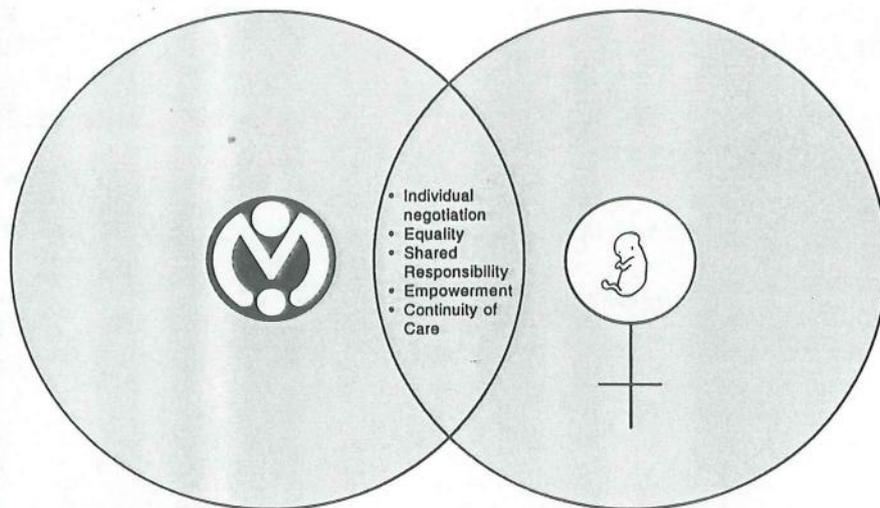




# JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, OCTOBER 1994

Principles inherent within  
the partnership



*Guilliland & Pairman 1994*



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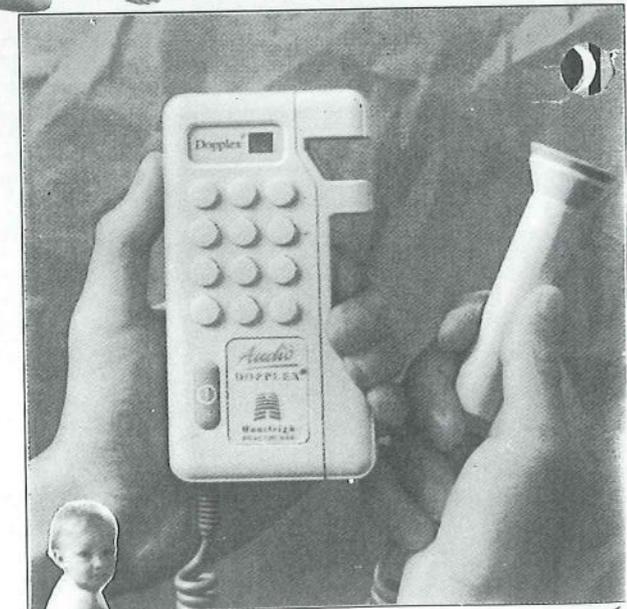
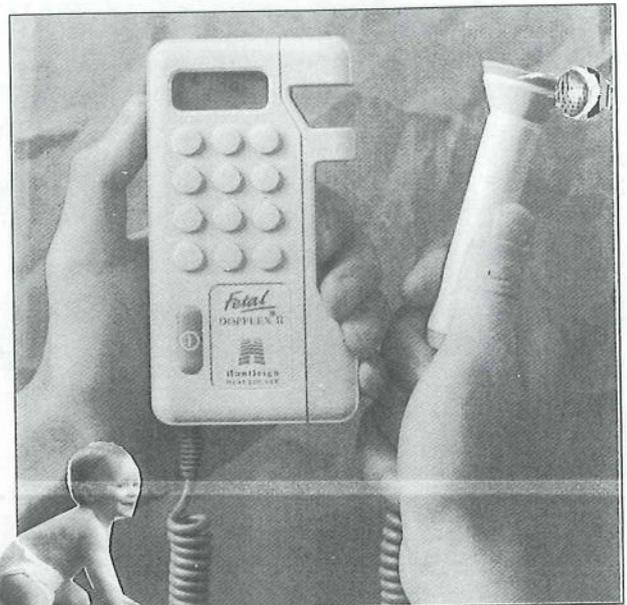
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- \* Promote women's health issues as they relate to childbearing women and their families.
- \* Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- \* Provoke discussion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

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## EDITORIAL

This issue celebrates the fifth birthday of the *New Zealand College of Midwives Journal*. Our inaugural issue was in September 1989 and it is truly inspiring to see how far we have come since then, both as a professional organisation and as a professional journal. The Journal continues to be produced almost singlehandedly by Helen Manoharan, still in a voluntary capacity. Every issue seems better than the last and it is a publication which should give us great pride. It is a wonderful resource and record of the development of midwifery as a profession in New Zealand. We are indebted to Helen for her ongoing commitment and energy in the production of the Journal.

In the five years since the College formed we have achieved a great deal. Independent midwifery is a reality and is being practised by many midwives throughout New Zealand, both in hospitals and in the community. Women now have greater choice both of caregiver and of place of birth and, as women share their experiences with one another, more women are taking up these options. Midwives and women alike are experiencing childbirth in a different way – a way which sees the woman at the centre of the experience, in charge, confident and strong, and which sees the midwife confident and strong in enabling women to meet their expectations of themselves. The ripple effects of these experiences go out through the children, the fathers, grandparents, aunts, uncles, neighbours, friends and slowly society itself is affected and changed. In time a culture of childbirth will be created which will place the woman at the centre, recognising her power and valuing her experience, cherishing the newborn as part of its family and returning birth to the family and the community.

Such a change in society is possible over time and must be the vision we hold before us. We need such a vision to sustain us in the almost daily onslaught of opposition we receive from many fronts. Make no mistake, the kind of threat we (women and midwives alike) pose to the institutional control of childbirth is significant. The backlash we experience is a result of midwifery independence and the daily reality of women exercising their right to choose and choosing midwifery.

This backlash is obvious in the media with the attention paid to the so-called 'unsafe' practice of individual midwives and the misinformation this generates. The backlash also comes from our own colleagues, often midwives now in managerial positions. As the competitive health model takes over it seems we have lost sight of the fact that we are all part of a publicly-funded health system. Maternity care is still free in New Zealand and we are all paid from the public purse no matter where we work. The birthing facilities of CHEs do still belong to the women of New Zealand who should have free and easy

access to them, no matter who their chosen caregiver is. The current single-minded approach by some women's health managers throughout New Zealand to impose barriers to access of self-employed midwives is depressing. A climate where midwives can no longer share information because it may be 'commercially sensitive' is heartbreaking. As midwives we must recognise that we all make valuable contributions to the maternity services and that we need not buy into the competitive model. We must work together, supporting one another and finding creative ways of improving the services we offer so that they truly meet women's needs first rather than our own needs or those of our employers.

We have major challenges ahead of us if we are to hold on to what we have achieved and make further steps towards our vision for the future. The only way we will overcome these challenges is to work together, allowing ourselves to grow and change and ensuring that the midwifery partnership is a way of life for us all.

We must make the proposed changes to the maternity system work for women and for midwives. This means midwives being lead professionals and providing the total maternity service. Women need to understand the significance of choosing the midwife as lead professional so that the midwife is free to provide the woman with the care she desires. Where midwives are subcontracted by other health professionals to provide components of care, they will lose their continuity with the woman and may well lose their involvement in decision-making. The midwifery profession relies on the statutory ability of midwives to practise independently. This means making all care through a normal pregnancy, labour and birth and postnatal period the midwife's total responsibility. The ability to do this is what makes midwifery unique and different from other maternity service providers. It is the reason midwifery has a social mandate from women to be a profession and it is therefore the moral obligation of midwives, as members of the midwifery profession, to practise in this way.

We must ensure that direct entry midwifery education survives and becomes easily available to women throughout New Zealand. These students are the future of our profession and are the first students for many years to be educated and prepared to practise independently from registration. They have not had to unlearn nursing philosophies and behaviour but are instead grounded in the New Zealand model of midwifery. They have experienced continuity of care and childbirth at home as well as in the hospital, and they have learned what it means to work independently. Their education has been significantly different from ours. They really understand the midwifery partnership – it is part of who they are as midwives. No one who heard the current midwifery students from all around New Zealand speak at the conference recently could not have been moved by their ability to

articulate the meaning of midwifery for them. They gave us great hope and a real sense that the future of our profession is safe in their hands. We must continue to nurture these students and the new graduates and give them a chance to practise as they have learned, so they will become more confident and more experienced and will make a real difference to women, to the maternity service and to our profession.

There are many other challenges facing the profession, such as our systems for quality assurance and accountability, our understanding of and commitment to biculturalism at both a professional and organisational level, and the integration of the midwifery philosophy into our lives. The conference in Rotorua in August provided the perfect opportunity for exploration of these and other issues as we talked, shared our knowledge and got to know one another. It was a wonderful conference, made even more special by its setting at Te Papaouru marae, and it engendered a real sense of unity amongst those who attended to work towards our shared vision for the future.

Sally Pairman  
President



## LETTERS TO THE EDITOR

Dear Editor

Re: Introduction to Obstetrics and Gynaecology  
by Cynthia Farquhar and Murray Jamieson

We would like to thank the authors of this book for donating a copy to the NZCOM Journal, who then gave it to the Nursing and Midwifery Department, Otago Polytechnic for reviewing. This is very much appreciated and a welcome addition to our resources.

Thank you for supporting midwifery students in this way.

Yours sincerely

Sally Pairman  
Course Co-ordinator Midwifery  
Nursing and Midwifery Department

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# The Midwifery Partnership ~ A Model for Practice

A paper for presentation at the  
NZCOM Conference,  
Rotorua, 12-14 August 1994



**Karen Guilliland**  
National Co-ordinator NZCOM



**Sally Pairman**  
President NZCOM

The bicultural nature of New Zealand society has evolved a practice and a profession of midwifery in a way which is unique in the world. What is unique is the regulatory and professional recognition and acceptance of the underlying principle of partnership in the definition of midwifery. The social context which provided the springboard for the midwifery partnership is a constitutional and legislative structure founded on the Treaty of Waitangi. New Zealand women's understanding of partnership under the Treaty has facilitated their understanding of, and their demand for, midwifery as a partnership.

Consumers in New Zealand were led to a greater awareness and involvement in their health care following the Cartwright enquiry of 1987-1989 into the denial of women's rights to informed consent at National Women's Hospital. Tully sums up this environment when she says:

*The Cartwright report fuelled a growing disillusionment with the medical profession. The enquiry led to consumers gaining a greater say in the provision of health services by various means including patient advocates in hospitals and consumer representation on medical committees (Tully, 1993: 11).*

It was out of this climate that midwifery recognised and built on a model of practice which was in partnership with women. New Zealand midwives have articulated this partnership between the woman and the midwife. In the Philosophy and Code of Ethics of the New Zealand College of Midwives (NZCOM) it is discussed thus:

*Midwifery care takes place in partnership with women. Continuity of Midwifery care enhances and protects the normal process of childbirth (NZCOM, 1993: 7)*

and

*Midwives work in partnership with the woman (NZCOM, 1993: 10).*

This partnership, therefore, is an ethical stance and a standard for practice.

These beliefs were generated from practice and women's experiences, and documented by practitioners, consumers and educators over a period of two years from 1988 to 1990, culminating in the publication *Midwives Handbook for Practice* in 1993.

Midwifery's regulatory body, the Nursing Council of New Zealand (NCNZ), in basing its standards for registration on the belief that 'the Midwife practises in partnership with the woman' (NCNZ, 1992: 1) reflects and affirms this position.

This theory sees the New Zealand midwifery partnership as a relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding. It is this sharing relationship which is midwifery and it is one which spans the life experience of pregnancy and childbirth. Because of the individual nature of the relationship, midwifery's practice of partnership is a personal one between the woman and the midwife. Each person in the partnership brings a different dimension and the negotiated outcomes will therefore be different between the different midwifery partnerships. However, because midwifery recognises the social context of all women, the partnership is also a political one at both a personal and organisational level. It is through this political and personal involvement with women that midwifery accepts its responsibilities as an emancipatory change agent. As midwifery is a force for social change and is a profession which works for, and is concerned with, women, it identifies itself as a feminist profession (Pelvin, 1990).

The realisation that midwifery is a partnership evolved from the conscious collaboration of women's groups and midwives who worked together politically to bring about legislative changes, ultimately achieved through the 1990 Amendment to the Nurses' Act 1977. This legislation enabled midwives to practise autonomously, independent from the medical profession, and reflected years of political activism by women and latterly by midwives as a profession.

Women's need to regain control over their childbirth experience and midwives' desire to regain independence in practice were complementary. The midwifery profession started to listen to and identify with women as opposed to medicine and nursing. The achievements, discussion, information sharing and networking which occurred between women and midwives in the course of this political activity led to a greater understanding of the relationship between women and midwives. The co-dependent nature of this relationship is personified in the catchphrase 'women need midwives need women' used by consumer groups and midwives alike to advertise



their partnership. The New Zealand College of Midwives was established in 1988 with the conscious decision of midwives to involve consumers as partners within the organisation.

This lived experience of partnership achieved change, improved the status of midwives and focused attention on a woman's right to choose her birth attendant. The major by-product of this partnership, however, was the accompanying sense of empowerment and control which success gave to those women and midwives. The sense of triumph over adversity and oppression of a minority group (midwives) had a profound effect on the individual midwife's ability to recognise partnership in her day-to-day practice with women.

The recognition of the power of this partnership enabled midwives to transpose the political power to a personal level. For many midwives the transposition and/or recognition of this political partnership exemplified the partnership between the woman and her midwife as the foundation for practice.

**THE THEORY OF MIDWIFERY AS A PARTNERSHIP**

Midwifery is the partnership between the woman and the midwife.

**Philosophical underpinnings**

The supporting structures or philosophical beliefs for this midwifery partnership are that:

- \* Birth is a normal life event.
- \* Midwifery provides the total childbirth service.
- \* Midwifery is a profession in its own right.
- \* Midwifery is women-centred.

*Pregnancy and childbirth are normal life events*

It is the belief that pregnancy and childbirth are normal life passages that constructs midwifery knowledge and practice. It directs the practice of midwifery and defines the role of the midwife as one of knowledgeable companion and kaitiaki or the guardian of the normal (Donley, 1986). Normal in this sense means the physiological and biological process of childbirth where most pregnant women will achieve a successful outcome given support and patience (DOH, 1989; WHO, 1985). Childbirth is also socially and culturally constructed and as such midwifery must define 'normal' on a one-to-one basis with women, recognising each individual woman's life experience (Oakley, 1977; Kay, 1982).

For a midwife to internalise birth as a normal life passage she must witness the total childbirth experience within its social and cultural framework. Similarly, for women to internalise birth as a normal life passage they must experience birth in their own way, unfettered by imposed belief systems. Western maternity services have been structured in ways which have denied midwives and women these experiences.

