woman to adopt a position in which the examination can be undertaken and then perform what is an intrusive and very intimate examination. It has the potential to cause distress and pain both physically and psychologically.

On the other hand, many would argue that the vaginal examination is an essential clinical assessment tool which can provide reassurance to both the mother and the midwife that the labour is progressing towards the birth. A woman may ask the midwife for a vaginal examination as it reassures her that she is making progress. Whilst the majority of labours will progress physiologically towards the birth, for some women this may not be the case. The vaginal examination can provide information which can be used to confirm normality or identify pathology. Regular cervical assessment by means of a vaginal examination can provide a measure of labour progress reassuring both

the midwife and the woman that labour is progressing toward the birth in a normal way.

How should midwives view the vaginal examination during labour? Is it an intervention or an essential clinical assessment tool? This paper examines this dichotomy in more depth by reviewing the research around vaginal examination and labour progress. The arguments for and against vaginal examinations are examined, along with a discussion on the benefits versus harms of undertaking vaginal examination during labour.

BACKGROUND

Defining labour progress

The seminal work defining labour progress was undertaken during the 1950s by Emmanuel Friedman an American obstetrician. He argued that of all the observable events that occur during labour such as uterine contractions and descent of the presenting part, it was cervical effacement and dilatation which he identified as being the most appropriate measure of overall progress (Friedman, 1954). The concern was that a prolonged labour increased the incidence of adverse outcomes for the mother and the baby. Time parameters were defined so that abnormalities of labour progress could be identified and action taken. Friedman developed a cervicograph to provide clinicians with an objective way of measuring labour progress (*ibid*) and which was later developed to become the partogram. However, whilst Friedman described labour progress in what he considered a 'normal labour' the understanding of what constituted normal was culturally influenced. The expectations and understanding of labour during the 1950s were vastly different to our contemporary understanding of physiological birth. In his sample Friedman did not exclude women with malpresentations, malpositions or multiple pregnancies and the usual care practices of the day were to give women enemas, pubic shaves and high levels of strong medication. Women were left alone, unsupported and expected to labour on their beds. Subsequent research has developed our understanding of the complexity of labour and how the interplay of hormones (which are necessary for labour to move towards birth), can be influenced by isolation, lack of emotional support, and the inability to move with contractions into positions in which gravity assists labour (Buckley, 2005; Enkin et al., 2000; Foureur, 2008; Odent, 2001).

Whilst many still consider a dilation rate of 1cm an hour to be the norm for labour based on Friedman's curve (Arya, Whitworth, & Johnston, 2007), this rate of cervical progress has been challenged by more recent research from both midwives and obstetricians (Albers, 2007; Gurewitsch et al., 2002; Lavender, Hart, Walkinshaw, Campbell, & Alfirevic, 2005; Zhang, Troendle, & Yancey, 2002). Albers (2001) used nine midwifery sites in the USA in which there were care measures to keep birth normal such as social support and non pharmacological methods of pain relief, activity and position change. With data from these centres she was able to calculate descriptive statistics collected over one year from 2,522 women. Her results demonstrated a slower progress of labour without an increase in complications for the mother or baby. She suggests an alternative rate of cervical dilatation of between 0.3cm and 0.5cm per hour (Albers, 2001).

Zhang et al (2002) analysed retrospective labour information from 1329 nulliparous women provided with contemporary obstetric care. Their sample included women with epidural analgesia and oxytocin augmentation. Whilst these interventions would not usually be considered a part of physiological birth, the authors argued that they wanted to provide parameters of contemporary childbirth. Their results demonstrate marked differences to the Friedman curve. They found the cervix dilated at a substantially slower rate in the active phase than Friedman's curve, taking twice as long to dilate from 4 to 10 cm (5.5 hrs versus 2.5hrs). They suggest that it is not uncommon for there to be no perceivable change for more than two hours prior to 7 cm and that the rate of cervical dilatation was below 1 cm per hour. They conclude that the criteria for diagnosing prolonged labour or dystocia are currently too stringent for nulliparous women (Zhang et al., 2002).

In their observational, longitudinal study of 403 multigravid women in spontaneous labour, Lavender et al (2005) found that progress was dependent on the initial cervical dilatation at presentation in labour. They conclude that a universal definition of failure to progress and therefore pathology during labour is inherently difficult to identify because labour is a complex combination of physiological and psychological processes.

