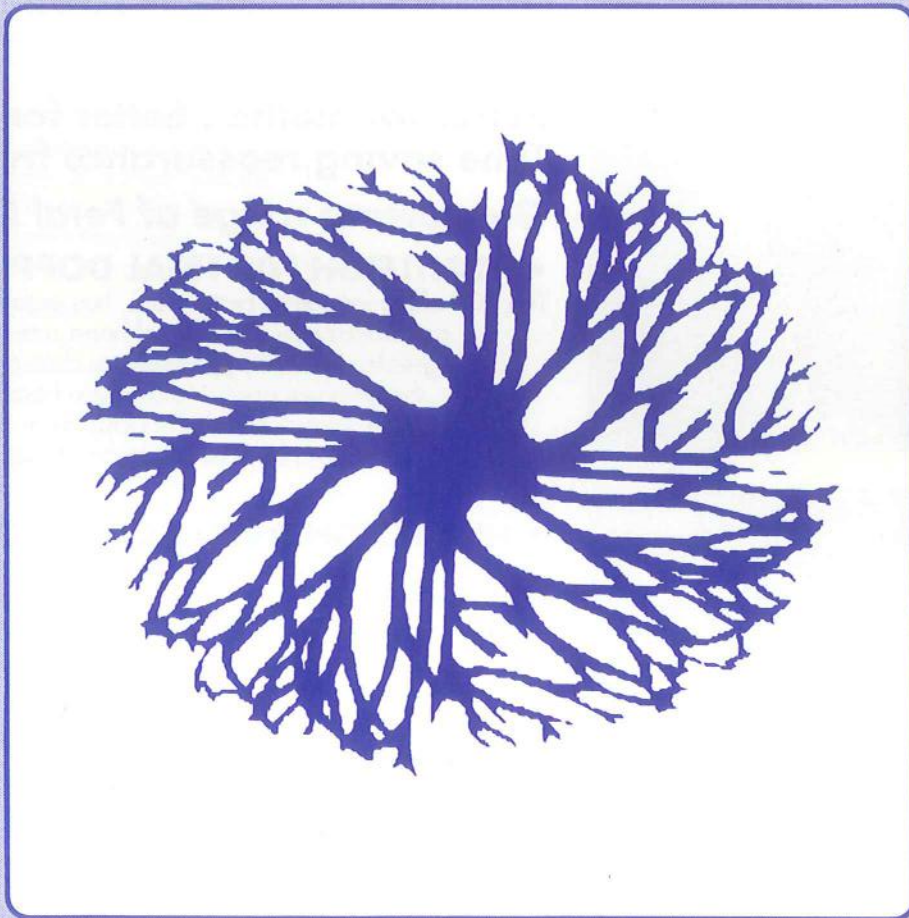




JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, OCTOBER 1995



THIRTEENTH ISSUE



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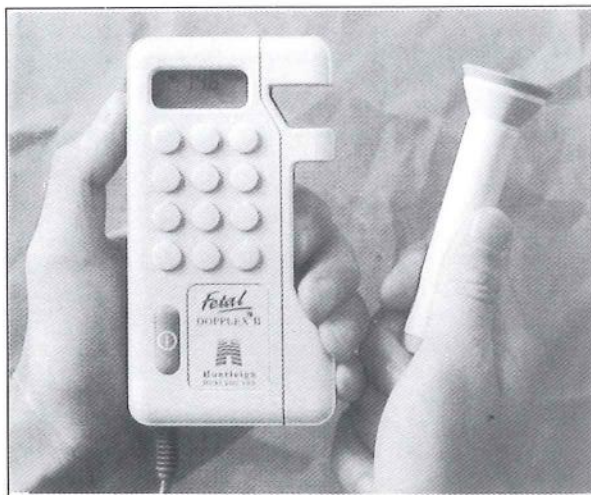
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- * Promote women's health issues as they relate to childbearing women and their families.
- * Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- * Provoke discussion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

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EDITORIAL

As I fly from Sydney to Adelaide on the last stage of my visit to New Zealand and Australia, I have a pause to reflect on my experiences over the last five weeks. As Visiting Scholar to the Department of Nursing and Midwifery at the Polytechnic of Otago in Dunedin, through my meeting with so many of New Zealand's midwives at the New Zealand College of Midwives annual general meeting, and a visit to the Victoria University, Wellington and the University of Otago, I have learned much to enrich my understanding of your system, and I have many good ideas to take home. I was impressed by a fierce pride in the unique nature of midwifery, a strong system of independent midwifery which is available to women through the health system, the commitment to work in partnership with women, a sense of strong cultural sensitivity, and a sophisticated system of professional review. The education of midwives is creative and fitting for contemporary practice.

Few of us can doubt that all of this will contribute to better maternity care for women. A discussion with a wise and down-to-earth woman in a country cafe summed it up for me. As we discussed what I thought of midwifery in New Zealand, she described her experience of four

caesarean births, and commented, 'I did not realise at the time, but now I can't help wondering if it might have turned out differently had I had my own personal guide'. This summed up the view I have heard from many women in different parts of the industrialised world.

New Zealand is a small beautiful country with a strong sense of integrity. Despite, or perhaps because of the small population, it leads the world in developments in midwifery. As leader of this movement into a new midwifery, you are facing some of the inevitable problems of fundamental change, and will be challenged to work them out ahead of others. Many questions arise. Are you able to quantify the effects and costs of your change, and will you be able to achieve a mutually beneficial collaboration with the medical profession? Last but not least, how many of the developments in independent midwifery will become mainstream and part of formal national policy?