In New Zealand over the last 70 years increasing medicalisation and increasing use of technology have led to the placement of birth and childbirth services within secondary care institutions or hospitals. The midwife's role became fragmented and the understanding of birth as a normal life event became distorted. Patterns of care within this environment taught women to fear birth, distrust their innate ability to give birth unassisted, and ensured the control of health professionals over an event previously owned by the community.

The reconstruction of childbirth for women and midwives has come through their ability to work in partnership throughout the entire childbirth process. Rediscovery of the meaning of midwifery has been experienced by midwives who have moved from dependent practitioner within the medical model to independent practitioner within the midwifery model. Alice Coyle (1992) describes this discovery when she says:

*I find that the more experience I gain as a Midwife, the less I physically do ... I have become a facilitator providing help and guidance where necessary and monitoring as required. When my care is completed, because this (the woman's) network is in place, there is not a gap (p. 22).*

The work of Mason (1993) also refers to this lack of physical activity which he describes as 'inactive-activity' which he believes to be 'the expression of underlying dynamic intuitions that arise from a consistent prior knowledge of the particular woman and a deep imaginative awareness of the ebb and flow of natural processes'. Mason believes that knowledge and confidence allow the midwife to 'do relatively little while observing and experiencing the sense of the rhythm of the labour'.

'Normal' is also a medically constructed and bounded concept used by medicine to assume control over the childbirth process (Arms, 1975; Enkin, 1989). Working with women in their own environments and valuing their ways of knowing has led midwives to reach a new understanding that there is a range of 'normal' which can only be defined on individual assessment of each woman. As Katz-Rothman (1984) says:

*For a (Midwife)with standard hospital-based training, doing homebirths is a radicalising experience. It makes her think hard about her work and its meaning. In this new setting she has to question many of the taken-for-granted assumptions of the medical setting and the medical model. And she finds herself constructing a new model, a new way of explaining what she sees (p. 304).*

The particular skill of the midwife is in recognising each individual woman's boundaries

of normal. The increasing trend towards the setting of protocols for maternity care by the medical profession is incongruent with the midwifery philosophical position of negotiated partnership. Predetermined boundaries deny the individual, women-centred philosophy and midwife's knowledge of the range of normal (Enkin, 1989).

Birth is a fundamental human event based in the family and the community. The midwifery partnership enables women and midwives to actively work together to reconstruct their meaning of birth and thus society's understanding of birth as a normal life event.

*Professional autonomy and the provision of total care*

The profession of midwifery relies on the statutory ability of the midwife to practise independently from other disciplines and in her own right. To be independent requires the midwife to provide the total service throughout pregnancy, labour and birth and the postnatal period on her own responsibility. Independence, therefore, is defined by the way in which the midwife practises not by employment status or where the woman chooses to give birth. Midwives who share care with practitioners from another discipline, in such a way that they do not have responsibility for the total service, remain responsible for their midwifery decisions and actions but cannot be said to be practising midwifery independently. It is theoretically possible for a midwife to share care with a practitioner from another discipline and still practise independently. However, this does require that both practitioners have equal status and responsibility and are equally involved in all decision-making with the woman remaining as the primary decision-maker.

When midwives practise in an environment which excludes continuity of care, they cannot be described as practising midwifery under our definition because they rely on another discipline to provide aspects of the total service. As midwives, they will be bringing to their service elements of the midwifery philosophy, enhancing the childbirth experiences of women, and making independent clinical judgments and decisions, but they will not be practising midwifery in its full tradition. It is the provision of the total maternity service which distinguishes the midwifery profession from other disciplines involved in aspects of maternity care such as medicine and nursing. Fragmentation of the woman's experience into discreet components of care means that the midwife is more likely to lose sight of the whole woman - the person with whom the midwifery partnership is formed. Fragmentation does not allow the necessary commitment of time required for the partnership to develop and for the midwife and the woman to get to know each other. Fragmentation undermines the midwife's understanding of childbirth as a normal life event and compromises the midwifery partnership. This is not to deny

that other types of partnership are possible, but they will have a different meaning.

Ultimately, midwives who, for whatever reason, choose to provide fragmented care such as labour care only or delegated care, are acting as midwives but are not independent in their practice and therefore are not practising midwifery. They do not have the supporting structure of autonomy and continuity of care necessary for the midwifery partnership.

For midwifery to be a profession relies on the majority of midwives practising independently in partnership. In the years leading to the 1990 Amendment midwifery clearly understood the need for autonomy in order to have a professional identity. This professional identity carries with it a moral obligation to provide the service women called for and which only midwives can provide. Without independent practice provided throughout the whole maternity experience, midwifery reverts to an occupation, midwives lose their 'with women' status, and women lose the opportunity for an alternative childbirth service.

*Women-centred*

Midwifery exists only to meet the needs of pregnant women and their babies. The midwifery partnership is women-centred. Within midwifery women-centred is defined in the context of pregnancy and childbirth and celebrates the centrality and value of women's experiences and culture. The woman's focus is on herself, her baby and her family, whilst the midwife's focus is on the woman. This is the essential difference between the midwifery and medical models of childbirth. In the medical model the central focus is on the fetus or baby with decision-making resting with medicine. In the midwifery model the woman is at the centre of care rather than the baby. It is not that the baby is unimportant or does not have needs, but that the midwifery relationship is with the woman who has the primary relationship with the baby and is responsible for decision-making. As Julia Cumberlege says in the recent visionary United Kingdom report 'Changing Childbirth':

*No one has a greater interest in a healthy baby and a happy outcome than the pregnant woman herself (Department of Health, U.K., 1993: ii).*

The midwifery partnership is women-centred because:

- \* The midwifery relationship can only occur with a woman.
- \* Each woman brings with her a unique set of characteristics and circumstances.
- \* The woman identifies and defines all other relationships within her childbirthing experience. The woman identifies the priority of these relationships. The midwife has access to these relationships through the woman.

- \* The midwifery service is dictated by each woman's identified needs.

The New Zealand College of Midwives and the Nursing Council of New Zealand define women-centred as:

*The woman is the focus of Midwifery care, and it is she, in partnership with the Midwife, who identifies her priorities for care (NZCOM, 1993: 48; NZNC, 1992: glossary).*

Women-centred care does not exclude or negate the important role others play in the woman's experience. It merely recognises the woman as the one who defines who these 'others' are and the part her partner and/or family will play. These relationships range from total independence and self-determination to collective decision-making within the context of the woman's family/whanau.

In the midwifery partnership the woman and her baby are surrounded by those whom the woman considers important. The beliefs and values of this group will impact on the woman and will be recognised by the midwife through individual assessment. She also recognises the variety of connections the baby will have within this group.

Whilst the woman and the midwife are always seen within their own culture and environment, it is important to remember that outside the intimate circles of the partnership, the woman and the midwife exist within the wider social context of New Zealand society. The woman and the midwife are shaped by history, family, socioeconomic structures, gender and culture. The midwife must understand her own cultural background in order to work safely with women from other cultures.

**Theoretical concepts**

The philosophical beliefs as discussed provide the conditions under which the midwifery partnership can be formed. Successful establishment and maintenance of the midwifery partnership, however, is dependent on the integration in the relationship of the following concepts or principles:

- \* Individual negotiation.
- \* Equality, shared responsibility and empowerment.
- \* Continuity of care.

*Individual negotiation*

This partnership is between the woman and the midwife who share an understanding of their lived and living experiences of pregnancy and childbirth. The underlying premise of the partnership is that it is individually negotiated, recognising the essential contribution of each. Each partner has an acknowledged expertise; the midwife for her midwifery intuition, scientific

knowledge and experience; the woman for her intuition, intrinsic wisdom, self-knowledge and experience.

Individual negotiation is the method by which the woman and the midwife work through issues of choice, consent, decision-making, power sharing, mutual rights and responsibilities as these arise within the partnership.

The ability to negotiate and maintain control over one's experiences is an important avenue for addressing the discrimination and inequalities within the health system which have been directed against women simply because they were pregnant.

Negotiated partnership also heightens the midwife's awareness of her historical oppression which divorced her from the women-centred relationship which defines midwifery.

Webb (1986) argues that this way of working and relating to each other helps all women to become more knowledgeable and assertive.

*Equality, shared responsibility and empowerment*

Within the partnership both partners have equal status. Knowledge and power are shared between the partners and must achieve a balance which is negotiated and mutually satisfactory. The balance will be influenced by the social context of both the midwife and the woman. Issues of education, class, culture, socialisation and gender all impact and can unbalance the partnership if not recognised. The partnership is a dynamic one and through negotiation the balance may change at times to reflect the changing needs of the partners. In this model power is not seen as property. It is not 'given' or 'given up', but exercised in the act of sharing. Foucault (1980: 98) argues that power 'only exists in action' and that 'individuals are the vehicles of power, not its points of application'.

In the midwifery partnership the midwife cannot be seen as the only authority in the relationship. Rather she is 'the experienced, accompanying, knowledgeable and supportive presence' to the woman (Pelvin, 1992: 7). Control of the experience and responsibility for decision-making remain with the woman. This belief is expressed by the New Zealand College of Midwives (1993) in their Code of Ethics as:

*Midwives accept the right of each woman to control her pregnancy and birthing experience (p. 10).*

The fact that the midwifery profession is autonomous enables the midwife and the woman to make their own decisions. The midwife, however, is not autonomous within the partnership. She supports decision-making as a shared responsibility between herself, the woman and her family, but the woman is recognised as the primary decision-maker. The midwife remains accountable to the woman and to the midwifery profession for the professional knowledge and skills she provides and cannot abdicate



responsibility for her own actions simply because the woman is the ultimate decision-maker. The woman also has the responsibility to share information with the midwife when it will impinge on midwifery care. In this balanced partnership the woman is also accountable for her decisions.

Women who are given the opportunity to reflect on their birth experience have often described feelings of powerlessness and lack of control. Fersterer's (1993) interviews with women in New Zealand explored women's experiences of childbirth in relation to their empowerment in childbirth. She quotes:

*The Midwife didn't really suit my way of thinking ... she didn't give me the kind of confidence to carry on ... I would have had a bit more confidence if I had ... had the chance to get to know the Midwife ('Caroline' cited Fersterer, 1993: 92).*

*I knew I would be like that and I knew that I should stand up for myself, because that's what they always taught us ... that it's the patient's right ... but when it came to it I didn't and I was really angry at myself, and I just wanted to get home ('Lisa' cited Fersterer, 1993: 128).*

*Having her (6th Baby) was quite a learning thing for me. I learned an awful lot having her compared to the others. I felt that I was in control and I gave birth to this child ... I was very pleased with myself ... I didn't panic ('Sue cited Fersterer, 1993: 91).*

midwife to be comfortable and confident to trust women to reach their potential. It enables her to constantly redefine her midwifery knowledge, to act without prejudice, free of evaluation and judgment. Pelvin (1990) describes the process of empowerment for women when she says:

*For it is in the relationship between women and Midwives as they go through the childbearing process together that the message of value and worth is given. It cannot be given by strangers mouthing words - it is given by the Midwife's commitment to the woman and the process she is involved in (p. 5).*

Mason (1993) takes the concept of reciprocity further in his dissertation *Becoming Midwife-Becoming Other*. He believes that the midwife's familiarity and knowledge of the normalcy of childbirth and the uniqueness of each woman means:

*... that the aware Midwife is not only 'being-with-woman' but also 'becoming-woman' with her client, as she 'becomes-mother' during the moments of birth.*



Equally, through the development of trust and confidence by the woman with a known midwife, the woman:

*... will 'become-Midwife' as she actively assists her child in the unfolding process of birth.*

Advocacy should not play a significant part in the partnership model. Advocacy, by popular definition, implies dependency and whilst there may be episodes which necessitate the midwife acting on behalf of or speaking for the woman, this is done in a co-operative model rather than an advocacy model. The midwife's role is one of empowerment towards self-determination rather than advocacy. A healthy partnership should achieve a personal sense of independence, achievement and self-fulfilment for both partners. Advocacy, however, does belong in the political arena at the professional organisational level. Midwifery as a profession committed to improving the health and status of women has an ethical responsibility to:

*... advocate policies and legislation that promote social justice, improve social conditions and a fairer sharing of the community's resources (NZCOM, 1993: 11).*

Informed choice and informed consent are also inherent within the midwifery ethos of partnership and provide an important mechanism for empowerment. If the woman is to be an effective partner within the relationship, she must make her own choices. The midwife's responsibility is to provide enough information to enable the woman to make an informed choice and decision. The Department of Health, in its publication *Principles and Guidelines for Informed Choice and Consent*, identifies the principles of informed choice and consent as autonomy, responsibility and accountability (DOH, 1991). They emphasise the autonomy of the individual and the respect for the rights of individuals to make decisions about actions which affect them. They say informed choice can help to:

- \* increase people's control over their lives, and increase their autonomy and integrity
- \* promote trust and partnership between the health care user and the health care provider
- \* encourage individuals to accept responsibility for their health (DOH, 1991: 7)

It is important that midwives understand how the dynamics of power and control can either undermine or ensure a successful partnership. When articulating midwifery as a partnership of equal status, midwives have redefined the accepted view of professionalism. Instead of seeking to control childbirth, midwifery seeks to control midwifery in order that women can control childbirth. Midwifery must maintain its women-centred philosophy to ensure that its control of midwifery never leads to control of childbirth.

*Continuity of care/continuity of caregiver*

Continuity of caregiver is fundamental to the ability of midwives to build the midwifery partnership. The woman and the midwife need the time and opportunity to develop a trusting relationship. Flint (1993) refers to this as 'getting to know her'.

Continuity of caregiver means one midwife (and her backup colleague) providing midwifery care throughout the entire childbirth experience. Continuity of care means a small group of midwives, one of whom is identified as the primary practitioner, providing midwifery care throughout the entire childbirth experience. This is sometimes referred to as team midwifery.

Team midwifery in an employed setting may be problematic depending on the organisational context. If the organisational philosophy is not women-centred the needs of the organisation may

take precedence over those of the woman. Furthermore, historical conditions of employment and ways in which midwives work may encourage midwife-centred rather than women-centred services. For continuity of caregiver to be a reality for both the woman and the midwife, the teams must be no greater than three and priority must be given to comfortable caseload numbers, access to significant leave periods and the ability of the midwife to carry her own caseload and practise in her own right. Part-time midwifery requires a decrease in caseload rather than increased team numbers. Ethically this concept of continuity of caregiver must be available for all women regardless of their health status.

Continuity gives the midwife access to the woman's complete maternity experience, which increases both her confidence and knowledge base as she witnesses the outcomes of the decisions made. This is described by Barrington (1985) when she says:

*Continuous care, involving generous commitments of time, allows a Midwife to gather a store of impressions that will substantiate future intuitions and actions. Her familiarity with the norms of mother and babe enables her to notice deviations from these norms immediately (p. 19).*

Continuity gives the woman the opportunity to build a trusting relationship with the person who will share this intimate time in her life. Trust will increase her ability to make informed choices and control her experience (Flint, 1993). Peta, cited in Fersterer (1993), explains how important trusting the midwife was to her.