Albers (2007) argues that with an improved understanding of the physiological processes of labour there is a need to ensure patience with the labour process. The first stage of labour is far slower than 1cm/hour and a rate of 0.5cm an hour can be considered normal. Whilst for

some women a rate of 0.3cm an hour may also be considered normal but consideration of other factors such as the frequency and quality of uterine contractions and state of wellness of mother and baby should also be taken into account (Albers, 2007).

Our understanding of labour progress has been developed without input from women and may not resonate with the woman's actual experience of labour as it progresses to birth. Labour is a unique process which only women who labour and give birth have experienced. Any theory of labour progress should be able to describe physiological labour as experienced by women. Walsh (2007) argues that the early descriptions of the rhythms of labour are based on clinicians' knowledge and are not woman centred. Midwives have invented euphemisms for early labour because to record a long length of labour puts the woman at risk of intervention once admitted to hospital (Walsh, 2007). For midwives it is important that our understanding of labour progress remains woman centred and incorporates the woman's perspectives and understanding of labour progress.

Frequency of vaginal examination

With labour progress defined by measurement of cervical dilatation the question arises as to how often the measurement should be undertaken. At present there is little consensus on the optimum timing of vaginal examination during labour (Enkin et al., 2000). In practice there is a range of frequency with some studies describing vaginal examinations being undertaken as often as every two hours (Lavender et al., 2005; Pattiinson et al., 2003), whilst Albers (2001) stated that in her study clinicians undertook a vaginal examination 'periodically', when maternal behaviour or clinical signs suggested a need for one.

Partograms to monitor normal labour progress

When measurement of the cervix has been undertaken there is a need to record and assess progress. Many countries and hospitals use a partogram to record and assess whether labour is progressing within normal parameters. Based on Friedman's (1954) original cervicograph, the partogram was developed to enable clinicians to identify labour dystocia (Philpott & Castle, 1972). However the benefits or harms of using a partogram are still under debate (Lavender & Malcolmson, 1999). There is little consensus about the use of the partogram and a variation in types of partogram used in many units in the United Kingdom and around the world (Lavender, Tsekiri, & Baker, 2008). There are

concerns that rigid interpretation of cervical dilatation without consideration of other indicators of labour progress could result in increased levels of other clinical interventions (Albers, 2007; Lavender, O'Brien, & Hart, 2007). Many partograms have an expectation that regular vaginal examination is done routinely and regularly (every four hours) so that the progressive dilatation of the cervix can be assessed, monitored and documented.

In many countries intrapartum care is provided by multiple caregivers (Hodnett, 2000) and women receive care in an unfamiliar hospital setting from midwives who are not known to them (Albers, 2007). In these circumstances there can be differences between how each midwife provides intrapartum care as well as how they interpret the progress of labour. In these situations using a partogram can be a valuable means of exchanging information and it can help in the handover of information between caregivers, other health practitioners and between shifts (Lavender & Malcolmson, 1999). By providing a visual representation of the labour it can be a mechanism for ensuring that the capture and exchange of information is available in a pictorial/graphical format. The partogram can be a valuable mechanism for standardising labour care especially when there are multiple caregivers who have no pre-existing relationship with the labouring woman.

Arguably, when there is continuity of midwifery care – as there is in New Zealand for the majority of women (Ministry of Health, 2007), midwives can observe and individualise care for that woman depending on the labour, their observations of the labour and the preferences of the woman. In New Zealand the Midwives Handbook for Practice (2008) states that the midwife should identify when there is a need for vaginal examination and discuss this assessment with the woman (NZCOM, 2008). Decisions and care provision during labour should be based on individual needs with midwifery care provided accordingly (ibid). In contrast, in the United Kingdom (UK) where there is less continuity of carer and a higher likelihood of multiple caregivers during labour, the NICE guidelines for intrapartum care (2007) recommend that vaginal examinations be undertaken regularly and routinely (every four hours) once labour is established to ensure that the labour is progressing towards the birth (NICE, 2007).

The United Kingdom and New Zealand have different models of midwifery care which influences how midwives within these countries practice. However, regardless of where a midwife practices there remains a concern within the

midwifery profession of how we define and monitor physiological birth. If we accept that the vaginal examination is an intervention, is it a tool that should be used in a regular, routine way to ensure that labour is progressing?

In their exploration of the nature of childbirth knowledge, Downe and McCourt (2004) suggest that, when assessing whether an intervention should be undertaken for an individual, the extent of the benefit or harm should be considered along with other aspects of the physical, social, spiritual and psychological environment (Downe & McCourt, 2004). What then are the benefits and what are the issues or concerns that could cause harm to the mother or child when undertaking a vaginal examination?