In your position of leadership to the world-wide community of midwives your ability to confront and resolve some of the inevitable conflicts your change has created will be crucial. The global community of midwives and doctors who support women and their families in childbirth is close knit. The pond we live in is small indeed and the ripples of the changes spread wide! Many of us will depend on you to make

even greater strides than you have taken already, in reforming the maternity services and evaluating the effects of your changes, then disseminating the results to the world-wide community. This will be essential to dispel some of the distortions which inevitably accompany such change, and which feed into some of the vested interests which do not want to see midwifery advance.

Lesley Page

Professor Lesley Page

Professor Page is the Professor of Midwifery Practice at Queen Charlotte's Hospital, London. She has been involved in setting up midwifery teams to provide continuity of care in Oxford and a large independent midwifery practice in London. Lesley co-ordinates one of only two Masters in Midwifery programmes in the U.K. She is the only midwife member of the Government Expert Maternity Group which looked at implementation of the 'Changing Childbirth' policy which has led to major changes in the organisation and delivery of maternity services in the U.K. She is a visiting scholar in the Nursing and Midwifery Department at Otago Polytechnic for two weeks at the end of August.

BOOK REVIEWS

Title: *At a Loss - Bereavement Care when a Baby Dies*

Authors: Alison Stewart and Ann Dent

Published: 1994

Publisher: Balliere Tindall: London

Reviewer: Sally McNeill, Midwife

As midwives and women, there are times when we are confronted with the death of a baby and the care of a grieving family and anguish over the best way to offer solace and practical help. *At a Loss*, written by Alison Stewart and Ann Dent, is a comprehensive book on bereavement care which provides excellent research-based information on all aspects of grieving and practical information for health professionals.

This book is easy to read and formatted so that each chapter stands alone to provide ready reference on individual topics if required. The text is accompanied by clear diagrams with key points and chapter outlines highlighted in boxes. Appendices include contact addresses for support agencies in various countries including New Zealand, specific information on selected topics, e.g. taking photos of babies and families, leaflet for grandparents after their grandchild has died suddenly and unexpectedly, and a useful glossary of terms.

Alison Stewart and Ann Dent have both had extensive experience in providing support for bereaved families and this is reflected in this sensitively written text. Alison is now married and living in Dunedin where she is continuing her work and research. Hopefully we can look forward to more of Alison's writing within a New Zealand context.

Reflecting on my own experience over the last 25 years there were many times when a text such as *At a Loss* would have been an invaluable asset. *At a Loss* deserves a place in the libraries of all midwives and will be a valued resource for health professionals providing care for bereaved families.

Title: Issues in Midwifery
Editor: Tricia Murphy-Black
Published: 1995
Publisher: Churchill Livingstone, Edinburgh
ISBN: 0-443-04864-9
Reviewer: Helen Manoharan

This book was born at the International Confederation of Midwives, 22nd Congress at Kobe, Japan in 1990. It examines contemporary and controversial issues in midwifery from an international team of midwives.

The three main sections in this book are Independent Midwifery, the Education of Midwives and Models of Midwifery.

The authors are from a variety of countries and healthcare systems - Australia, U.S.A., New Zealand, Canada, U.K.

The three New Zealand contributors are Joan Donley, who writes about the challenges and emergence of Independent Midwifery Practice within a restructured health system in New Zealand; Judy Hedwig and Valerie Fleming discuss a model for midwifery practice that arose from research prior to the 1990 law change. The challenge they present is the necessity for a theoretical framework for midwifery practice.

This book will give midwives a greater understanding of what has shaped midwifery services in the past and may affect them in the future. It should stimulate discussion among undergraduate students and midwives with an overview of current midwifery issues.

LETTERS TO THE EDITOR

Vaccination Information

Dear Editor,

Dr Gillian Durham justifiably expresses 'grave concern that the midwives' professional organisation is happy to selectively use the medical literature to exaggerate the risks of immunisation, downplay its benefits, and apparently to oppose immunisation which has the endorsement of all major scientific bodies as being one of the most cost-effective means of preventing disease' (NZCOMJ, April 1995).

It is, of course, the Public Health Commission's (PHC) prerogative to selectively use information in order to impress upon New Zealanders that spending their taxes on pro-vaccination propaganda, vaccines, vaccinations, salaries for administrators and other bureaucrats is money well spent. Such funding includes the \$328,000 given to the Maori Women's Welfare League in 1994 to raise vaccination rates on the northern half of the North Island and the \$400,000 worth of vaccines wasted every year in the North Health region because they are stored or transported at the wrong temperature. While the Americans have sent men to the moon, a Third World country like New Zealand can, after all, not be expected to organise a cold-chain because it lacks know-how and infrastructure.

Considering the above considerable costs and difficulties, it is truly a miracle that vaccination is provided free to protect our babies and children from suffering and death. If everyone co-operates with Gillian Durham and Jenny Shipley, we may be able to wipe out terrible killer diseases like measles – second only to Ebola – by the year 2000. People should support this noble purpose and stop being so ungrateful and unco-operative and should stop questioning a public health measure to which humanity surely owes its continued existence.

Everyone, therefore, needs to wholeheartedly subscribe to the unproven theories that vaccination works, and that the broken cold-chain is the reason why vaccination doesn't work. No credence whatsoever should be given to the likes of Joan Donley who, after all, is only a midwife, not a doctor, or to Viera Scheibner who is only a retired principal research scientist for the NSW government and not a real doctor either, only a PhD who describes vaccination as 'the epitome of ignorance and the unscientific approach to illness' and that 'vaccination is the leading cause of cot death' when everyone with even half a brain and a title to their name knows that vaccination PROTECTS babies from cot death!