*I was perfectly happy with Kathy ... because she listened. She listened and she cared. That really surprised me because I didn't believe that professional people cared (with tears in her eyes). I didn't believe that they would listen. Once I realised that she did care and that she was listening, and she was thinking about me the person I began to trust her (p. 84).*

Continuity also means following the woman wherever she chooses to give birth. This means that there are no different kinds of midwives – a midwife is a midwife is a midwife! Some years prior to the Nurses' Amendment Act, midwives recognised this in their advertising poster 'A midwife is where a baby is born'.

Surveys of women who have experienced maternity services have consistently identified continuity of care as a priority (Bickley, 1989; Canterbury Area Health Board, 1991; Auckland Maternity Services Consumer Council, 1993). The current health reforms have led to a restructuring of the country's maternity services, based on a preliminary report by Coopers and Lybrand (1993) which consulted maternity care

providers and consumers throughout New Zealand. An underlying principle for this restructured service is continuity of care.

*The people with whom we met were unanimous in their support for the concept of continuity of care, despite differences in the actual definition applied (Coopers and Lybrand, 1993: 11).*

The report contends that continuity of care will decrease fragmentation and will lead to a more women-centred service.

### Conclusion

We have endeavoured to show the historical and cultural influences on midwifery's development in New Zealand. This theory of partnership has evolved from practice and the process has been collaborative between the authors. Partnership is demonstrated on a daily basis by observing women and midwives working together. Our own experiences as midwives have reinforced it. Any theory which arises from practice is accessible and meaningful to all practitioners. As more midwives reflect and research their practice, so too will this theory evolve.

It must be recognised that what has happened in New Zealand maternity services is revolutionary. To challenge and turn around decades of medical-centred maternity services to a consumer driven women-centred maternity service in such a short time frame is a remarkable achievement. The challenge for women and midwives is to sustain the momentum and bring about long lasting and meaningful social change which continues to value women's status and experiences within the childbearing continuum.

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## Midwifery Practice

Dear Editor,

It was with great interest that I heard the College of Midwives is now taking up the cause of the hospital-based midwives. I was overwhelmed at this positive initiative towards that ever-present group of midwives who practise midwifery in a hospital. I say 'practise midwifery' on the premise that as a hospital-based midwife, I consider I do practise midwifery. So how can I possibly consider this after all, tantamount to the practise of midwifery is the 'partnership'. Naturally this must be qualified by the principles that this very specific partnership is developed over a long period of time and thus there are many opportunities to extend and deepen that relationship. Yes, knowing a woman allows for many justifications of the issues of midwifery such as continuity of care, something hospital midwives can provide, a midwife at every step of the way. (More important is continuity of 'carer' and this is the significant factor in consumer pressure for a service tailored to the individual, this is something hospital-based midwives cannot provide except via the team concept.) Paramount to all is the safety of woman and baby (homebirth being the safest of all, something hospital-based midwives cannot provide unless, again from the team midwifery perspective). For these things I applaud my colleagues who 'really' practise in this way.

Why is it argued that an effective 'partnership' cannot be formed between a midwife and a woman transferred for emergency care or a woman who may find herself in the care of a hospital-based midwife? A 'partnership' that may only be short but is functional and robust is just as important as the longer-term relationship formed in the community and extending through the term of pregnancy serve a specific purpose. I would suggest, as an observer of the NZCOM, that the demarcation between hospital-based and community-based practice exists because the adoption of the term of the specific 'partnership' of midwifery, and its qualifications is a superficial term, coined to justify the lack of substance engendered by the dogma of a small group that signify what midwifery has become in New Zealand. It is a 'front' for a far more fundamental process. That process can occur in a room, on a beach or, dare I say it, in a hospital. It is something that is part of us all, it is gender less, but as devotees we can afford the term 'midwife'. It is being with a woman, providing a back-drop for the maintenance of her integrity, providing her with space in any environment to take each step, small or large, through an experience so fundamental that we can only watch.

Yours sincerely  
Kim Wheeler  
Wellington

## Royal New Zealand Plunket Society (Inc.)

Dear Editor

I would like to take this opportunity to add clarity to the title 'Plunket Nurse', used in the review article by Gail Warwick in the book *New Zealand Baby and Toddler* by Helen Tomson and Sylvia Wood.

The review description is fair, honest, relevant and interesting to readers. I support the comments made, and agree with the reasoning given. I would like to share with readers dialogue about the use of the title 'Plunket Nurse' referred to in paragraph four.

Plunket nursing represents an occupational group of nurses certificated by the Royal NZ Plunket Society Inc. The 1994 certificate states that 'NURSE'S NAME has achieved the required knowledge and skills for the promotion of family health and parenting in the community, and is registered with the Royal New Zealand Plunket Society as a Plunket Nurse'.

Therefore Plunket Nurses are able to claim the title when they are employed by the Society, once they have accomplished the certification process which takes almost six months involves at least 500 study hours. Although the Nursing Council recognises Plunket Nursing as an occupational group along with other organisations, the qualification has greatest meaning to the Society and their stakeholders. Plunket Nurses are proud of their achievements and identity, which is not always fully understood by nursing at a time when the politics of nursing knowledge are being redefined.

Plunket Nurses who may not work for the Society find it difficult to know what to call their expertise, so the title of Plunket Nurse is often used out of context.

The Society has recently updated many of the hallmarks of professional nursing for employed nursing staff. Statements, claims and views of nurses using the title 'Plunket' (Nurse) do so without necessarily gaining the support of the whole group of Plunket Nurses in current practice.

However, it is rare that the employed Plunket Nurse group objects to ex-colleagues using the title Plunket Nurse and, so far, there is no mechanism to prohibit the use of the title out of context. I imagine that this phenomenon occurs in other fields of nursing as well.

The logical status of nursing knowledge more often than not arises from the needs of practice. The thesis by Joan Lambert (1994) titled 'They Don't See What We See' is an excellent description of this point. Practitioners produce their own way of organising a matrix to account for their work and associated problems. The book by Helen Tomson is one example of this. I, for one, take the position that differing views are as valuable as claims made.

I conclude by extending an invitation to midwives who may wish to learn about the professional activities of the Plunket Nurse group to contact us any time for dialogue, sharing of views, networks, information - whatever.

(Abridged)

Yours faithfully  
Florence Trout  
National Educator/Quality Facilitator  
Royal NZ Plunket Society Inc.

## A Uniquely New Zealand Problem?

A copy of a letter sent to the Chairman of the N.Z. Wool Board.

Dear Sir,

I have recently looked after a woman who works as a shedhand in a shearing gang. She is suffering from repeated breast abscesses and she tells me this is a common occupational hazard.

I talked today with another woman who used to be a shedhand and she assures me this is a fact. One country GP has told me of a woman who is contemplating having both breasts removed surgically because she is sick and tired of recurrent breast abscesses. The causes seem to be:

- short second cuts of wool penetrating the clothing and getting into the milk ducts and subcutaneous glands, causing infection and abscess formation,
- greasy and dirty wool, and
- wet fleeces.

This is obviously an Industrial Health and Safety issue and I am wondering:

1. Is the Board aware of it?  
How widespread is the problem?  
Is the Board doing anything about it?
2. If the Board is not aware of the problem, is it prepared to investigate the issue and set aside some of its research budget to develop some form of protection for female shedhands who work in the industry?
3. Are shearing contractors aware of this problem and do they educate their female shedhands about the risks and hazards?

I am told that there is some protective clothing available from the U.S.A. which is impenetrable and therefore does not 'breathe' which makes it too hot to wear in the shed. It is also very expensive and that is a problem for people on a low and seasonal income. I am acutely aware of the fact that a great number of women who work as shedhands are Maori women who would be reluctant to talk to their employer about this issue but this is 1994 and, as a midwife, I think it is time it was brought out into the open.

The consequences of this industrial hazard are horrendous. These women have great difficulty establishing breastfeeding because the infections damage the milk ducts and the lancing of the abscesses produces further scarring. Of course, non-breastfeeding has its own cost to the nation and to the family. Research has shown that an artificially-fed infant is 10 times more likely to be admitted to hospital in the first two years of life than a breastfed baby. Postnatal depression is more common in women who do not breastfeed. The cost of milk formula is around \$14 per tin. Initially this may not create a problem, but by the time a baby is four-or-five months old it goes through two tins per week which is an enormous cost to a family already financially stretched, or to the tax payer in the form of extra benefits. I feel this is an important issue and I look forward to hearing from you with answers to my questions. I am sending a copy of this letter to the New Zealand College of Midwives.

Yours faithfully  
Gelske Gardiner  
Kaipoi

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	185213	L-Combur-5-Test	50				✓	✓	✓	✓			✓
	Screening	398454	Nephur-Test + Leuco	50		✓	✓	✓	✓	✓			
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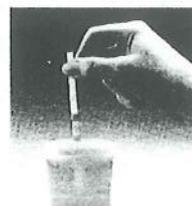
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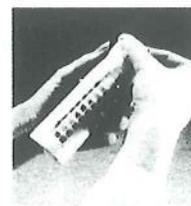
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# Six Myths that can Lead Us Astray

Murray W. Enkin

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First, and most importantly, I want to thank the New Zealand College of Midwives for the opportunity to visit your beautiful country, and to meet and exchange ideas with so many beautiful people. The midwives of New Zealand have set a standard of care, dedication, and organisation that is without parallel, and should serve as a shining example to the rest of the world.

During my all too brief time in your country, I travelled from North Island to South, from Auckland to Dunedin, with many stops en route. I met with independent midwives, hospital midwives, obstetricians, representatives of the Ministry of Health and of Regional Health Authorities. The people that I met were all dedicated to the concept of effective care, accessible by and available to all childbirth women. They all recognised the difficulty, even with the best of intentions, of putting that concept into practice.

In an ideal world, the most effective care for every condition would be known; every caregiver would know the most effective care for each woman, and every caregiver would practise the most effective care they know. Unfortunately, we do not live in an ideal world. Much of what should be known is not known; the essential research has not been done. Much of what could be known, based on good evidence, is not known by most clinicians; the evidence is voluminous, scattered, and its validity is difficult to assess. Most seriously, clinicians often fail to practise what they know to be the most effective form of care, because of the many other factors that tend to motivate and determine their behaviour.

In my presentations throughout New Zealand, I tried to raise our collective consciousness about some of the common but invalid assumptions, or myths, that can lead us seriously astray. The myths that I drew attention to included the following:

1. Association means causation.
2. If everyone believes it, it must be true.
3. Prevention is always better than cure.
4. The myth of the magic bullet.
5. The myth of authority.
6. Experience is the best teacher.

## Myth Number 1 Association Means Causation

Perinatal mortality has dropped significantly during the past few decades. This improvement has been associated with improved methods of antenatal surveillance. It has also been associated with increasing use of electronic fetal monitoring in labour; more intensive neonatal care; improved nutrition and general health of women; an astronomical rise in the rate of caesarean section; a small but significant rise in the rate of childhood handicap; a major increase in crime and violence

on television and in the streets; the introduction of in vitro fertilisation; the formation of the National Perinatal Epidemiological Unit in Oxford; the election of Ronald Reagan and Margaret Thatcher; New Zealand declaring itself a nuclear-free zone; and the Oscar-winning performance of Anna Paquin in *The Piano*.

Which, if any, of these associations are causal? If any, which is the cause, and which is the effect?

The myth that association means causation is seductive, and dangerous, because it can lead us far from the truth.

There are too many exceptions to the simple dictum '*post hoc, ergo propter hoc*' (after this, therefore because of this) for us to put any reliance on the observation 'I was sick, now I am cured, therefore the treatment was the cause of my recovery'.

## Myth Number 2 If Everyone Believes it, it Must be True

The widespread use of electronic fetal monitoring throughout the industrialised world testifies to the ubiquitous belief that it will almost guarantee a healthy baby. Yet, well controlled clinical trials have shown that continuous electronic fetal monitoring has no effect on important outcomes like perinatal death or childhood handicap. It does, however, have an important adverse effect on the mother, resulting in an increase in caesarean section rates, in maternal infections, and in women's feelings of being restricted or of being left alone.

Similarly, many childbirth educators, midwives and childbearing women believe that a natural childbirth, with involvement of their partners and immediate breastfeeding of their infant, will lead to instant bonding and a happy family ever after. Worse still, they may believe that if natural childbirth or instant contact with the baby is not possible their future relationship will be seriously jeopardised. Sadly, sometimes this can prove to be a self-fulfilling prophecy. Bonding is not an instant glue, and nature has devised a multitude of mechanisms for mothers and babies to form and cement relationships. The birth experience, while important, is not an overriding one.

Beliefs, when not based on valid evidence, can be both misleading and dangerous.

## Myth Number 3 Prevention is always Better than Cure

Antenatal care is a prime example of preventive care, and the association of antenatal care with improved pregnancy outcome is unquestioned; but what exactly antenatal care consists of, and how it works, is much less clear. As carried out today, much of antenatal care has become a gigantic screening exercise in which the most serious 'crime is a missed diagnosis. The result is that 'nonsense' (so-called problems that would have been a problem without being labelled) is much more common than missing a true diagnosis. This has resulted in the bizarre dictum that 'no pregnancy is normal except in retrospect'. Carried to its logical conclusion, this would mean that 'health is simply a state of inadequate diagnosis'. The example of 'gestational diabetes' comes to mind; a biochemical variant in pregnancy, with no reproductive diagnostic criteria and no meaningful treatment.

The aphorism 'a stitch in time saves nine' is appealing. But a single stitch taken a hundred times to save the need to take nine stitches once, does not really help matters. Excessive diagnostic effort can 'reveal' pathology that is not there, cause unnecessary anxiety, and unnecessary intervention.

## Myth Number 4 The Myth of the Magic Bullet

The success of antibiotics in treating formerly serious infections has led to a widespread faith that there is an effective treatment for every problem, if only we can find it (a pill for every ill). This has resulted in the pernicious tendency to report, publish and believe positive results, and to suppress or ignore negative results. We are much happier to read that something works (even if it is not true), than that something does not work.

*Continued on Page 21*



Photo: Jane Scotts

# Immunisation

Joan Donley O.B.E.

Independent Midwife, Auckland

## Response to Public Health Commission Draft Immunisation Standards Paper

Public Health Commission – In order for the standards to be effective, they need to be reasonable, realistic and widely supported.

In responding to this Immunisation Standards draft, reference was made to the Public Health Commission (PHC) *Report of the Expert Working Group on the National Immunisation Strategy* 1993. Some of the attitudes reflected in this report gave cause for concern. We are therefore responding with reference to this publication.