THE BENEFITS VERSUS THE HARMS OF THE VAGINAL EXAMINATION

Benefit and rationale for undertaking a vaginal examination

Whilst the majority of women will have a physiologically normal labour and birth there are a minority who will not. Understanding when a labour has deviated from the normal physiological processes and the reasons for the deviation are important (Thorogood & Donaldson, 2006). Vaginal examination provides a variety of information, such as fetal presentation, position and descent of the presenting part along with information on cervical effacement, consistency and dilatation of the cervix (Thorpe & Anderson,

these factors can be variable, overall the vaginal examination is an important skill that midwives should develop and which can help them to interpret labour rhythms and signal deviations from the physiological process. Indeed for many midwives it has been the use of the vaginal examination that has helped them to develop their skills in observation of labour by improving their abilities to understand the signs of labour progress that may vary with each woman. For newly graduated or less experienced midwives the vaginal examination can be seen as a means of developing an improved understanding of each individual woman's labour as it progresses towards birth. Having the skills to understand and interpret labour is important to midwives and is developed through the experience of working with and being alongside women during their labour.

Psychological harm and physical pain

Vaginal examination can be distasteful for some women due to the intimate nature of the examination and can be very distressing for others (NICE, 2007). Devane (1996) suggests that prior to childbirth, women regard the vagina as mainly associated with sex and therefore has a sexual function but during labour and with the first vaginal examination it changes status as the role of the vagina for giving birth becomes more significant. He argues that the vaginal examination can cause anxiety and be embarrassing for both the woman and the midwife (Devane, 1996).

THE VAGINAL EXAMINATION IS AN IMPORTANT SKILL THAT MIDWIVES SHOULD DEVELOP AND WHICH CAN HELP THEM TO INTERPRET LABOUR RHYTHMS AND DEVIATIONS FROM THE PHYSIOLOGICAL PROCESS

2006). When put into the context of what is happening to the woman and her labour with regards to the length, strength and intensity of the contractions, the midwife can improve her understanding of that individual woman's labour. Whilst interpretation of

However, for some vulnerable women the vaginal examination can be more than just embarrassing, it can cause feelings of loss of control and have psychological sequelae. Parratt (1994) undertook a small qualitative study exploring the childbirth experiences

of women who were survivors of incest. She found that intimate touch could be linked to unpleasant associations for these women. Many aspects of childbirth triggered memories of the incest, however internally and touching of the vagina during labour caused feelings of vulnerability and loss of control (Parratt, 1994). Parratt's research is supported by Robohm & Buttenheim (1996) who explored the gynaecological care experiences of adult survivors of childhood sexual abuse, compared with non-abused women. Using a self-administered survey they found that the survivors reported more intensely negative feelings during a vaginal examination than did the non-abused women (Robohm & Buttenheim, 1996).

Menage (1996) investigated whether trauma experienced during obstetric and gynaecological examinations could lead to post-traumatic stress disorder. She found that out of a self-selected sample of 500 women, 100 gave a history of an obstetric or gynaecological procedure that they found was distressing or terrifying. Of these 100 women, 30 fulfilled the criteria for diagnosis of post-traumatic stress disorder. These women described feelings of powerlessness during the procedures, felt that they had been given inadequate information, had experienced physical pain and found an unsympathetic attitude on the part of the examiner. Nine of the women had a past history of sexual abuse or rape in addition to the obstetric or gynaecological trauma (Menage, 1996). Despite the small sample sizes and the subjectivity of the participants these studies provide an important insight into how intimate touch can be perceived by vulnerable women during childbirth.

The behaviour of midwives when undertaking a vaginal examination also suggests a level of embarrassment as well as possible issues around power and control. In her study exploring the midwives and women's experiences of vaginal examination in labour Stewart (2006) found that the midwives' behaviour suggested high levels of discomfort when undertaking a vaginal examination. Stewart (2006) used a critical ethnographic approach to focus on how the vaginal examination is discussed with the woman and how it is undertaken in practice by midwives. She found two main themes that she describes as sanitisation through action and verbal sanitisation (Stewart, 2006). Stewart suggests that midwives use a number of verbal and physical strategies to distance themselves from vaginal examinations. These included the use of abbreviations or euphemisms, whilst some midwives also used a ritualised method

of washing the woman's genitalia. This she argues could be a strategy to establish power differentials (ibid).