The PHC continually has to fight ignorance and prejudice. Incredibly, there is persistent

opposition to the PHC's tooth-saving programme 'Fluoridation 2000' which aims to extend fluoridation from its present 1.9 million New Zealanders to 2.4 million. Everyone ought to follow Auckland's example where 117 tonnes of hydrofluorosilicic acid are dumped into the public water supply at a cost of \$200,000 to ratepayers each year. Fluoride, as the toxic ingredient in the 1080 rabbit and possum exterminating agent and as the toxic component of the nerve gas Sarin of Tokyo subway fame, has long ago been proven safe and effective by scientific evidence. There is, therefore, no reason why it shouldn't be good for teeth as well. The minds of fluoridated people are soon so far gone that they no longer notice they are being dosed with this carcinogenic poison anyway, and soon stop complaining, so why all the fuss? This versatile chemical's potential as a political tool is truly exciting.

Dissidents such as Dr Ulric Williams who 50 years ago commented in his book *Hints for Healthy Living* that 'modern medicine is the most lunatic system ever devised by man to his own undoing except for the financial system, of which it is a part', should be ignored. Dr Guylaine Lanctot MD, who last November published her bestselling book *The Medical Mafia* in Canada, was quite rightly asked to resign by the Medical Association. This impertinent woman's claim of an unholy alliance between the World Bank, the UN's World Health Organisation, multinationals, governments and the medical establishment is ludicrous. The PHC's *Healthy Lives* (March 1995) front page report 'Irradiated Food Safe Says WHO' was, of course, published having only New Zealanders' best interests at heart, because, horribly, 'In the U.S.A. ... undercooked hamburgers killed four children, hospitalised almost 200 people'. Such casualties here would put a severe strain on our hospital system already under stress as a result of the estimated 2,500 deaths and 5,000 injuries in New Zealand hospitals caused by medical error (*Herald*, 26/6). The PHC should immediately mount an 'Irradiation 2000' campaign to prevent any New Zealand man, woman or child from ever eating such killer hamburgers the PHC luckily warned us about, or any non-irradiated food after the year 2000 for that matter. New Zealanders should feel proud to support the ailing nuclear industry now that the production line for nuclear weapons has apparently slowed down. Surely we will also see the prompt addition of a vaccine against food poisoning to our vaccination schedule. Medical science, Jenny Shipley and the PHC will not let us or our children perish.

Dr Lanctot's warning that 'Vaccination has been a disaster on the immune system, that it actually causes lots of illnesses and that we are actually changing our genetic code through vaccination' must be regarded as alarmist scare-mongering. She even says that 'In 10 years from now, we will know that the biggest crime against humanity was vaccination'. This flies in the face

of scientific wisdom and PHC policy which recommends sticking lots of needles into babies and giving them sips of monkey kidney soup as the only way to stop them from ending up in iron lungs and worse. Any sensible person would, of course, realise that the 25 vaccines including boosters prescribed to be given between the ages of six weeks and 15 months under the new vaccination schedule have been carefully chosen as absolutely essential for children's survival.

Surely it is contrary to the UN Convention on the Rights of the Child to deprive children of their rights to receive the best that medical science has to offer and of their chances to become fully vaccinated, fluoridated global citizens. We are sure no responsible parent or midwife (this of course excludes Joan Donley) would wish such deprivation on any child. Lay people must stop meddling in things that do not concern them and stop judging technologies which only experts understand. Consumers only need to know that the benefits far outweigh the risks.

Anyone still suffering from doubts after reading this information should repeat 'Be Wise – Immunise' while visualising the owl, after going to bed – until falling asleep. Warning: Disturbed sleeping patterns and even nightmares have been reported by people (especially children) attempting to visualise Jenny Shipley so we advise sticking to the owl.

Erwin Alber
Vaccination Information Network

Midwifery Model

Dear Editor,

Re: 'The Midwifery Partnership – A Model for Practice', Guilliland and Pairman (October 1994), NZCOMJ.

I found the above article brilliant!

It is clear, articulate and real. As a tool, I have used this article to clarify with my colleagues both midwifery and medical – not to mention hospital management – just what it is that is so unique and powerful between women and consumers.

What else is there to say?

Is there more?

May we have more?

I want to give the highest accolades to the women (Karen and Sally) who have given us these riches!

Vivienne Axon
Midwife, Auckland

Cultural Safety: Implementing the Concept

Speech given at the Social Force
of Nursing and Midwifery
Conference - May 1995

Jrihapeti Ramsden

**Nursing Educationalist
Ngai Tahu / Rangitane**

Mihi

In July 1993 there was a minor media explosion as the notion of cultural safety in nursing education hit the national newspaper headlines, the television news and the radio talkback circuits. Cartoonists in their succinct way also had a romp. Interestingly, the debate was located mostly in Wellington and Christchurch, sustained by the local daily newspapers.

Today any activity associated with cultural safety in nursing education or practice is still capable of attracting front page coverage. From time to time there is an eruption from some area of the media which is usually followed by the administration of some indigestion remedy by the Nursing Council of New Zealand. Despite the best efforts of the nursing and midwifery professions, the national digestion has not settled.

What is Causing the Discomfort?