## Informed Consent

The Draft states:

Informed consent must be obtained, but need not always be a written consent.

For consent to be 'informed' parents have to be fully informed on both the pros and cons of the issue. Therefore, each parent should be provided with a leaflet outlining, not just the PHC's rationale for immunisation, risks and contraindications for deferring treatment, as listed in the PHC's *Immunisation Handbook*, but also the basic arguments referred to as 'anti-immunisation propaganda' (p. 19). This infers that the PHC deals only with unadulterated truth while the anti-immunisation parents spread opinions or beliefs – hardly the basis for 'informed consent'.

Does the PHC fear that this 'propaganda' could undermine its immunisation programme? If so, one has to question the PHC's scientific base.

If standards are to be reasonable, realistic, widely supported and meet the terms of informed consent rather than passive compliance, or 'mandatory choice' (p. 13), the parent certainly should give written consent based on all available information – at least at the beginning of the immunisation programme.

It is not only parents who question the PHC's aim to have 90 per cent or more New Zealand children immunised by the year 2000.

In a radio broadcast on Radio New Zealand, August 1991, Dr Roger Booth, PhD in Immunology, Auckland Medical School said:

*We've learned a lot in the last 20 years, we've learned that the (immune) system is very, very complex and has enormous subtleties. One of the striking things we've learned in the last 10 years about the system is it interacts with other systems in the body in numerous ways ... the more we learn, the more we find there is to learn about it ... If one was going to introduce a change in the system, I think we'd have to be fairly certain as a society, the sort of benefits that would accrue from the procedure outweigh the potential risks. At the moment, it doesn't seem to me we have had long enough evaluating, for example, vaccine-related adverse effects, to be able to say what the statistics are, with any great certainty.*

On the same programme, Professor Campbell Murdoch made a comparison between mortality and what parents teach their children about how to eat, drink, drive a car safely. 'In contrast ... the decision to immunise one's child is not going to have any impact at all on the mortality of these children ...'. He felt it was unnecessary to 'extract an inquisitorial confession from those who happen to disagree with society in terms of immunisation'.<sup>1</sup>

## Advice on Side Effects

Parents should be given a written list of possible side effects and contraindications.

The latter is listed in the *Immunisation Handbook* which costs \$7.00. With 510,000 New Zealanders currently living below the poverty line, they are not likely to have access to this information in order to make an informed decision about what the PHC defines as a 'true' contraindication. It would appear that an important measles side effect has been missed (see below).

The parent should be advised to report any side effects to the provider, and s/he should also

make a report to the Adverse Reactions Committee, Otago Medical School, PO Box 913, Dunedin.

## Strategies for Improving Coverage

One of the PHC's key components is to establish a 'mechanism for follow-up and immunisation of those missing out'. Are there any 'plans' for those exercising their democratic right to opt out?

One would hope that any strategies for improving 'coverage' would not stoop to some of the campaigns of the past – like the Health Department plan to encourage meningitis immunisation in conjunction with Homestead Chicken offering GREAT PRIZES!

## Measles, Mumps and Rubella

As midwives we are especially concerned about the PHC's aim to have 95 per cent of preschoolers vaccinated against measles – German (rubella) and English.

Vaccination against rubella was introduced in 1966. Six years later, medical virologist, Dr Beverley Allan, University Department, Austin Hospital, Melbourne, conducted trials on army recruits. These recruits had been selected for lack of immunity as determined by blood tests and immunised with attenuated virus (Cendevax). All were confirmed as serologically immune. Four months later, 80 per cent of these 'protected' men succumbed to rubella. Dr Allan undertook a further trial at a mental institution with similar results. She questioned the immunological security of antibody titres and the usefulness of mass vaccination.<sup>2</sup>

On 26 February 1976, Sir Henry Yellowlees, then Chief Medical Officer of Health (U.K.), in a press statement, said that in spite of high levels of vaccination there had been no detectable reduction in the number of babies born with birth defects.

Paediatrician Dr Mendelsohn claims: 'A large proportion of children show no evidence of immunity in blood tests given only four or five years after rubella vaccination. As women they may contract rubella while pregnant, with damage to the unborn child.'<sup>3</sup>

Nobel Prize winner, Dr John Enders, in the



*New England Journal of Medicine*, states that 'vaccination of young girls make the chances of their contracting rubella when they grow up greater, not less, since vaccination only confers partial protection, unlike the naturally acquired disease which gives full protection from reinfection'.<sup>4</sup>

It has been known since 1992 that rubella vaccine does not act on the immune system in a fashion similar to the natural disease. The antibodies after vaccination are inferior to those measured after the disease. Some vaccinated subjects develop dubious immunity which suggests insufficient protection. Immunological failures range from 5-15 per cent. In 1982 a few cases of embryopathic rubella were reported in spite of maternal vaccination.<sup>5,6</sup>

In New Zealand in the last 10 years there have been an average of two such notifications of congenital rubella each year,<sup>7</sup> i.e. 20 affected babies. (Animal experiments show it is vitamin A deficiency in combination with the virus that causes defects.) Yet, *Immunisation Choices*, Department of Health, June 1993, states:

*It is to prevent congenital rubella that immunisation against rubella is recommended ... . Almost all children who receive the (MMR) vaccine as recommended will have lasting immunity to all three diseases.*

Is the Department unaware of these studies? Surely, in the interests of standards being reasonable, it would have carried out a literature review before making the above statement? We would suggest that a literature review be carried out in preference to putting a guilt trip on women for failure to have babies immunised against rubella.

### English Measles

Our concern about English measles is the danger of atypical measles following immunisation. This is a very severe form which has been noted in 50 per cent of children vaccinated when under 12 months of age and occurring up to 16 years later.<sup>8</sup>

On 23 July 1991, the *North Shore Advertiser* reported that school children who were previously immunised against measles were among those affected – seen as the 'tip of the iceberg' by Dell Hood, North Harbour Deputy Medical Officer of Health. Hood suggested that when babies were immunised before they were 15 months they did not respond due to the persistent antibodies passed on from the mother during pregnancy.

By November the *New Zealand Herald* reported that nearly 8,000 cases of measles had been reported to the Health Department since June. The Director of Health acknowledged that 50 per cent of the reported cases occurred in immunised children.

In 1992, AP wire service reported that a large number of those vaccinated for measles

had reached childbearing years. Their babies were unusually susceptible to measles in their first of life when the disease is potentially life-threatening. At present more than one-quarter of all U.S. measles victims are under one year old. Before the era of vaccination, everyone who recovered from measles carried high levels of antibodies for the rest of their lives and women passed these antibodies to their fetuses.<sup>9</sup>

Further, babies breastfed by a vaccinated mother are far less protected.<sup>10</sup>

Side effects of measles vaccine not mentioned by the Department of Health are ataxia, seizures, aseptic meningitis and hemiparesis.<sup>11,12</sup> Our concern about these side effects has to do with demyelination. A child's nervous system develops in two stages – during pregnancy and after birth. After formation of the neurons and axons, the process of coating with tough, white waterproof insulating myelin occurs. Prior to myelination,

the nerve fibres are vulnerable as nerve impulses travel more slowly through unmyelinated fibres and can short circuit. At birth, myelination has only just commenced. In some nerves it does not even start until eight months or later.<sup>13</sup>

Since the cerebral hemispheres and cerebral cortex are the phylogenetically newest parts, they are the last to be completely myelinated – even to the fifth year or later. Anything that interferes with myelination hinders the child's neurologic development and maturation.

Almost any ... vaccination can lead to a noninfectious inflammatory reaction involving the nervous system ... . The common denominator consists of a vasculopathy that is often associated with demyelination.<sup>14</sup>

### References

Available from Author on request.



## INTERNATIONAL SYMPOSIUM

- Eminent speakers from around the world will share their knowledge on an issue of concern to every parent and health professional.
- The safety and effectiveness of vaccines.
- The role of the drug companies in research.
- The relationship between vaccination and cot death.
- The international move to compulsory vaccination.

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# Perineal Suturing

Jan Carew

Midwife  
Auckland National  
Women's Hospital

It is estimated 70 per cent of women (in the developed world) are likely to require repair of perineal trauma following childbirth. Grant (1986) states that the majority of these women experience perineal pain or discomfort in the immediate postpartum period. Three months later, as many as 20 per cent still have problems, such as dyspareunia, which can be attributed to perineal trauma and/or its repair.

The repair of perineal trauma should be carried out by doctors or midwives fully trained in this surgical technique.

In 1990 the midwives researched the suturing practices within Auckland's National Women's Hospital - a level III referral centre with approximately 8,600 deliveries per year. At this time, midwives were repairing less than one per cent of perineal trauma. It was then decided to review techniques of perineal repair, with reference to current research findings. A quality assurance programme was designed to enable midwives to become skilled in the techniques of perineal repair.

It seems likely that the skill of the operator is more important than the materials and techniques used. At present there is little research on the effects, skill or symptoms associated with perineal repair. Experience does not necessarily result in a better outcome - the same mistakes may be made with increasing confidence!

As training is likely to have an important effect on the outcome of perineal repair, which has been a neglected area of research, it was time to implement a training programme at Auckland's National Women's Hospital.

From the research of literature, optimal perineal repair was dependent on three factors:

1. skill of the operator
2. choice of material
3. method of repair.

## Method of Repair

Grant (1985/6) stated: 'in England there was no consensus about which technique is superior.' To date there has been no controlled clinical trials which have been compared for repair of the vaginal wall, or methods for repair of deeper perineal muscle layers.

A continuous interlocking suture for vaginal repair is often preferred, on the grounds of providing better haemostasis, rather than a

continuous over and over suture which may concertina the posterior vaginal wall. This, however, remains purely an operator preference as no trials have compared these two methods.

Continuous subcuticular suturing appears to be superior to interrupted transcutaneous sutures for repair of perineal skin (Capony and Werner, 1980; Isager-Sally *et al.*, 1986; Mahomed *et al.*, 1989).

The clear-cut advantage of subcuticular sutures significantly less pain in the immediate postpartum period.

Interrupted sutures clearly have a place for particularly ragged tears which are unsuitable for a subcuticular suturing method, or for small skin tears requiring one or two sutures.

## Choice of Material

Traditionally, the absorbable material used for perineal repair has been catgut for the vaginal wall and muscle layers, with either silk, catgut or occasionally nylon used on the skin.

Clinical trials have indicated that Polyglycolic Acid (PGA) sutures should be used for both deep layers and the skin. This synthetic absorbable suture material is associated with up to 40 per cent decrease in perineal pain in the early puerperium when compared with catgut (Grant 1989).

Overall, from a review of the clinical trials comparing catgut, silk, nylon and PGA suture materials, a clear choice reducing postpartum perineal pain was PGA, with a subcuticular suturing technique to the skin.

Mahomed *et al.* (1989) noted in a trial the need to remove some PGA suture material during the puerperium, due to irritation and tightness, but this was offset by the reduced need for resuturing when compared with chromic catgut (this trial did not look at the operator, training and other variables).

## The Development of the Programme

In 1990, a quality assurance programme was developed to enable midwives to become skilled in perineal repair.

*Midwives Competency in Suturing of 1st Degree, Small 2nd Degree Episiotomy and Small Labial Lacerations*

To acquire skills in suturing and achieve an accepted level of competency, the midwife will:

- \* Attend a teaching session on suturing the perineum (videos are also available).
- \* Witness a minimum of five instances of suturing, including an episiotomy, 1st degree tear, small 2nd degree tear and a labial laceration.

- \* Perform a variety of repairs supervised by a designated midwife, consultant/registrars. A record must be kept of these repairs.
- \* On completion of these repairs, the midwife requests assessment of competency by the midwife manager/consultant or designated midwife.
- \* Competency in suturing is then recorded on the midwife's record.

The following points are guidelines only:

- \* Repair episiotomy/tear as soon as possible after delivery (otherwise this can cause unnecessary blood loss and discomfort).
- \* Explain the procedure to the woman.
- \* Ensure aseptic swabbing technique is performed.
- \* Change bottom green-drape prior to the procedure.
- \* If appropriate, change gloves.
- \* Adequate analgesic is important, one per cent lignocaine may be required, maximum dose 10mls.
- \* Apex must be visualised and oversewn.

Techniques may vary, but, in general, chromic catgut for all layers with interrupted or subcuticular 2/0 chromic catgut suturing to perineal skin.

## Termination of Procedure

1. Remove vaginal pack.
2. Vaginal examination - visualise apex.
3. Rectal examination.
4. Count swabs.
5. Count needles.
6. Apply ice packs.

Approved Delivery Unit Review Committee 1991.

## Self-Sufficiency

In the next stage midwives are to become self-sufficient.

Two midwives, with a particular interest in suturing, have assumed the responsibility of running suturing workshops and teaching sessions.

Sessions are held once a month. These sessions are open to all staff who want to attend.

The regularity of the sessions enables new staff to attend fairly early and then begin supervised practice without too much delay.

## Summary

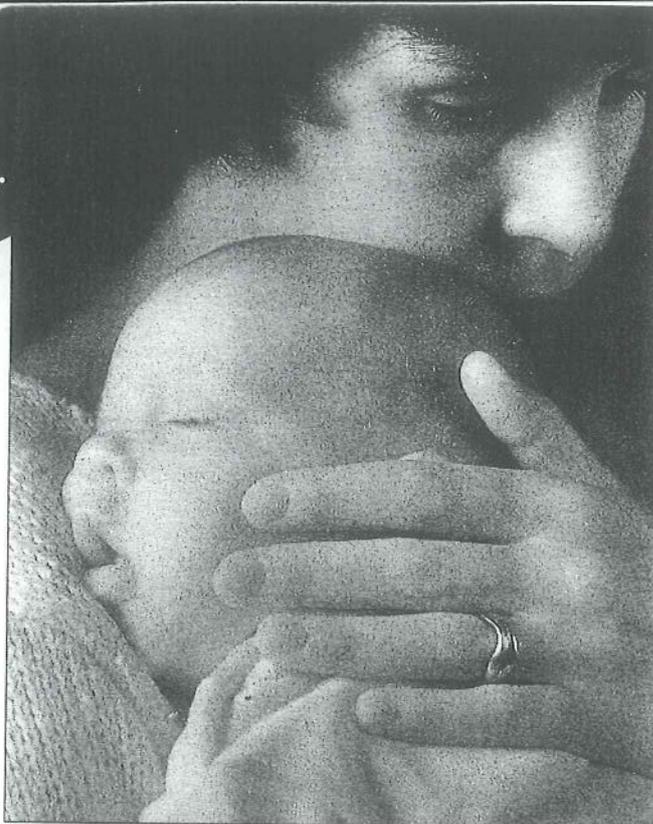
A standard, research-based technique has been developed for perineal repair, supported by a teaching/training programme by midwives for midwives.

Changes have also been made as a direct result of applying research findings to practice. It confirms midwives are self-reliant professionals able to adapt to change.