Bergstrom and colleagues (1992) also found issues of ritualisation of the procedure and the exercise of power over the woman by the caregiver during labour in their USA-based ethnographic study. They examined the frequency and use of the vaginal examination during the second stage of labour (Bergstrom, Roberts, Skillman, & Seidel, 1992), revealing a variation of between two and 17 vaginal examinations whilst for one woman the procedure was done following every contraction. The stated purpose of using a vaginal examination during the second stage was to assess the woman's bearing down efforts and to teach the woman how to push correctly (ibid). Bergstrom et al (1992) question the necessity of the procedure at this time and suggest that the vaginal examination sends an implicit social message communicating the power and authority of the caregiver. They argue that this demonstrates an inherent philosophy of distrust in the woman's ability to give birth unaided (Bergstrom et al., 1992).

Both Bergstrom et al., (1992) and Stewart (2006) have used a critical feminist approach within their research. In this approach women are viewed as oppressed by a patriarchal culture. Women's experiences are the focal point of the research and the issue is understood from the woman's viewpoint. Issues of power and gender control can be identified more easily using this approach.

Contrast this approach to that taken by Lewin and colleagues (2005) in a quantitative survey of primigravida women and their perceptions of the vaginal examination. The focus of this small survey of 73 primiparous women was to explore the women's perceptions of vaginal examination during labour in three different maternity units in the UK (Lewin, Fearon, Hemmings, & Johnson, 2005). Respondents were asked to fill out a questionnaire posted to them within a month of giving birth. The questionnaire had statements about vaginal examination from which the women could indicate a range of responses in agreement or disagreement (using a Likert scale). The results suggested 'an encouraging measure of contentment with the privacy, dignity, sensitivity, support and frequency with which vaginal examinations in labour were managed' (Lewin et al. 2005 p 267). The use of a questionnaire restricted the ability of the women to provide information in their own words and therefore provide real insight into their views. Despite this, nearly

half of the women reported that the vaginal examination was painful and distressing at some point with 42% reporting it would have been difficult to refuse the examination.

There is little other formal research looking specifically at the woman's perspective of pain during vaginal examination, and none which takes into account continuity of care models of maternity, informed consent, and shared decision making. What is available is found in birth stories or other anecdotes from the United Kingdom. These suggest that women find vaginal examination painful regardless of who is undertaking it, whether midwife or doctor (Beech & Phipps, 2004). Whilst pain is part of a physiological labour, the ability to work with the pain is complex and may be influenced by psychological, spiritual and cultural factors as well as the physical presence of pain (Leap & Vague, 2006). It would appear that, unlike other clinical assessments such as palpation and fetal heart auscultation, the act of undertaking a vaginal examination to assess cervical dilatation can cause embarrassment, vulnerability and further pain during labour which is often already an intensely vulnerable and painful time for women.

The use of vaginal examination can also be seen as disempowering for women with the perception that the childbirth professional will trust the 'science' rather than woman's knowledge of their body or their labour (Beech & Phipps, 2004). This may occur when the woman is labouring well but on vaginal examination is found to be 'only' four centimetres or where the woman feels like pushing but has to have a vaginal examination to confirm that she is truly ready to push (Beech & Phipps, 2004; Halldorsdottir & Karlsdottir, 1996). Women can also lose confidence in their ability to labour if they discover that there has been less cervical dilatation than expected. In these circumstances midwives describe using distraction techniques as a means of waiting longer before undertaking a vaginal examination (Dixon, 2005).

INFECTION

Infection in the form of puerperal fever has been described as early as 1599 and has always been a threat to women's health and their lives (Loudan, 1992). Following the introduction of antibiotics and improved hygiene and health status for women, death from puerperal fever has become extremely rare in contemporary society. However, the vaginal examination continues to carry a risk of introducing infection with chorioamnionitis occurring

in between 8 and 12 women per 1000 births (Lumbiganon, Thinkhamrop, Thinkhamrop, & Tolosa, 2004). Vaginal organisms can be introduced into the cervical canal even during sterile conditions (Imseis, Trout, & Gabbe, 1999) with increased rates of infection in women who had vaginal examinations after premature rupture of membranes (Lewis & Dunnihoo, 1995). Babies are also at risk from ascending infection with 30% of neonatal infections caused by group B haemolytic streptococcus thought to be caused by vertical transmission from an infected mother (Stade, Shah, & Ohlsson, 2004). Therefore the vaginal examination can increase the risk of harm for women and their babies.