Like all issues in which Maori are involved, there is a large race relations component in cultural safety. Race relations issues are usually controversial and therefore newsworthy. This increases the potential sales of newspapers and attracts advertisers to prime time television and talkback radio and sustains the news business.

The combination of Maori and nurses was particularly interesting to the New Zealand public since most people have some contact with nurses or midwives during their lives and everybody has an opinion about nurses and certainly about race relations.

Nursing and midwifery as female-dominant professions are regarded as somehow less professionally credible and more open to public comment than their legal or medical counterparts. Medicine and the law continue to be seen as male institutions despite the many women who belong to them. The nurturing nature of nursing also makes it particularly vulnerable to countering aggressive debate.

The stereotype of nurses as helpmates to medical doctors and wiping the fevered brow is still fondly held by much of the New Zealand public. More recently, and highlighted by the cultural safety debate, nurses are being seen as technically skilled, but the stereotype of nursing is still firmly located in secondary care. The role of nurses as promoters of community health or their location outside of hospitals is a concept which still does not sit easily in the public perception as evidenced by the cartoons depicting nurses dressed in symbols from cultures regarded as 'primitive' and being incapable of technical skills but good at greetings in Maori, which emerged during the debate.

When it appeared via the news media that Maori people were having input into the education and preparation of nurses to practise, very deep chords in some aspects of the New Zealand psyche were struck.

This is a neocolonial country. It was very rapidly and vigorously colonised, formally beginning only 154 years ago. The response of the indigenous people was passionate but their numbers were severely reduced by new diseases, civil war and the colonial wars. Now the numbers of Maori are increasing. Urbanisation and formal education have helped to create a critical mass of informed and analytical people who identify as Maori and require change in all service delivery and independence from the colonial systems with regard to the Maori future. People are wanting choices and to that end are becoming active in a range of ways.

In a climate of increasing new frontiers of debate and challenging political interaction between Maori and the state, the Crown, the government and the next door neighbour, the idea that the comfortable and trusted nurse image was being influenced by Maori who were demanding unreasonable and unrelated input into nursing education, was all too much for some people.

Nursing is inevitably involved in the cultural safety process because the role of nurses in all areas of society often involves frontline work with people suffering from the outcomes of poverty, as many Maori are. It is not coincidental that nursing has responded as solidly as it has to the ideas of cultural safety. The realities of barriers to service are norms for nurses, particularly those who work in communities outside secondary care and are able to equate the feelings of cultural risk which many people express, with missed opportunities in service delivery.

The underlying issue, and the cause of much anxiety, was the apparent power of Maori to create meaningful change in an established Pakeha system. In some views, a Maori takeover. If this type of liberal educational change had not been seen to have a heavy Maori involvement there may have been little public disturbance.

There are clear resemblances in the public aspects of the cultural safety debate to the media created moral panic associated with the Maori gangs of the late 1970s and the overstayer issues. Much smoke and a limited amount of fire.

The public response held some important lessons for nurses. On one level it illustrated how unprepared most nursing people concerned with the debate were to work with the people from the news media. Although the nursing teachers, students and Nursing Council personnel coped extremely well in an area which nurses traditionally did not occupy, the requirement for instant responses to media pressure highlighted the need for nursing to develop a much more realistic public persona. A public relations programme which puts the people in touch with the realities of the public-funded nursing and midwifery educational processes and with the activities of the Nursing Council would be very useful in helping to create informed debate.

On another and very serious level, the professional judgment of nurses and midwives to decide the parameters and content of educating future professionals was held up to public scrutiny by the media and found to be wanting by a largely uninformed public. This was trial by ignorance.

The issue of professional judgment and the confidence of nurses and midwives to set standards and to maintain, refine or defend those standards while remaining answerable to the public, helps to define professionalism. It seemed that the New Zealand public were not prepared to permit nursing to make these decisions.

Some areas of nursing did not feel well informed about cultural safety and therefore were not confident enough to defend them. The relationship between education and practice is an issue here.

There is a further issue of communication between education, practice and the older generations of nurses (many now retired but vocal in defence of the nursing philosophy of their times) who respond to their memories of service with little analysis of the power relationships and their implications. In those days a 'one size' service was intended to fit all. The condition was nursed rather than the person.

Traditionally nurses were educated to work with people without recognition of their difference. The now obsolete Florence Nightingale oath sworn by generations of nurse graduates stated that people should be nursed regardless of colour or creed. Power was located solidly with nurses trained in the military culture inherited from the British tradition. Cultural safety requires that all human beings be nursed regardless of all those things which make them unique.

Each person to whom nurses offer service should be understood to be part of a social, economic and historical framework. The idea of expanding the view that nurses have of patients to include their families and other relationships must expand even further if it is to be truly holistic and nursing is to be called comprehensive. Peo-

ples' individual and group histories have a direct bearing on their attitudes towards communication and their interpretation of barriers and access to service.

Attitudes which block access to service are held by both nurses and patients. It is the responsibility of the service provider to identify such barriers and work towards eliminating them in the interests of improving service. It is not the responsibility of people made powerless by illness, poverty, age, youth, sexual orientation, ethnicity or any disadvantage. Barriers may be as subtle as the body language of the provider or as complex as understanding the poverty cycle and designing effective nursing interventions.

Nurse leaders in education were quick to realise that the fault lay with the service design and delivery rather than the people who had little choice but to use it. Cultural safety was designed to focus on the nurse as the bearer of personal and corporate culture, attitudes, preconceptions and power. Such attitudes are often seen by the powerless as arrogant and controlling, all of which obstruct access to free communication and service which the patient could define as safe.