## References

Available from author on request.

**VIDEO**  
Tutorial on episiotomy suturing  
techniques. Available on loan  
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Leading article. *BMJ* 1973; iv:565.

"The post-partum assessment indicated the high level of pain experienced. Attempts to relieve pain will clearly be beneficial."

Reading AE et al. *BMJ* 1982; 284:243.

"There is a high incidence of long-term dyspareunia in patients with damaged perineum, . . ."

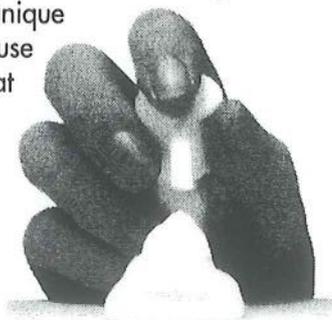
Garner P. *Br. J. of Sexual Medicine*. July 1982:11-13.

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# A Fresh Look .....

**Jean Sutton**  
**Independent Midwife, Tauranga**

**D**uring my years as a midwife and mother I have pondered about the miracle of birth and why it should be that one species, our own, seems to have more problems than any other.

I have studied and observed the birth process in many species – from tiny cage birds to kittens, piglets, lambs, calves, foals and human infants. For all of them there seems to be one and only one effective position. It would take too long to detail them all, but it seems that unless the optimal position is adopted, the young one trying to be born is doomed to failure.

Valuable animals may have the help of a veterinary surgeon but many do not, and in these cases at least the young one and probably the mother as well are lost. Humans have the help of highly trained medical and midwifery practitioners to assist, especially in the developed world.

Why is it so many of our mothers need this help? In the past 30-40 years the numbers of women apparently unable to give birth unaided has increased dramatically. The World Health Organisation states: 'No more than 10-15 per cent of women should need help', but in New Zealand between 20-40 per cent do!

### A Brief Overview

The human pelvis is perfectly designed to allow the passage of the fetus in only one effective, efficient position. This is the Occipito Lateral-Anterior (OL-A) position. In this position the fetal skull is able to fold into the smallest presenting diameter.

It is able to make use of the widest diameters of the maternal pelvis. The direction of force of the contractions is down the fetal back which increases the flexion of the head and neck and enhances the passage of the fetus. The angle also ensures the maximum pressure is exerted on the cervix to speed dilatation.

### The Functions of the Pelvis

To understand how to help an infant make the transition from fetal to independent life, we need to understand clearly the relationship between the maternal pelvis and the fetal skull.

The female pelvis is internally wider from side to side at the inlet and from front to back at the outlet. It is circular in the portion known as the cavity and is reduced at the base of this by the ischial spines.

A major function of the pelvis during natural labour is to change its angles and planes in response to the movements of the infant's head. This function can only occur if the mother is mobile.

The flexibility of the coccyx is acknowledged, but no mention of the ability of the sacroiliac area (Rhombus of Michaelis) to lift up between 1-2 cms just before involuntary pushing begins.

As the unhindered mother lifts her lumbar spine upwards and forwards (even mothers confined to bed try to do this by lifting their bottoms off the bed at the crucial stage) the posterior pelvic wall becomes almost straight! So much for the Curve of Carus!

Much time and effort have gone into measuring planes and angles which are only of importance if the mother is put to bed and attached to a variety of intravenous fluids and monitors.

The muscle tissues of the pelvic floor also need their function reviewed. In a natural birth process the perineum and its associated muscles are under very little stress, as the tilting of the maternal pelvis ensures the uterine pressure is directed into the flexible vagina, and not towards the anus.

Placing the mother on her back, whether semi-recumbent or in lithotomy position, prevents any of the natural adaptations occurring.

The maternal activity at this point was described to Sheila Kitzinger as 'opening her back' by native midwives in Central America.

### Uterine Functions

At the end of pregnancy the uterus lies with its fundus tilted towards the mother's right. This means it is easier for the fetus to lie in the LOL-LA – or ROL-P position. Currently a great many fetuses choose the ROL-P.



During pregnancy the uterus has the function of providing for the infant's total needs. Braxton-Hicks contractions have no effect on the position as the pressure is even over the whole uterus. The lower segment develops. What is its special function? It's certainly not just to provide a convenient place for a caesarian section! During labour it has a major role of moulding the fetal head. This is hard to prove, but is clearly described in old textbooks, when discussing internal version and can be confirmed by farmers and veterinary surgeons as an extremely painful grip on one's forearm – yes, I can speak from experience!!

So during labour the body of the uterus is pressing the fetus down and out, and the lower segment is shaping the baby to fit.

### The Fetus

The fetal skull is longer from front to back – at the top. The fetal neck is able to flex towards the chest. Another vital fact is that the infant's shoulders are wider from side to side. These facts give us the clue to the movements the fetus must make if it is to be born with the least possible trauma to either party.

The fetal skull is provided with areas of membranous tissue which enable it to fold efficiently when in the O-A position or to mould slowly when in the O-P position, more correctly described as Occipito-Oblique. These positions may occur in either the left or right areas of the maternal pelvis. In any other position the result is usually failure to progress or a transverse arrest.

The angle between the maternal spine and the pelvic brim determines the amount of space in which the fetus is able to manoeuvre. The fetus needs as much room as possible.

### Preparation for Labour

The head enters the pelvis at an angle of 90 degrees to the pelvic brim. Thus, if the mother spends most of her time with her knees lower than her hips, she will provide her fetus with an increased chance of entering the pelvis in the OL-A position.

On the other hand, if she rests with her knees higher than her hips she reduces the angle of the pelvic brim to her spine from 130 to approximately 90 degrees and makes it almost inevitable that the baby, if it is to enter the pelvis at all, will do so in the OL-OP position.

If the baby enters in the lateral position, as many of them do, even if she is supported by pillows, the body weight of her baby will cause it to rotate to the O-P position.

Where the membranes are ruptured, the baby is also denied the support of the liquor as she attempts to turn towards the O-A position.

The mother needs to be able to move her body in response to the movement of her baby's head. It is always amazing to observe how small a movement by the fetus will cause it to rotate to the O-P position.

### How Did We Get Where We Are?

The current problems with maternity care, with its unacceptable rate of interventionist births, may have begun when the custom of midwifery care in the home became fragmented into ante- intra- and post-natal areas to fit the staffing and teaching patterns of modern hospitals. In previous centuries pregnant women were cared for by midwives who were taught by the more experienced practitioners in an apprenticeship role. This meant that the teaching was oral, rather than written, so when schools of medicine and midwifery were established little value was placed on existing knowledge.

When medical practitioners began to consider ways to reduce the infant mortality and morbidity they had three anatomical factors to consider. These were:

1. the maternal pelvis
2. the fetus, and
3. the strength of uterine contractions.

They chose to travel down the path of increasing the strength of contractions. This has led us to the present state of affairs where increasing numbers of mothers are unable to give birth unaided. In some Western countries this has reached the level of 30-50 per cent.



### What Can be Done?

My idea is to influence the fetus before it attempts to enter the maternal pelvis. This will mean midwives taking a more active role in antenatal education, rather than leaving it to childbirth educators. Only midwives and mothers follow the infant as it enters the world. It is our privilege to help this partnership achieve the best possible outcome. To do this we must put more emphasis on the need for co-operation, as the infant attempts to prepare itself for birth. Current teaching fails to explain that all infants carry in their genes the knowledge of the most efficient attitude, so they rarely need maternal help to achieve it. Their efforts may be very uncomfortable, so mothers need to be aware of this, and prepared to move into postures that provide the most manoeuvring room.

There is one angle of entry which almost guarantees an uncomplicated birth. This is the Occipito-Lateral-Anterior position. In this position

the fetal head is able to bend forward onto the chest, ensuring the smallest possible diameter (Sub-Occipito-Bregmatic) presents. Also the fetal skull is able to fold along the suture lines and easily reduces the presenting circumference to 27.5-30.5 cms which will pass the ischial spines.

The other position in which this reduction occurs, though much more slowly, is the Occipito-Posterior/Oblique. In this position the skull bones are moulded rather than folded, but eventually the circumference is reduced sufficiently to enable the infant's head to pass the spines. Once the pelvic floor is reached, it provides a solid base for the head to rotate into the Occipito-Anterior position in the majority of cases leaving the Face to Pubes.

If the fetus fails to engage in one of these positions but continues as an Occipito-Lateral position, its skull bones are not acted on by the force of the contractions. The head reaches the spines still 36-36.5 cms in circumference and is unable to leave the pelvis. Why this occurs needs further research.

The female pelvis and the fetal skull match perfectly, if the fetal head enters the pelvis as Left-Occipito-Lateral, rotates to Occipito-Anterior before or as labour commences, the head flexes onto the chest. The pregnant woman can increase the chance of this occurring:

#### *Primigravida*

At 32-34 weeks gestation she is taught where her fetus should be lying. She should not rest/recline with her knees higher than her pelvis.

Long car trips will upset her fetus especially if she uses 'bucket' type seats.

If she rests with her knees level with or preferably lower than her seat and abdominal muscles relaxed her fetus will tend to rotate to the Occipito-Anterior position.

If the fetus does not respond, yoga exercises or the use of a rocker such as the MATERNITY COMFORT or HENDERSON will encourage the rotation of the fetal head. These rockers have a wide seat and knee pad which are necessary to accommodate the changed maternal centre of gravity.

#### *Multigravida*

If a position check at 38-40 weeks reveals the fetus in a relatively posterior position the above rules apply.

These fetuses frequently remain mobile until the start of labour and are more easily influenced. Increasing the Occipito-Anterior positions definitely has advantages – shorter labours, less intervention, more comfortable post-natal mothers and much happier newborns!

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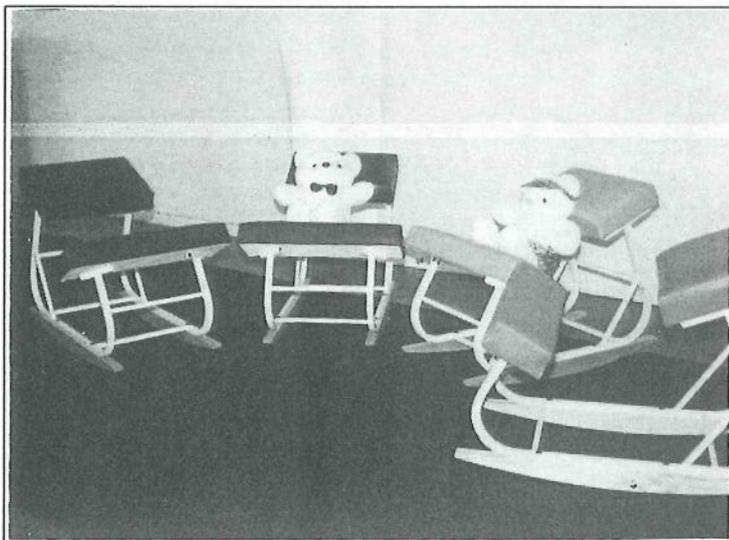
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### Myth Number 5 The Myth of Authority

Our belief in authority seems to know no bounds. We believe it because the doctor said so, we saw it on TV or read it in *The Lancet*. Yet, we know that the advice we have received from acknowledged experts over the years has been conflicting and changing. Women were admonished to gain weight during pregnancy, to have routine X-rays of the chest and pelvis, to undergo enemas and pubic shaving in labour. How many current practices continue because those in authority support them, despite a lack of evidence that they improve the health of the mother or baby?

The myth of the expert is seductive. Patients who receive treatment are happy to believe that their treatment was decided by someone who really 'knows', while the expert has every reason to encourage this belief; a sort of *folie a deux* affecting doctor and patient alike. But no childbearing woman can entirely shed the responsibility for her choices because she, not the expert, must live with them.

### Myth Number 6 Experience is the Best Teacher

Perhaps the most misleading myth of all, because our clinical experience can so often lead us astray, is that experience is the best teacher. Serious outcomes of pregnancy are so rare, we forget that they can occur. Obstetricians may claim that

'in their experience' caesarean section was always safe, and they had never heard of a maternal death with caesareans. Yet between two and four times as many mothers die following caesarean as following vaginal birth, even when there was no underlying disease in the mother contributing to the mortality. Midwives may say that in their experience, induction for postmaturity results in an increase in caesarean section; yet controlled trials comparing induction with expectant care for women who go past 41 weeks of gestation show fewer caesareans among the women allocated to induction.

Sometimes experience only helps us make the same mistakes with greater facility.

### How Can these Myths be Dispelled?

Serious efforts are underway throughout the world to encourage well-controlled, valid, credible research into the prevention and treatment of the problems that are important to women, and to the widespread dissemination of the results of that research in a number of readily accessible formats. The international Cochrane Collaboration is in the forefront of those efforts, and the Cochrane Pregnancy and Childbirth Database provides up-to-date systematic reviews of relevant research. It is to be hoped that those who plan, provide and, most importantly, the childbearing women who use maternity services, will use and benefit from this important information. ■

Perhaps the most dramatic example occurred in the 1950s when uncontrolled care reports made extravagant claims for the benefits of stilboestrol to improve the outcomes of pregnancy. These claims received wide publicity. Evidence from controlled trials, also carried out in the 1950s clearly demonstrated that the drug was useless, and no more effective than a placebo. Nevertheless, it was prescribed for, and taken by, millions of women throughout the world. It was only in the 1970s, far too late, that the adverse effects, including vaginal carcinomas in young women who had been exposed to stilboestrol in utero, were discovered.

The tragic next-generation effects of stilboestrol could not have been foreseen. But the tragedy could have been avoided if we paid attention to the negative results of the valid evidence from controlled trials, rather than the attractive, but false, evidence from methodologically weaker studies.

Perhaps our search for a magic bullet would not be so serious, except that more and more dangerous drugs and invasive procedures are now available. In former years, perhaps, we could do little good, but also little harm. Now the potential for good with effective care, and harm with ineffective care, is enormously greater.

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- **MID** is extremely fast for all screen enquiries and reports.
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  - Monochrome or colour display
- The program has been trialled and modified over an extended period and we can refer you to independent midwifery practitioners currently enjoying the benefits available.
- The program cost of \$250.00 + GST will be recovered in your first few months of operation from the ease and access to your client information.

**MID** has been developed by: **SOFTWARE UNLIMITED**, PO Box 725, Nelson.  
Phone (03) 546 8900, Fax (03) 546 8900.

In conjunction with: **Domino Midwives Ltd., Nelson, & Halifax Midwifery Practice, Nelson.**

## Mutually Exclusive or Mutually Supportive?

What does feminism say about breastfeeding and what is the relationship between the two? Both may evoke intensely personal and emotive responses. It is interesting how certain viewpoints are almost automatically attributed to anyone who is identified as a feminist, or as a breastfeeding advocate. Feminists are not an homogeneous group; neither are breastfeeding women.