DISCUSSION

Whilst the use of vaginal examination has a long midwifery tradition (Donnison, 1988), the expectation of regular, routine use to monitor cervical dilatation has only developed since the 1950s, and has an underlying discourse of controlling the parturient body through use of time limits.

Midwives have a body of knowledge that is unique to midwifery. It is a combination of knowledge, experience, intuition and

judgement that enables midwives to monitor the physiological labour as it moves towards birth from a variety of clues. Within the midwifery profession there has been discussion on other means of assessing physiological labour as it moves towards birth (Hobbs, 1998; Stuart, 2000; Warren, 1999). Burvill (2002) suggests that midwives have many ways of knowing when a woman is in labour and that they are skilled in diagnosing labour onset in women by interpreting the cues provided without physically interfering with a woman's body and birthing process (Burvill, 2002). This has been reinforced by research undertaken by Cheyne, Dowding & Hundley (2006) which suggests that midwives used information cues from the women to help them diagnose labour including the physical signs such as strength, frequency and regularity of contractions along with how the woman was coping and what supports she had around her. However, the midwives did also consider that the vaginal examination was an important factor in establishing whether the woman was in labour. They suggested that there were many aspects of the assessment that should be considered such as cervical consistency, confirmation of presentation and application of the presenting part, and effacement in conjunction with cervical dilatation when making a judgment as to whether labour was established (Cheyne et al., 2006).

Arguably a vaginal examination during labour can be considered both an intervention and an essential clinical assessment tool. Assessing cervical dilatation can help midwives determine whether there is a normal presentation and rhythm to the labour. However, it can also disturb the fine balance that supports physiological birth.

Understanding the normal rhythm of labour is an important facet of midwifery care, and whilst the actual mechanisms that initiate and promote labour are complex and poorly understood it is generally agreed that labour progress is mediated by hormones that stimulate and govern uterine contractions (Baddock & Dixon, 2006). Effective contractions lead to progressive dilatation of the cervix and to the birth of the baby. However, there are some conditions such as malpresentation, cephalo-pelvic disproportion and obstructive labour which lead to a prolonged and difficult labour or birth and a need for obstetric intervention (Thorogood & Donaldson, 2006). More research is necessary to improve our understanding of the normal rhythms of labour for physiological births, as well as the

abnormal or disrupted rhythms which may indicate prolonged or obstructive labour. In particular how do midwives assess that labour is progressing physiologically and what is the evidence around what should be considered the normal parameters of a physiological labour? There is also a need for research exploring the woman's perspective of labour as it progresses towards birth and the impact of continuity of midwifery care in these situations. Does knowing the midwife make vaginal examination less painful for the woman? To date contemporary research suggests that patience with the physiological process is required and that there should be a reassessment of the current time parameters and the need for partograms especially when there is continuity of midwifery care.

Intrapartum care should be individualised to the woman and there is a need to balance the benefits of undertaking a vaginal examination with the potential harm that may be caused by the intervention itself. The use of the regular routine vaginal examination is questionable when the midwife is seeking to individualise care to each woman in labour.

CONCLUSION

Vaginal examination is a physically invasive procedure which can have psychological consequences causing disruption to the natural body rhythms as well as emotional and physical pain (Edwards, 2005). The birth process is individual to each woman and there is a wide range of what can be considered physiological. At the same time, the vaginal examination is also an important and essential assessment tool which can help midwives understand labour and whether it is established and progressing (Cheyne et al., 2006). It can reassure both the woman and the midwife that the labour continues to be physiological in its rhythms.

Arguably, the vaginal examination can be considered both an unnecessary intervention and an important clinical assessment tool. It may be an unnecessary intervention if used routinely and as part of standardised labour care. Vaginal examination should be used judiciously when there is a need for more information that cannot be gained from observing the various external aspects of labour. Interpreting labour progress is complex and requires experience, knowledge and judgement which is aided by continuity of care from a midwife known to the woman.

A VAGINAL EXAMINATION DURING LABOUR CAN BE CONSIDERED BOTH AN INTERVENTION AND AN ESSENTIAL CLINICAL ASSESSMENT TOOL

Dixon, L., & Foureur, M. (2010). The vaginal examination during labour: Is it of benefit or harm? New Zealand College of Midwives Journal 42, 21-26.

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