During the 1993 cultural safety debate there were difficult moments defending the issues because there were few standards which had been nationally agreed upon. There were very good reasons for that. The rapid evolution of cultural safety was keeping pace with the demand for change in a very immediate way. There was a great deal of broad brushwork and little time for academic debate.

Nursing was in agreement that cross-cultural issues in service delivery were critical and that change was required. Significant data demonstrated that, and from the early 1980s challenges from Maori were consistent and strong. Government directives and the Department of Health required that the status of Maori health be brought to the same level as the rest of the New Zealand population. Education was an obvious place to begin.

The co-ordinating role played by the Department of Education in nursing education, particularly in relation to cultural safety, was lost in 1989 when the economic reforms of the Labour government restructured the department.

Along with the advisory and support functions of the tertiary education unit, the role of the Education Officer to Nursing specialising in Maori Health disappeared. This happened as the theory and application of cultural safety in nursing education and practice were being developed. Along with many other initiatives, cultural safety in nursing was no longer able to be funded or nationally co-ordinated. The report, *Kawa Whakaruruhau, Cultural Safety in Nursing Education in Aotearoa*, published in 1990, strongly recommended that teachers of cultural safety were able to meet regularly to peer review teaching practice, compare experience, build on successful teaching styles and outcomes and discard those which were not useful. Because this was not

funded or supported to become a regular, national process, opportunities to set national teaching standards could not be developed.

Although responses were based on goodwill and concern, they were also often naïve and uncritical of the quality of service, focusing instead on the idea that becoming aware of traditional and rather romantic information about Maori could somehow translate into nursing practice.

Taking student nurses to 'marae' in order to sensitise them to Maori ritual and custom has little relation to practice. The equivalent in Te Ao Pakeha would be to take student nurses to Government House and hope that the experience would enable them to work with the diverse range of human beings who make up Pakeha society.

It was essential that students were enabled to understand the legitimacy of difference, and the Maori Studies approach was an early attempt to do this in the light of the little available information and the current educational climate. This process occurred regularly throughout the 1980s, most prominently in government departments, across the spectrum of education and in the private sector.

The colonial history of this country is referred to in a skewed and often very romanticised way in the general education system. When nursing and midwifery students begin to realise that the facts are very different and that they have a direct relationship to health in New Zealand for specific groups, they react in a range of ways. There is little in their educational experience or their daily lives for them to compare the new information with, and yet it becomes very clear that there are deep and complex issues to which they have not been introduced. Often students are angry at the shallowness and lack of critical analysis in their former educational exposure.

The evocation of sentiment or guilt has not been useful in nursing education which should be about creating allies. It is extremely difficult to avoid those reactions in some individuals and there have been disgruntled people who have had difficulty with new information. There are disgruntled people in all areas of education and in the wider society, and in combination with race relations quick ignition of emotional reactions can always be guaranteed.

Although the polytechnic nursing departments had responded so rapidly to the need for change, the loss of a central source of ideas and funding was critical to national development. Cultural safety became regionalised and dependent on variable local input. There was also a requirement that each polytechnic develop courses in response to local communities. Nursing teachers worked constantly to fulfil that.

This inevitably resulted in a wide reinterpretation of what cultural safety might be in education. Some course content drew public censure because it appeared to relate much more to Maori Studies rather than to nursing practice. It was often impossible to illustrate a relationship

between the study of traditional Maori activities and ritual, and contemporary practice. Students were quick to identify this and were clear in their objections. Relating information to practice rapidly evolved as a critical issue.

It was necessary to develop a body of knowledge which could demonstrate the social, economic, political, historical and often emotional reasons for the high incidence of, for example, rheumatic heart disease, the rates of asthma deaths, cot deaths, mental hospital readmission rates, uptake of tobacco smoking among young women, the rapid rise in high-risk behaviours and suicide, in which one sector of the New Zealand population far exceeds the rest. The people in this sector are Maori.

All these conditions are directly associated with poverty and can be found wherever poverty prevents access to help. In New Zealand there are clear reasons for these disease outcomes. Cultural safety does not justify the antisocial behaviours which happen in the context of poverty, unemployment and social stress, but it does help to explain them. This background assists nurses to make informed decisions and prevents the formation of attitudes which often blame victims.

This is an example of the educational theory of Brazilian educator Paulo Friere who believes that teachers must respond to student needs and tailor pedagogy to the realities of daily life. Nursing has learned quickly and, on the whole, well.

The Nursing Council of New Zealand provided a national shape for the terms of the development of policy and guidelines for polytechnics in curriculum development and the assessment of curricula when cultural safety became testable in the state examination for registration of nurses and midwives in 1992. Despite the media hype, the work of Nursing Council established guidelines and 'cultural safety' became part of the normal nursing and midwifery lexicon assuming parity with the philosophy of safety in all aspects of service.

Teachers were free to develop their course content and teaching styles locally as they did in all other courses. The Nursing Council does not have the right nor the will to restrict academic freedom of expression.

The term 'cultural safety' is consistent with normal nursing language. It has been firmly retained because the word safety is subjective. It gives the power to the user of the service to say whether or not they feel safe. The nursing skill involved here is to enable the person to express degrees of felt risk or safety so that they can expect and monitor changes in the behaviours of health professionals as a result.