Breastfeeding involves more than just the right information and help. Maher (1992) believes that the type of infant feeding women choose, and whether they 'succeed' or 'fail' at breastfeeding, is embedded in socioeconomic and gender inequalities in any given society. These dimensions can have as significant an impact on the incidence, exclusivity and duration of breastfeeding as physiological factors. There are women for whom the ultimate barrier to breastfeeding is **not** sore nipples, supply problems, night feeds or work outside the home – it is the disapproval and constraints encountered from within society. This also includes the tensions and so-called 'horizontal violence' sometimes occurring between women (such as 'earth mothers' vs 'career women'; 'breastfeeding women' vs 'bottle feeding women'; 'mothers' vs 'non-mothers', and so on).

This discussion is not so much about rearguing the case for breastfeeding. It is an endeavour to integrate feminist thinking about the position of breastfeeding women in society: to examine what has shaped the way things are and maybe to raise consciousness about a future agenda; how to reconcile the right of women to full participation in public life and economic independence with the realities arising from the unique function, lactation.

At the risk of oversimplification, feminism challenges systems of domination and oppression such as patriarchy and capitalism which are mutually supportive. It addresses relationships of class, race and gender and how these impact on women's socialisation. Selected person definitions of feminism illustrate this common thread.

*Feminism means being more involved on a political level with the situation of women ... to be a feminist means putting women first (Oakley, 1984: 196).*

*Feminism is a way of life, a value system and a flexible means of explaining the world and women's place within it – a set of explanations trying to make sense of women's lives and experiences and a deliberate choice to improve the quality of life [emphasis mine] (Spender, in Mitchell and Oakley, 1986: 208-215).*

*An analysis of women's subordination for the purposes of figuring out how to change it (Leonard, 1988: 54).*

*Theory that analyses and explains the causes of women's oppression and actively seeks eradication of gender subordination and other forms of social and economic oppression based on nation, class or ethnicity (Sen and Grown, 1987: 18).*

*Any attempt to improve the lot of any group of women through female solidarity and a female perspective. (French, 1992)*

Feminism has been slow to **directly** and adequately define breastfeeding as a feminist issue. It might be assumed that breastfeeding would not easily be separated from any motherhood analyses (e.g. challenges to the paradoxical double standard whereby motherhood is simultaneously idealised and undervalued). However, relatively few of the analyses of motherhood and the family have incorporated a response to lactation. A consistent feminist position on breastfeeding has been lacking.

Although there is agreement amongst feminists in identifying oppressive features of contemporary society, what differs is how these are explained or analysed. Breastfeeding opinions run the gamut from conservative to radical feminism. To examine these positions, the classification frameworks developed by the Jagger (1983) and expanded on in a breastfeeding context by Van Esterik (1989) are utilised. Each perspective or framework has conceptual strengths and weaknesses – contradictions may occur within and between frameworks. Some can be applied to fundamental questions/issues better than others. None are 'right' or 'wrong'; neither is it necessarily a case of finding the right 'fit' within one framework alone.

# Is Breastfeeding a Feminist Issue?

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## Conservative 'Feminists' Arguments

It is reported that new conservative 'feminism' is growing in popularity and support in North America (Van Esterik, 1989: 92) alongside 'moral majority'-type groups. Within this category, some may actually reject or deny the feminist label. The conservative position tends to accept that human nature is determined largely by biological differences. Some even accept that it is 'natural' for males to dominate females. According to conservative logic, women are totally fulfilled only through pregnancy, birth and lactation. Motherhood is sacred and is a career. The feminine qualities associated with mothering are celebrated and traditional values are affirmed. The movement declares itself pro-family, claiming the rest of the feminist movement denigrates housewives and seeks to destroy the family.

Conservative feminists make much out of the 'naturalness' of breastfeeding. Assurances are given that breastfeeding will not endanger sex appeal of the breasts and that men may, in fact, be more attracted to enlarged lactating breasts. Concern is expressed for mothers to obtain the approval and support of their husbands (assumes heterosexual marital relationships are the norm) for breastfeeding. Considerable focus is on 'infants' rights' vs 'the mothers' rights'. A significant proportion of conservative reasoning has underlain many breastfeeding policies and breastfeeding manuals, even when couched in what is now more widely acceptable feminist rhetoric.

### *Some Responses to Conservative Positions*

It is of concern that the conservative position tends to reinforce the biological bigotry which has perpetuated and justified oppression and exploitation of women. If total fulfilment is only through pregnancy, birth and lactation, then it is but a small step to assume women's primary duty is to stay home as breeder, nurturer, cook and cleaner. It also implies value judgements if women have difficulty with or reject some of these duties, or if they happen to find motherhood unpleasant.

Any overemphasis on 'naturalness' possibly causes confusion in the women who go on to encounter difficulties with lactation and breastfeeding. Unfortunately, much pro-breastfeeding rhetoric alienates many women. Themes concerning women's duties and the 'naturalness' of breastfeeding have been reflected in what might otherwise be described as excellent help-yourself breastfeeding manuals. Rightly or wrongly, critics have targeted La Leche League and/or their publication *The Womanly Art of Breastfeeding* (Phillips, 1986; Van Esterik, 1989). The 'naturalness' of breastfeeding has come to be interpreted by some as continuous bodily contact between mother and baby.

The shift in emphasis from mothers' rights to infants' rights underlies concern by some that much breastfeeding material is being written and presented by those who believe a baby has a right to its mothers' milk no matter what her

feelings on the alternatives or what her life situation may be. When lactation is viewed as the essence of mothering, women who do not breastfeed may be accused of depriving their babies; implying also that there must be something wrong with their personalities. Some might argue there is undue focus on 'a relatively restricted area of behaviour', ignoring the complexity of other behaviours and interaction, i.e. it is not just a matter of doing it (breastfeeding), but also how the mother feels about it.

Conservative positions risk becoming oppressive as they develop ideals and standards against which mothers judge themselves and are judged. It must be noted that conservative logic can also be used by anti-feminists as part of the 'backlash' (Faludi, 1992) to preserve the status quo (e.g. to help keep women at home and allow jobs for men). Others find the glorification of motherhood suspect if it is used to restrict/exclude women.

## Liberal Feminism

Equity (catching up) with men is a dominant tenet within liberal frameworks. Asking for simple fairness is the least threatening stance – even for those who say 'I'm-not-a-feminist-but ...', or those who claim never to have benefited from feminism. This approach comes closest to a lot of so-called 'mainstream values'. Liberal feminists work to remove gender inequalities and to ensure that women enjoy full access to all the benefits of society. A major focus is on individual rights and the right to choose. Familiar issues are: equal pay for equal work; educational opportunities and legal rights; and challenges to the sexual division of labour, e.g. the sharing of housework and childcare.

Early, and perhaps some current, liberal perspectives viewed breastfeeding as restrictive, unappealing and incompatible with liberation. Bottle feeding, childcare centres and maternity leave are the issues seen to allow women to compete more equitably with men. Both breastfeeding and artificial milk feeding can be defended equally on the basis of individual rights and pro-choice philosophy. A common theme reminds those preferring not to breastfeed never to feel guilty about it.

Liberals do recognise existing discrimination against lactating mothers; they do, and have, object to the lack of feeding facilities in public and in workplaces; and they do argue for more extended parental leave without loss of seniority. However, their hallmark is an emphasis on GRADUAL reform – usually from within the oppressive institutions.

### *Some Responses to Liberal Positions*

Liberal feminism has not yet gone far enough with efforts to promote protective legislation for breastfeeding women. Previous liberal feminist rhetoric has served and perhaps still serves, the infant artificial milk industry very well – 'liberation in a can' is very compatible with their propaganda. Artificial milk has been seen by many to be a prerequisite to emancipation. Commercially-prepared breast milk substitutes fit very well with other commercialisations of infancy and childhood.

In the early days of 'humanised' artificial milk it was believed there would be no adverse consequences from its use. This can be compared to the early oral contraceptives which were exempt from thorough testing before widespread prescription because they fulfilled a major social



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need. So too did artificial milk escape sufficient scrutiny (Minchin, 1987). Now that scientific evidence about the hazards of infant artificial milk is mounting (ILCA, 1992), these views are changing, but still there are those who do not want to know. Commercial interests still portray artificial milk as equivalent to breast milk. Health work neutrality endorses these interests. Liberal positions generally ignore the deep contradictions between ideas of individual choice and the assumptions guiding the vested commercial and political interests.

The fear of creating guilt in women who choose not to breastfeed reflects a paternalistic view of women needing to be protected from knowing the possible consequences of making a poor choice. Withholding information does not make for an informed choice, neither does it diminish guilt (ILCA, 1992).

Although liberals are defensive of women's rights to equity (jobs, pay), what about their rights to be women?

Are needs being ignored over rights? Fairness arguments tend to break down at times, especially in the workplace, when gestation and lactation occur; e.g. take the 'a-lawyer-is-a-lawyer', etc. argument (whether male or female). Once the latter is pregnant/breastfeeds; then it is as if she has a disability.

Historically, women have always breastfed and participated in economic production. Now social endorsement is needed for this. As Palmer (1988: 265) asserts:

*The prestigious worlds of business, academia and politics have grudgingly let women put one foot in the door only on the condition they behave like men. They must hide their reproductive functions.*

Much how-to information on combining working and breastfeeding is aimed at women who are 'classically' career-oriented in the professions, 'white collar' occupations or self-employed. What about those factory jobs? When jobs are scarce, it can be difficult to negotiate part-time or job-share situations to suit lactation when there are many others willing to fit into the traditional ways of the workplace. The implied message is that to achieve equality with men may mean restricting or denying lactation. Lactation can be blamed for disrupting the balance between private-and-public/work-and-home lives. Women who do integrate these activities have to work extremely hard and use a lot of ingenuity. For too long parental/maternity leave has been viewed as the only answer to this issue and it often comes down to haggling over how much, for how long. Yet, if workplaces were to become truly mother/baby/family-friendly and provide for, and facilitate, women to continue breastfeeding then conditions of maternity leave might not be so problematic.

The other ambiguity seldom addressed is the woman who stays home to care for and breastfeed her child. For her there are the eternal questions: do you work?/what do you do? - 'working' meaning earning money. The 'non-working' woman may in fact work harder than her sisters

in paid employment, simply because she is poor. Women who leave paid employment risk losing prestige, promotion and economic security. It may be perceived as a backward step in social status. Episodes of childcare contribute little value to a curriculum vitae, nor gain salary increments.

### Radical Feminism

Radical feminism has tended to assume oppression of women originates from universal patriarchy, and from women's reproductive functions (Jaggar, 1983) which have developed a dependency on men. The so-called 'mainstream opinion' others refer to is regarded as nothing more than patriarchal values and ideologies. There is concern that the predominantly male preoccupation with 'rational' thought marginalises and trivialises women's issues (such as breastfeeding). Radical feminism focuses on the need for equally powerful rhetoric and political action to counter this. It is easy to see how meaningful is the adage 'the personal is political'. Radical (rationalism, scientism) as this approach is, it tends to give a one-dimensional view, and seeks to balance this with concepts of wholeness and interconnectedness and to have intuitiveness revalued and recognised (Belenky, Clinchy, Goldberger and Tarule, 1986). Some radical feminists feel the requirement to separate themselves entirely from men in order to create a non-sexist environment for women.

Radical feminists seek a more fundamental restructuring of gender roles to allow women to develop their full potential. It is argued that equal opportunities have only been accrued by some women, not all, and that some so-called liberated women merely display an outward guise of liberation, but inwardly conform to the male model. Some may have only emancipated themselves from other ('traditional/ordinary') women. Perhaps some identity as a woman is being sacrificed to achieve a degree of liberation.

A key issue has been women's loss of control over their own bodies and lives. In respect of this, radical feminism has formed the Women's Health Movement and the Reproductive Rights Movements. Early focus was on demedicalisation of childbirth, tending to ignore the concurrent medicalisation of the lactation and breastfeeding. Now this focus is redressing factors that make it difficult to establish lactation and breastfeeding in hospital settings. Procedures such as breast-binding have been likened to 'castration'. Women are now being urged to 'experience their breasts in a new perspective ... where pleasure and function are inextricably intertwined' (Bloom, 1981: 262).

Women's right to choose motherhood or not is advocated (this can be extended to include breastfeeding); and if chosen a woman's control over the processes involved is endorsed. Whilst radical feminism opposes the devaluation of motherhood, over-romanticising of it is rejected. It has been claimed that motherhood is/can be an oppressive institution. Much endeavour has gone into dispelling the myths of 'maternal instinct', 'the motherhood mystique' and Bowlby's (1969) phenomenon of 'maternal deprivation' (Rich, 1977). Stereotyped views of 'the family' and the ideology of 'the cult of domesticity' have also

been challenged (Thorne and Yalom, 1982; Rothman, 1989). Not all families are nuclear with breadwinner fathers and homemaker mothers. Radical feminism also takes the strongest stances on issues such as pornography, rape, sex-oriented tourism and violence against women.

### Some Responses to Radical Feminism

Although radical feminism is internationally inspiring, assumptions about universal patriarchy are difficult to apply to women's issues in every country (Maher, 1992; Van Esterik, 1992). An emphasis on sexual politics and separatism may have confused some and made for difficulty in reconciling what appeared to be contradictory arguments about reproduction/motherhood being the basis of women's oppression. If so, lactation also translates as oppressive, and indeed may women have found it to be so as they experience constraints towards breastfeeding imposed by society.

The previous paucity of responses to the infant artificial milk controversy as outlined in the above response to the liberal positions, has been equally applicable to radical positions.

### Socialist Feminism

Socialist feminists generally maintain that it is not just patriarchy, but the interaction of both class and gender discrimination that reinforces oppression (Jaggar, 1983; Anderson, 1988). Socialists bring political and economic arguments into their analyses. Helsing (1979:72) maintains that industrial capitalism forces women to compete with men without adjustment to meet their unique needs. Capitalist expansion of market forces in the Third World is also blamed for the infant artificial milk controversy.

Waring (1988), in her critique *Western Economic Theory and Practices*, details how women/mothers are undervalued. Broadly, her thesis is: that women's work, reproduction and production is invisible. It is not accorded value and therefore does not feature in the National Accounts. Because of this, women remain invisible in the distribution of benefits. Rather than suggesting wages for housework, mothering and breastfeeding (i.e. time, effort and associated costs), she suggests these be taken into account by attributing (monetary) value to these activities - a process termed 'imputation'. This would make women's work more visible and influence thinking and policy making. Waring's challenges to statisticians met with 'can't do it/won't do it' responses. It is difficult. One difficulty that is conceded: even if costed out, what is the value of a superior product like breast milk?

Breastfeeding *per se* is not always expressed directly as a primary concern by the socialists, but the broader socialist perspective encourages examination of social institutions and how they impact on women's lives. Therefore, the transformation of social conditions that socialist feminism envisages would generally be beneficial to breastfeeding. For example, this includes self-help clinics for women; returning childbirth to

midwives; empowering women to have more control over their lives; more parental leave and childcare facilities; flexible working hours with breastfeeding breaks if necessary. The latter being in line with the recent Mother-Friendly Workplace Initiative launched by WABA (World Alliance for Breastfeeding Action) 1993.

#### *Some Responses to Socialist Feminism*

As already mentioned, there has been slowness to address and include breastfeeding specifically as part of the agenda for reproductive freedom. Promotion of protective legislation for breastfeeding women has not yet gone far enough. However, because of sensitivity to the diversity of women's needs, and because arguments are linked to the broader social issues, socialist feminism may be best placed to forge alliances with a broad range of women in order to create an integrative feminist framework which includes breastfeeding on the agenda – globally.

#### **Why Breastfeeding is a Feminist Issue**

Van Esterik (1989; 1992) has outlined some reasons why breastfeeding is a feminist issue. These are further elaborated.

- 1. It encourages women's self-reliance.**  
It requires women to have confidence in themselves and demand their rights to breastfeed. Self-reliant women are less likely to doubt the quality and quantity of their milk.
- 2. It confirms a woman's power to control her own body.**  
It can be argued that the more control women have over their lives, the more likely they are to breastfeed. Breastfeeding can decrease when women's social power decreases relative to that of men.
- 3. It challenges medical hegemony and reduces dependency on the medical profession.**  
Breastfeeding increases and revalues the knowledge of mothers and midwives. Breastfeeding discourages the medicalisation of infant feeding *per se*. However, lactation and breastfeeding have not escaped medicalisation. The potential for undue intervention being applied to normal physiological functioning is still evident (Beasley, 1993). The need for, and application of, 'expert' advice, specified intake/quantities and 'rules' have been transferred to breastfeeding from the mechanics of artificial feeding to fit in with the socially conditioned ordering of time in our culture. This in turn stems from the prevalent industrial and economic models in Western society where timetables and deadlines dominate. Mothers and babies have their own individual rhythms which conflict with patterns of 'social' and 'work' time (Balsamo, De Mari, Maher and Serini, 1992). This process of medicalisation/

mechanisation requires modification, or even resistance, for breastfeeding to survive.

#### **4. It challenges the predominant model of women as consumers.**

Because commercial markets constantly need to expand, relentless campaigns are directed at women as consumers. A rejection of breast milk substitutes and the associated hardware is a rejection of a capitalist pattern which makes women reliant on commercially produced foods. It is also rejection of a commercial solution to a physiological need.

#### **5. It challenges views of the breasts primarily as sex objects.**

Breastfeeding rejects the view that only artificial milk feeding is acceptable in public. However, as Waring (1988) points out, the decision not to lactate does not free a woman's breast from exploitation. They can even be classed as 'productive' via audiovisual and published pornography; by advertising to make profits for the lingerie industry ('higher and thrusting' vs 'low-slung and natural'); by cosmetic surgeons rebuilding breasts according to male concepts of how they should look; and last, but not least, breasts contribute to the hidden economy via prostitution.

#### **6. It encourages solidarity amongst women.**

Feminists, women, kin, friends and community (nationally and internationally), should work collectively for social and political action.

#### **7. It requires structural changes in society to improve the position and condition of women.**

This begins with adequate time off from other responsibilities after childbirth and better access to resources and support throughout lactation, so it is better able to be integrated into other activities and is acknowledged as social meaningful.

#### **8. It requires a new definition of women's work/workplaces.**

A women-centred approach that values women's productive and reproductive work

is needed (in line with mother-friendly workplace initiatives) to ensure adequate maternity leaves affordable childcare, flexible working hours with access to infants, and an equitable wage with no loss of seniority or promotion because of childbearing or breastfeeding.

In conclusion, any contraindications between breastfeeding and feminism cannot be resolved overnight because their origins are embedded in all the social, political and economic issues that impact on women's lives. Leonard (1988) claims we are all needed for consciousness-raising activities. Breastfeeding needs to be put on the agenda whenever possible – not as a nice little 'women's issue' when there is nothing else to discuss.

A feminist agenda must go beyond calls for inclusion in the world that is, and must go beyond the bottle-breast debate. There needs to be awareness of those who appear to be supportive of a breastfeeding agenda but who will in effect use it to preserve the status quo.

The goal becomes not so much to have every woman breastfeed her baby '... but to create conditions for individuals, households, communities, nations ... so that every woman could ... making breastfeeding possible, successful and valued in a given society' (Van Esterik, 1992). During Suffrage Year we honoured the hard work done to gain us something we now all take for granted. Can breastfeeding be liberated (without following a male script) so that future generations will be able to take a breastfeeding culture for granted – one that is compatible with a wide range of material styles and accommodated by all social institutions?

#### **References**

Available on request from the Author. ■

An earlier and abbreviated draft of this paper, 'Breastfeeding and Feminism', was presented at a World Breastfeeding Week Seminar: Women, Work and Breastfeeding. Christchurch. August 1993.

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# Direct Entry Midwifery

Sally Pairman

Midwifery Course Co-ordinator

Bachelor of Midwifery Degree  
Otago Polytechnic, Dunedin

The first group of Direct Entry midwifery students commenced study at Otago Polytechnic on 22 March 1992. On 3 December 1994 they will graduate – the first Bachelor of Midwifery graduates in New Zealand.

The three years have flown by in many ways yet at times it has felt like a long, slow road. The course has been challenging for everyone involved, from students, to lecturers, to clinicians, to the students' families. It is not easy to make a major life change and become a student after being a mother, a partner, a worker and to try and meld all the many roles women have in their lives with something that becomes so all consuming – midwifery. It has been exciting to be involved with this course and to see where it would take us. The students have been remarkable for their commitment and energy and thirst for knowledge, and for the maturity, wisdom and life experience they all bring with them. I feel very proud and privileged to have been associated with them and to have been able to learn so much from them.

As lecturers, we have had tremendous support from our colleagues in practice who give so freely of their knowledge and experience. Such role models make such an impact on students and the experiences they have to offer give life and meaning to the work we do in the classroom. We are extremely fortunate in the south to have so many midwives who willingly share their time with students in such a positive way, and who demonstrate a real commitment to supporting the future of our profession. We have also had huge support from women who have generously shared intimate and private aspects of their lives by permitting students to work with them. The contribution women make to student learning is significant and something we acknowledge and value.

The course has provided students with a wide range of learning opportunities which bring together all aspects of midwifery knowledge, supported by a strong philosophical base. We believe that midwives are independent practitioners who provide all care through the range of normal childbirth on their own responsibility. Midwifery care is women-centred and practised in partnership with the woman. I feel very confident that all the graduates from this course are grounded in this midwifery model. They have had significant opportunities to work in continuity with women and with midwives in both home and hospital settings. They are able to work to the standards of the profession and to work independently, regardless of setting. They know the limits of their skill at present and the boundaries of their own practice and will work within these. As their

experience and confidence with normal childbirth grows their boundaries will expand. I believe the challenge for the profession is to have trust in these graduates and to support them as they find ways to practise which are right for them. They have had a very different education from most of us, and they will start from a different place. These are the first students in New Zealand to be educated and prepared to practise independently from graduation. It will be exciting to see where they take the profession.

One of the most affirming experiences I have had recently was listening to the midwifery students from around New Zealand at the student forum at the national conference in Rotorua. They were all wonderful and I, like so many of my colleagues, was impressed by their ability to articulate what midwifery meant to them. A second year student from Otago Polytechnic, **Annabel Farry**, was among them and she has generously permitted me to use her words here. She says much more clearly than I ever could what this direct entry midwifery course is all about.

In brainstorming with my class about our feelings toward midwifery, I was reminded of the incredible depth of emotion involved. In learning about midwifery we have all learned a great deal about ourselves. It has not always been easy. We have been challenged on many levels; the way we speak, the way we act and the way we react have at times been questioned. This constant questioning and self analysis which has become part of our lives has brought us to a better understanding of ourselves. We have had to face our own racism, sexism, homophobia and do our best to move out of these old frameworks and into new ways of seeing the world. Change is always painful and there have been conflicts at times. Indeed there is continuing conflict, but for the most part disagreements have been resolved and have resulted in positive developments. The modern philosophy of midwifery is revolutionary. I believe this is true because within a partnership there is no room for a power struggle. As partners we work together to attain the best outcome. We are equal in status and we learn from each other. With continuity of care we hope to know a woman and all she cares about – her partner, her children, her family, her profession, her pets, her garden. In knowing her we can share in the joys and the sorrows of her experience. Whatever happens we will have the knowledge necessary to empathise.

Some of us came to this course as firm advocates of homebirth who now

hesitantly declare that they have observed some benefits of being in the hospital. Some came with hospital birth held as the optimum, but now feel confident about supporting women having homebirths. This illustrates another important principle we have learned as midwifery students; the principle of balance. Balance is crucial when caring for women. Without a sense of balance, it is impossible to impart the information necessary to enable a woman to make an informed choice, and without informed choice the partnership model crumbles at its foundations.

So far I have mentioned three principles: partnership, continuity of care and informed choice. I can promise everyone here from the bottom of my heart that if we emerge from this course understanding nothing else, these three concepts will be with us until death. I can say this with such certainty because we have been taught them not just from one angle, but they have been like an umbrella extending over the entire course. But don't be afraid. Our course has a strong grounding in practical experience. We are learning how to be clinically competent health professionals, but in doing so we never lose sight of women as our focus. The client is always there, right beside us in everything we do. Our work is for her and no matter what is discussed she is never forgotten. Really, in a nutshell, we are learning to work with love, to take love with us everywhere we go. As one woman from the Kaitiaki workshop said, 'Aroha, approach, attitude', and this seems to me to be the perfect way to say it.

Many of us have found the hospital a challenging place. Not only because we are expected to apply our practical knowledge, but also because we feel committed to defend all that we have come to believe in as a result of our course. We would like to extend our gratitude to all the midwives in the hospital and the community who have supported us in our clinical experience. We appreciate the amount you have to teach us and we are hopeful that we will not be seen as a threat because of our habit of questioning. We need your help and support and we need to be nurtured. One classmate described us as 'the arrowhead of a changing profession' and this is exactly how it feels. It is exciting, energised and sharp. We are on the cutting edge of the modern midwifery movement. We appreciate that we have been given the opportunity to study midwifery from our diverse backgrounds. We would like collectively to thank the midwives and consumers who fought to make this course a reality. We can assure you that your vision is alive and well. We are growing at a healthy rate and will carry the philosophy forward into the next generation.

# Israel

Lydia Miller

Student Midwife, Otago Polytechnic

I am a third year Direct Entry Midwifery Degree student at Otago Polytechnic in Dunedin. As part of this years clinical elective, I spent six weeks working in the labour and delivery ward at the Holy Family hospital in Nazareth, Israel.

Finding a placement in Israel was difficult because, legally, student midwives must be a registered nurses before studying midwifery. After many months of searching, I was thrilled to be accepted by the Holy Family hospital for six weeks placement during June-July 1994.

Holy Family is an Arab hospital (as opposed to an Israeli hospital) funded by Italians. Most staff are Arab, although management and supervisory positions are filled by clergy from Italy and India.

The majority of birthing women are Arab with Moslem, Druse and Christian being the three most common religions. Religious identification is strong within Arab communities, and significant in terms of providing culturally and spiritually appropriate care for birthing women.

Arabic is the most common language spoken, with Hebrew, English and Italian also used.

Midwives, doctors and nurses use English when they do not want the 'patient' to understand what is being discussing about them. The power differential between 'patient' and 'professional' varies depending on the economic status of the woman. The fewer economic resources a woman has, the more power the 'professionals' assume, giving the woman no information and no choices. I received the warmest of welcomes from the staff at Holy Family. I was treated extremely well throughout my stay and was continuously overwhelmed by the generosity of traditional Arab hospitality, especially from the birthing women. It is tradition for the family of the newborn to give chocolate and baklava to all those who visit the woman and her newborn child. (My pockets were always full of sweets.)

On my orientation day, I was moderately shocked at the extremely unprivate conditions that women were expected to birth in. There were two beds (with stirrups and side rails) in the delivery room, separated only by a plastic curtain. The labour room was very small, with four beds and no privacy. A two-bed day assessment room was used for Cardiotocographic (CTG) monitoring, antenatal and pre-admittance 'examinations'.

On my first day of work, I arrived to see two women lying (looking unconscious) on surgical beds in the corridor. I was shocked to find out that they had just birthed, and would be 'held' there for the next two hours for postnatal observations before being transferred to the postnatal ward. The babies had gone to the nursery immediately after birth. Women are not allowed to walk after their births and are wheeled on surgical beds to their postnatal beds. They need to gain permission to get out of bed the first time after their birth!

I spent my first three days cleaning as the head sister wanted me to learn to be a 'good' midwife, which meant polite and subservient to doctors and an 'efficient' cleaner. I thought 'Oh, oh ... we have totally different ideas of what a "good" Midwife is'. I was not allowed to spend time with the labouring women until all the dusting had been done, gauze folded, beds made and all lotions and potions had been refilled. By the third day, I began to wonder if I had unknowingly agreed to providing six weeks of free cleaning service. My patience was running low and when asked how I liked my work, I said I was an expert cleaner before I came and that I really needed experience with pregnant, labouring and birthing women. There were no deliveries during the day shift until the fourth day when I was 'allowed' to observe one birth. I felt very uncomfortable as the woman was not asked for consent. In fact women had NO choice about who would be at their births. Their family members (except husbands) were not allowed. I was shocked by the baby extraction type birth. (It was then I realised why women looked devastated after the birth, because they were!) What I was seeing was as far from women-centered maternity care and partnership as the Sun is from Pluto. The first three births that I 'observed' were so traumatic that I left the third one crying and stayed away for over an hour. Everyone wondered what happened to me. I told them I am accustomed to being at quiet, gentle births where women are in control of their experience and I had difficulty watching what had been happening. (I also felt useless for not doing anything about it.) The head sister wanted me to show her how 'we do it in N.Z.'. I could only share what I have learned, which was challenging with women in the lithotomy position, many of whom had been given pethidine. It was difficult to try and encourage active, natural birth at the end of a medically-managed labour of which the woman was

a 'subject' rather than a partner in the process. Being a student enabled me to ask, 'why?' about everything, and I did exactly that. After asking why, I would explain how I was taught differently, and offer the rationale of why I would do it differently. I had plenty of reading material to substantiate what I was saying and shared it with those who wanted it. I also listened to what the midwives and doctors were saying because it would be arrogant to deny their experience. I definitely wanted to avoid 'the west knows best' syndrome, as it is Western medicine which was responsible for the current situation.