Part of the public response to the idea of cultural safety was that somehow clinical teaching and technical skills would be sacrificed to undefined Maori 'things'. Cultural safety makes up 5-10 per cent of most degree programmes in nursing, that is, 90-95 per cent of programmes are not cultural safety.

The concept of cultural safety began to formalise at the Hui Waimanawa in Christchurch in 1988. Much of the basic theoretical work evolved at Christchurch Polytechnic Department of Nursing and Health Studies as well as at the Otago Polytechnic Department of Nursing and Midwifery. Both departments have important relationships with Ngai Tahu, Otago extending to co-ownership of the cultural safety component of the curriculum. Further developmental work from Maori nurses and from many other Maori, as well as people from other cultural and social groups, enabled work to progress.

There seemed to be a theme or continuity in the origin of cultural safety in Christchurch, the arising of the debate there and the support that tangata whenua were able to give the nursing department and the Polytechnic when it was besieged by the media in 1993. Several years before, a quiet gathering of senior Ngai Tahu had promised nursing their support in the development of cultural safety in return for a commitment to help improve the health status of Maori people through nursing education. Although most of those people have since died, the support has continued from their mokopuna.

Cultural safety has also evolved differently in North Island regions. For example, the Tihei Mauriora elective programme for Maori students at Waikato Polytechnic will be an important source of Maori nurse leaders who will be able to specialise in issues of Maori health. The Waikato programme has been developed in conjunction with the Tainui people in response to the Polytechnic charter to honour the Treaty of Waitangi and work in partnership with local communities.

The art of nursing in itself is a subjective experience between two primary people and others. All nurses and midwives understand the 'grey areas of care where professional distance is minimised and intangible skills are employed which become critical turning points in care. These skills improve the quality of human emotional and spiritual interaction and break down barriers to service as people feel safer. Without the art nurses become biomedical technicians. It is assumed that by graduation the level of beginning clinical skills have been tested and assessed in the basic course and that such skills are the tools of the art of nursing.

This work is about communication and access to service, quality assurance and patients' rights. However competent any nurse or midwife may be technically, such skills and experience will not be of use if people do not feel emotionally safe to approach the service, or if they use it too late.

If the term safety is changed to awareness, it immediately shifts the power away from the patient to define their subjective response and gives it to the service provider. Only the patient is able to say whether the nurse is safe regardless of how many awareness courses the nurse has attended.

Cultural safety differs profoundly from the Western traditional anthropological view in that it assumes that the nurse is exotic in the view of the patient, that the nurse is not the norm.

This view does not permit nurses to set up simple multicultural cultural check lists which deny the real and diverse lives of people who use their service. It insists that nurses and midwives become experts in understanding their own diversity within their own cultural outlines as well as their potential for powerful impact on any person who differs in any way at all from themselves.

This internationally original nursing innovation developed from the reality of nursing in New Zealand. There will be recognisable elements in other neocolonial societies. It has come out of the interaction of the indigenous people with a nursing service designed from the values and social shapes of another ethnospecific group. This makes it unique to the New Zealand experience and its interaction and evolution will eventually speak of a nursing service which has come from real neocolonial interaction and has created something new and positive.

Instead of standing by and allowing the misconceptions which the media have set up about cultural safety, nursing should rapidly and clearly respond to basically unsubstantiated accusations by adopting a marketing approach to clarifying the realities. Confidence in practice and positive change in service delivery need to be demonstrated.

There are six major categories of difference in the practice of cultural safety; between nurses practising in New Zealand and people who differ from them:

1. Tangata whenua and the Treaty relationship, and people of Maori descent in their neocolonial diversity.
2. The intercultural difference between aged and young people.
3. The intercultural difference between genders.
4. The intercultural differences in sexual orientation.
5. Socioeconomic and class difference - the cultures of rich and poor.
6. The cross-cultural difference between ethnospecific New Zealand nurses and midwives, and people from ethnospecific migrant groups.

These categories acknowledge that health is a dynamic combination of social factors which are contained in, but not restricted by, a package which can be called culture. Religious difference and difference by disability have been recently suggested for inclusion.

They involve understanding the universal theories of homophobia, of racism, sexism and ageism and issues of social class. They can all be applied to life in New Zealand. The skills of cultural safety should work as well for homosexual people being nursed by heterosexual

nurses as for people who differ by the apparently simpler context of their ethnicity.

The objectives of cultural safety in Nursing and Midwifery education are:

- To educate student nurses and midwives to examine their own realities and the attitudes they bring to each new person they encounter in their practice.
- To educate student nurses and midwives to be open minded and flexible in their attitudes towards people who are different from themselves, to whom they offer or deliver service.
- To educate student nurses and midwives, not to blame the victims of historical and social processes for their current plight.
- To produce a workforce of well educated, self-aware registered nurses and midwives who are culturally safe to practise, as defined by the people they serve.

These objectives do not include Maori Studies. Rather they are designed to help create self-knowledge and lead to practice wisdom.

The angry public and student response to some of the teaching anomalies must be seen as constructive and creative since it accelerated the awareness of teachers of the need to develop a framework of ideas in which to embed the concept of cultural safety. The outcomes of a culturally safe health professional graduate should be agreed upon. They should be achievable and assessable.

For example:

- * all – to be able to recognise that change is needed
- * all – to develop the skills of critical analysis
- * $\frac{2}{3}$ to be able to recognise the opportunities to create change and see where to intervene
- * $\frac{1}{3}$ contribute to change
- * outstanding graduates – initiate change.

It also became very clear that suitably qualified nurses needed to teach cultural safety and to design and co-ordinate curricula and external input to the courses.