Among the Arab population, birth and breastfeeding were normal life processes prior to this generation. Women's confidence in their bodies' ability to birth their children and produce enough milk for them is rapidly being undermined by the medicalisation of childbirth. Women lost control of their pregnancies and birth experiences when they became medical events, 'monitored' and 'managed' by medical professionals. Fear tactics are used freely to scare women into compliance, i.e. 'Your baby will die if you don't listen to us'. Patronising language and simplistic answers to women's questions are the norm. Midwives and doctors answer all questions with 'Enshallah liom', meaning 'If God is willing, today'.

Mothers are unimpressed with the 'modern' way and daughters know their mothers birthed differently. Mothers are not allowed to support their daughters in the labour or delivery room because they 'cause problems'. The intergenerational link of women supporting one another in birth is being lost with modern obstetrics. Care is focused on 'convenience of the professionals' rather than centered on the woman.

Almost everything was unacceptable to me because the birthing women were given little or no choice. Midwives and doctors rely heavily on CTG readings almost to the exclusion of the woman's experience of her pregnancy and labour. One woman came into Holy Family in obviously very strong labour. She had a 'routine' 20-minute CTG, required by all women on admission. The contractions hardly registered on the paper. The midwife told her she was not having contractions, 'look at the paper'. From observation she was having very intense contractions, which completely consumed her, and sounded as if she was nearing second stage. A vaginal examination confirmed full dilatation and the woman delivered her baby. After delivery the Lebanese midwife expressed her dislike of modern medical midwifery and the way she is currently expected to practise. This incident helped develop a good rapport between us. She told me of her amazing experiences as a homebirth midwife in Beirut, Lebanon, during the war. Most babies were born at home because it was dangerous to try reaching the hospital. She attended twin and breech births at home in those days, and had her hands, her experience and a fetoscope to rely on.

She often laughed at me during births saying I reminded her of how she worked during the war. She used to sit with the woman throughout labour, waiting quietly and patiently and supporting them as they birthed. Most women birthed without complications even amidst war.

At Holy Family, food and drink are 'not permitted' once contractions became painful, which meant many women had IV fluids. Women are discouraged from having bowel movements during the birth, so enemas were routinely given on admission. Women are 'sentenced' to bed as soon as they reach 3 fingers (1 finger=1.5cm) dilatation and often given pethidine. All primiparous women are given pethidine (IM [Intramuscular] or IV [Intravenous]) or an epidural. Women are given no information about the side effects of drugs, but are told it will 'help them sleep' or 'help them avoid shouting in front of their husbands'.



Vaginal examinations (VE) are AT LEAST four-hourly, usually more often than two-hourly. Almost every woman had her membranes ruptured, to speed things up. When I asked why they were rupturing membranes and then 'sentencing' women to bed to avoid cord prolapse, I was told if they didn't speed up the delivery the women would want to leave and go to another hospital to deliver. I suggested that perhaps improving the quality of care would ensure continuous clientele. The doctor suggested I didn't understand Arab mentality, it was speed they wanted - not satisfaction. A live mother and live baby are priority, without regard for psychological, emotional and spiritual satisfaction. However, the women I had the privilege to get to know appreciated being treated with respect and having gentle births.

Doctors sporadically 'monitored' women in labour. Decisions are 'their responsibility' and assessment consisted of regular VEs, reading CTGs and signing documents. Doctors were seldom present at births unless there was need for intervention. They did, however, create a need for intervention when they were around. Suturing was done by doctors unless it was during night shift or they could not be contacted due to an emergency elsewhere. The skills of midwives were determined by the whims of doctors. It was similar with cannulation and taking blood. The understaffed maternity floor was a busy place, which made it difficult for midwives to spend time with each labouring/birthing woman. Once women reached full dilatation, all hell broke loose! Her feet were up in stir-ups at breakneck speed

(EVERY woman birthed in the lithotomy position!), sterile greens covered the woman except for her face and hands. Cleaning and kitchen workers arrived. I quickly realised they doubled as cheerleaders as they shouted shidee, shidee, shidee at maximum volume (shidee is Arabic for push). The noise level was shocking and the woman was lost in the pandemonium. From the moment of full dilatation, the attending midwife began stretching (pulling) the perineum downward as far as she was physically able to in order to help speed things up, whilst contributing verbally to the 'shidee' choir. A cleaning person would stretch her arm across the bed and with her elbow on the woman's fundus push with all her strength. Episiotomies were routine for women birthing their first child and generously given to any other woman that didn't push fast enough to avoid it. The midwife kept the scissors out of the woman's sight, and did the episiotomy before the woman could object. Informed choice? Not here, in any way, shape or form. Privacy was nonexistent. As the woman finally managed to give birth, the baby was routinely suctioned whilst its head was at its mother's perineum. The cord was quickly clamped, cut and the baby disappeared before the mother could see it. Intramuscular syntometrine was routinely given after the birth of the placenta to avoid postpartum haemorrhage. The babe was left lying alone under a wall heater, after being suctioned and slapped (to make them cry), until someone from the nursery came to take them. They were put in an incubator and left until someone had time to bath them. Bathing consisted of holding the baby face-down with one hand under a running tap whilst vigorously scrubbing them with the other hand. Most babes had numerous bruises and needle marks on them and it was difficult to find out what they were from. Intramuscular Vitamin K is routinely administered to the babies, without parental knowledge or consent. Guthrie tests are done by putting an injection needle into a hand vein and filling the card with the blood coming from syringe end. Complementary feeding is at the whim of the nursery staff, and babes are delivered to their mothers four hourly to breastfeed. If they don't fit into this routine, they are given artificial milk. This is affecting women's confidence in their bodies' ability to produce 'enough' milk.

'Husbands' are the only people 'allowed' in the delivery room and many Arab women don't want their husbands with them because they feel they will lose his respect if he sees her in 'that state'. (Note: I say 'husbands' as birth outside of marriage is almost nonexistent among Arabs because of the extreme pressure on girls to maintain their virginity until marriage.) I felt continuously caught between staff and clients for trying to advocate for the women. I encouraged mothers to come into the labour and delivery rooms with their daughters, but they were always sent out when another midwife arrived. This was frustrating as the woman's family were wonderful

support and helped her relax. Many tears were shed as families were forced apart at a time when they were traditionally together. The corridors were often full of waiting families. Most women leave their own village and go to live with their in-laws when they marry. Mothers-in-law generally accompany labouring women into hospital and wait until they have given birth.



Women are under extreme pressure to produce sons, and the fact that men determine the sex of the baby was relatively unknown. In traditional Arab villages, women can be physically and emotionally abused or divorced for producing too many daughters. Not surprisingly, there is a higher incidence of postnatal depression after the birth of girls. Raising daughters is considered a stress as a family's honour is based on their reputation. Girls are 'supposed to be' virgins, obedient, feminine, submissive and quiet in order not to 'disgrace' their families. In some traditional villages, young women can be threatened with death for disobeying their socially prescribed role. Some boys are raised to believe they are the guardians of their sisters' reputations, meaning girls can be under the control of several males. Sons have little or no restrictions placed on them. In July, a young Druse woman who had returned from studying in England was murdered by her brother. He decided she had become too Westernised and a threat to their family honour. He is unlikely to be punished by Israeli law as it seems to be applicable to Arabs only if they harm Israelis. There are, of course, varying degrees of this situation. I worked with a young woman who could not read or write as her family thought it was unimportant for her to be schooled. She needed a friend to read X-ray results of her eye after she had been beaten by her brother for being insufficiently obedient. Her brothers had complete control over her life until they could find a husband to take control.

One woman who had five daughters and two sons refused to deliver her sixth daughter after asking what the female sign meant on her ultrasound record. She started punching herself round the abdomen. She did not want this baby and was clear about expressing it. Was I to support her choice or try and facilitate the birth of a live baby which she did not want? She was fully dilated for one-and-a-half hours with little progress. The baby was not descending and the woman refused to push. The baby was showing signs of distress with fetal heart decelerations and fresh meconium stained liquor. It was an ethical dilemma whether or not to call for help. She told me she did not like the male doctors and

didn't want them to check her. When I tried to talk with her about the baby's distress she told me to take the baby and keep it. I felt as though I was betraying the woman when I called for help, and more so when a male doctor came. He ignored me when I said she wanted a female doctor, mostly because she was not rich. I tried my best to provide emotional support as he proceeded to attempt vacuum extraction, and failed. The head of maternity department (an obstetrician) came and she also attempted vacuum extraction whilst the first doctor was applying pressure to the woman's fundus. She was eventually taken for an emergency caesarian after the fetal heart beat was no longer detectable. I was astounded when this woman's daughter was born crying. The woman was unimpressed. I still wonder how I could have better respected this woman's choice. As I had met this woman in labour, I was unaware of her situation. I was unsure what would happen to this woman after having her sixth daughter. And who was I to judge what was best for this woman? The cultural and professional baggage of the caregivers determined what was best for this woman, without her consultation or regard for her self-determination.

I was honest with doctors (the midwives already knew how I felt) when they began to ask me how I liked the way things were done at Holy Family. I said I did not like the way pregnant and birthing women were treated. This was obvious by my non-compliance with protocol. I encouraged women to walk and spend time with their families during their labours, instead of keeping them in bed, until they themselves chose to do otherwise. I questioned EVERY decision to rupture membranes. I refused to do episiotomies, even under extreme pressure. I had to literally physically block one woman to prevent someone else from doing the episiotomy because I was refusing, whilst everyone was shouting 'cut'. When told to do enemas I would draw the curtain and use the time to get to know the woman. I encouraged women to birth in any position they wanted, but without antenatal education women had not been exposed to information and had no knowledge of choices. When midwives and doctors told me, 'These women don't know any better', I said that it was our fault for not sharing the information. I was continuously questioning everything. (Fortunately the good humour of my work mates meant we had many hearty laughs in the midst of it all.) I was under tremendous pressure to do things to women which I thought unnecessary. When I suggested trying other ways of doing things, I was under even more pressure to 'prove they worked'. It was a very stressful experience and more than once I contemplated early, permanent retirement from midwifery (even before registration) with the prospect of becoming a helicopter pilot growing increasingly more appealing. Although constantly challenging things, I tried not to slip into arrogantly stating 'I am right and you are wrong', as I think arrogance produces resistance to change. I always mentioned

I was taught to do things differently and I could see the difference in women's satisfaction.

The head obstetrician had been trying to meet with me for days, and I was trying to avoid her as I assumed (wrongly) I was either going to be 'fired' (although I was unsure how unpaid students can be fired) or told to be an 'obedient and well socialised handmaiden'. Much to my surprise, she spoke about all the positive feedback she was hearing from the women I had been with as they birthed. She pleaded with me to return to work with her after I graduate to help design and work in the new labour and delivery ward. They are building a new hospital in 1995. She wanted me to help implement major changes in the care provided and was very moved and impressed with my care and concern for 'the patients' (blush!). I was very honest about the way I wanted to work and suggested that we try team midwifery so we can begin to provide continuity of care, giving women far more information than they have at present, to make informed decisions. I told her it was difficult being pressured to do things I could not agree with, and she was going to meet with the team of doctors and talk about implementing changes immediately.

The care really did change, and what was happening when I finished my six weeks with these very open and accepting people was totally different from my first week. The delivery room, although still not private, was very quiet. There was a decrease in the episiotomy rate, although two midwives continued with routine, without-consent episiotomies. There was less physical attack on the birthing woman, although women were still on their backs, the stir-ups were optional and she did not have people shouting at her and pushing on her abdomen and pulling on her perineum. The 'shidee choir' was silenced. The women who helped at births (cleaning and kitchen workers) were wonderful. They were bringing hot water for compresses and helping support the woman to a more upright position. They were genuinely happy to be doing things differently and I would not have been able to do what I did without their magnificent support. Doctors began to consult with the women and midwives about whether or not membranes should be ruptured. Doctors began to ask midwives about what they had found with previous VEs, rather than doing another one, which substantially reduced the number of VEs each woman was having. The omnipresent tension seemed to have lessened making it a much easier place to be in. I am still trying to decide whether I will return to the Holy Family hospital when I graduate, but regardless, this experience was an incredibly growthful, affirmative and memorable one. ■



## COMING EVENTS



### OTAGO POLYTECHNIC

#### Bachelor of Midwifery Degree Programme 1995

Applications for the 1995 Bachelor of Midwifery for Registered Midwives are being accepted now. This course can be taken on a part-time basis and is available for Midwives in the Southern Region. Applications close 1st November 1994.

#### Further Information:

Please contact:

Trish Fennessy  
Nursing and Midwifery Department  
Ph. (03) 479 6145  
Fax 474 1957

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#### The 24th Triennial Congress of The International Confederation of Midwives 26-31 May 1996. Oslo, Norway.

**Theme:** The Art and Science of Midwifery  
gives Birth to a Better Future

**Contact:** Team Congress  
PO Box 6  
N-6860 Sandane, Norway

#### International Conference on Water Birth 1-2 April 1995. London, England.

**Theme:** Exploring the Issues.  
The Conference will bring together  
leading experts from all over the  
world.

**Contact:** Administrator  
Parkside Communications Ltd  
Charles Hospital, Exmoor St  
London, W10 6DZ, England.

#### Birth Issues – 1st Annual Conference 18-20 November 1994.

**Theme:** Choices – Design – Making and  
Control.

#### International Speakers including:

Karen Guilliland  
National Co-ordinator  
NZ College of Midwives.

**Contact:** Jan Cornfoot-Capers  
PO Box 567, Nundah  
QLD, 4012.

## BOOK REVIEW

**Book Title:** Introduction to Obstetrics and  
Gynaecology

**Editors:** Cynthia Farquar, Murray Jamieson  
Department of Obstetrics and  
Gynaecology  
The University of Auckland

**Date Published:** 1994.

This book has been written as an introductory textbook for medical students, midwives and candidates for the postgraduate Diploma of Obstetrics. Readers who are familiar with the earlier departmental text, edited by G.H. Green, will recognise the similarity in layout and some diagrams.

The contents are well laid out and accompanied by clearly-defined and well-labelled diagrams. Each section of information has key points identified which are listed in boxes for quick reference.

This book acknowledges the New Zealand context and states that if there are no risk factors, antenatal care is undertaken by a midwife or general practitioner. The role of the midwife in

providing labour care is clearly stated with the optimum being one-to-one care. However, this book essentially follows an obstetric model of childbirth which recommends minimum care for nulliparous women including ultrasound scanning at 18 weeks and polycoase testing at 28 weeks. While this may be 'routine practice' in parts of New Zealand, in the absence of specific indication it is by no means universally accepted and certainly open to debate.

*Introduction to Obstetrics and Gynaecology* sets out to provide an introduction and summary and this it does well. It may well be a useful addition to ward bookshelves and libraries and as a quick reference for medical students while on clinical, but my feeling is that the libraries of practising midwives would be better served by more comprehensive texts to extend the boundaries of our knowledge and serve as references.

*Reviewed by Sally McNeill  
Midwife*

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