Cultural safety must continue to develop in a well thought out and co-ordinated way. A body of academic knowledge and tested paradigms will continue to be developed. Standards for teaching and for the education of teachers will require further co-ordination.

It is much simpler to teach bioscience, surgical, medical or other areas of nursing because there is a documented background of assessable knowledge and experience as reference. Working in the area of new liberal material, some of which is still being researched (as all knowledge always is), translating that into a teaching style which challenges without distressing students as well as relating to health and disease outcomes is a daunting task. To the credit of teachers, it is generally being achieved

very credibly and although there have been difficulties along the way, approximately 4,000 students have graduated from the courses since their formal inception in 1992. If even a tenth of those people had expressed dissatisfaction there would be real reasons for anxiety. Three years have seen a rapid development in this area of education.

As well as traditional social science, anthropology and history skills, cultural safety teachers have to be well trained in issues of attitude development and change. They need to be able to teach so that students feel safe to be able to examine their own attitudes and realities. For this to happen teachers also need to be safe to teach.

A process to establish and define such safety will be developed. Teachers require a sound knowledge of New Zealand history to be able to place the health and illness issues in this society in their neocolonial framework and establish the cause and effect relationship for students. This is inordinately skilled work and cannot be achieved overnight.

Teachers in this area do not need to be Maori except where issues of Maori intellectual property are concerned.

Cultural safety has happened very rapidly as an educational process and is still being refined. There will be continuing controversy because it is an easy scapegoat, a useful diversion in toughening economic times and a climate of right wing economic reform.

If Maori had not acted upon the need for change in nursing education such a course may not have attracted the level of public attention that it has. The level of ignorance, misinformation and irresponsible media hype has been very painful for nursing and midwifery. Pain is intended to identify problems and problems call for change. Change is happening and happening very positively in many places. There is a deep groundswell of understanding and better educated nurses will translate that into practice.

People should have mechanisms to comment powerfully on all aspects of quality in nursing

service. This can be achieved in several ways. Informal patient surveys seeking quality assurance which include access issues, such as illiteracy, are important. Formal qualitative research should seek to record a broad range of service indicators including subjective responses, or the intangibles. Quantitative research also provides insight into the use of service. There should be no fear of breaking down the groups of people into their ethnospecific or intercultural backgrounds if that is their primary identification. Only by allowing them to self-identify will any real approach to specific service needs be developed.

Although it was identified and initially shaped by the indigenous people of this country, Kawa Whakaruruhau, a process for protection, cultural safety, is the gift that Maori offer nursing, midwifery and all those who are different.

In the end cultural safety is about quality assurance and patients' rights, whoever those people may be. The nursing skill does not lie in knowing the interesting and exotic customs of ethnospecific cultures, that is completely unrealistic. It lies in enabling people to say how service can be adapted and to negotiate compromise.

It came out of the Maori pain experience, the unnecessary loss of beloved people, reduced life expectancies and the impaired quality of life still experienced by many Maori, but is offered out of that experience to all others.

The development of cultural safety belongs to life in New Zealand and to the story of this country. Nursing is to be congratulated on the journey it has made and the courage and determination it has shown to work with the issues. There will be an ongoing process of self-examination towards the expansion of practice in the search for excellence in the service offered and given to those fellow human beings who differ, fully regardful of their difference and of the realities of those people who are nurses or midwives.

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Needles in the Haystack: Finding and Reading Research Articles

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As members of a profession which claims to have a practice which is research-based (as opposed to practice-based on myth or authority), it is increasingly important that we develop our skills in 'consuming' research. First, this means finding research which is relevant to our practice or interests. The most current work is published in journals whereas a book may take one or two years to produce and publish. It is also important that we distinguish between primary and secondary sources of research information. Primary sources, which are 'straight from the horse's mouth', are where the researcher is writing about their own work and consequently there is generally more detail about the actual study. Secondary sources are where the research is reported by a person other than the researcher, often in readable terms and without specific details.

So where to go for the research?

The first question to ask is why do we want the research information? Is it a consciousness-raising exercise about different practices and ideas? If so, we might start by reading a book which is a secondary source such as the series by Alexander, Levy and Roch (1990) which provides readable text summarising and commenting on research article findings in relation to practice, with actual references to the articles given.

Are we concerned with exploring existing research on a subject area with a view to altering our practice? In this case, we might want a detailed review of the research in the area before going on to actually read the primary sources of articles written by the researchers. An example of a review is the article written by Greenwood (1994), exploring the different findings of five studies in relation to Vitamin K and subsequent childhood cancer. A well-publicised extensive review is the work by Enkin, Keirse and Chalmers (1990), reviewing the effects of care during pregnancy and childbirth drawing on both published and unpublished data.

If we turn to accessing the actual research articles, it may be journal subscription, picking up odd articles, waiting for the *MIDIRS Digest* to arrive, or a literature search undertaken personally or with the help of librarians/resource centre staff.

A literature search using library resources can either be manual or computerised using keywords such as 'postnatal care' to search for

references to articles on the topic. A good starting point for midwifery is *CINAHL (Cumulative Index of Nursing and Allied Health Literature)* which is available in journal and computerised form on CD-ROM. Medical literature can be accessed on CD-ROM using Medline and for some midwifery topics (e.g. communication, interaction, bonding, bereavement) it is also worth considering other indices of articles in the social sciences such as *Psychlit* and *SSCI (Social Science Citation Index)*. Some libraries have the *Cochrane Database* available. Although using CD-ROM to search for references can appear daunting, libraries offer training sessions and once learned the skill opens the door to finding literature world-wide.

Once references to articles are found the question is which ones to go and find. Sometimes this is a process of guesswork based on the title of the article, since not all the references which appear on a keyword search will necessarily be of interest. Once selected, an alphabetical national index of journals (generally presented on microfiche) is needed to allow us to check which library holds which volumes of which journals. If the library you are using has a subscription to the journal that you want, then it is just a question of finding the relevant volume on the shelf. Otherwise an interlibrary loan is needed so that a photocopy of the article is sent to you at a minimal cost nationally. If the journal is only held overseas then the cost of search and photocopying is a minimum of \$15.

Once you have research articles, whether randomly acquired or carefully selected, the next step is to read them. Everyone develops their own strategy for finding the time to read (or not) ranging from having piles for bedtime reading, one article to read per day, a buddy to chat over articles with and a folder full of the unread 'must read soon' articles.

Different journals have different in-house styles so presentation can vary. In general the layout of an article generally follows the form of:

Title - Author(s)

Abstract (brief outline of everything covered in the article)

Introduction/literature review

Methods (details of sample, how the data were collected, ethical issues and how the analyses were done)

Results and Conclusions

The readability of articles can vary drastically with some articles remaining a mystery to the reader in a mass of unintelligible, dry jargon. Having an article published does not guarantee that the researcher can write clearly or enthuse the reader. However, one 'dry' article does not mean that all articles are like this.

Another bewildering feature of research articles is that there are different approaches to research (e.g. surveys, experiments, phenomenology, case studies) and we will return to this in a later issue. However, without knowing the finer differences it is still possible to read an article and find it of interest personally or in practice.

One way to develop research reading is to have a record of the information which you have read with a brief summary of the article on a card index or on a computer, focusing on the main points of the article.

What is the study about?

Who is in the study (e.g. particular women were studied such as only primiparous women)?

Where and when did the study take place?

How was the study done (e.g. how was the data obtained analysed)?

What were the results/conclusions of the study?

This provides a resource you can refer back to and can form the basis of critiquing articles. Once we have found research articles, we need to then assess them to decide what evidence (if any in some cases) they provide for changing our practice. In the meantime, if you have anything relating to research which you would like to publish please do send it in.

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The position of psychiatric liaison midwife (PLM) has been identified as necessary to interface obstetric services with mental health services, thereby streamlining and improving services offered to women and families with psychological/psychiatric disturbances.

This position is a resource for the hospital. Care is planned, reviewed and adjusted as necessary for the pregnancy – childbirth continuum. Acknowledgement and adjustments for the mental health perspective are incorporated. The PLM is also available in a consultative capacity for crisis management of a woman and family. With early identification of risks being critical, staff education is seen as a priority.

The following is a case history of a woman I recently worked with.

Background

A 24-year-old woman, following the birth of her first child, presents at four months postpartum with depression and suicidal impulses. Onset of depression dates back to two weeks postpartum. I was asked as a PLM to assess and monitor progress. During my discussion with her it became obvious that there were areas of concern with labour and delivery. I invited my client to revisit the delivery unit and the following is her written account (condensed) of what happened to her. I suggested a follow-up session with her independent midwife which was helpful in resolving the situation. My client was discharged five days postpartum and ceased antidepressants three weeks later.

I Gave Birth to a Dolphin

Revisiting the delivery suite with my bonny five-month-old daughter, I sit on the delivery bed suckling her for the now umpteenth time and I remember five months ago when I gave birth here after carefully planning a homebirth.

When my waters broke, I was scared, not elated – failure number one. Peter was elated. He danced around the bedroom. I had diarrhoea. We were sent back to bed by the midwife on the phone. But my contractions built up like a flash flood in an unbelievably short time. Before I knew it, I was being tossed in a sea of pain while sitting in a quickly cooling bath. It was the depth of night, and dark and stormy outside. Peter was attempting the soothing techniques that he'd learned at antenatal classes, but withdrawing as time went on to a fantasy future of happy fatherhood, not the wild and bitchy woman whose labour is not progressing as the antenatal class teacher had said it would.

When the midwife finally arrived aeons later, I demand to go to hospital – no pride! All my fierce individualism gives way. I want to be an anonymous patient given the strongest painkillers known to the world. I want no more responsibility.

I was taken down to delivery suite by wheelchair at some hour of the morning, blood soaking into my T-shirt and dressing gown. I thought they allowed that grudgingly, only because I was a sack of baby bursting at the seams and I had several contractions while standing at the reception desk giving my name and address. I was wheeled through warm labyrinths, past strange faces who seemed unconcerned. I thought I was beyond caring about my failure to give birth in the spiritual haven I had created at home, but the narrow hospital bed spoke failure at the same time it spoke safety. I still do not know what this safety is that I wanted so desperately.

I reached for the gas mask like an addict, and it's rattle of failure at not being able to do it without pain relief. I was told I was fully dilated and would have a baby by breakfast time. Two hours elapsed of which I have no recollection except farting loudly when Sylvia's head began to squeeze me like a toothpaste tube. I clung to some threshold, some long-trained and white-knuckled discipline. 'You will do it because you have to,' it said sternly as I was ejected into motherhood. Was the woman strong or was she weak?

I return to the present. It is hard to believe this body knitted itself together again. I feel like a sham mother, sometimes, with a terrible secret. The contractions forced her out of me. It was not me, but the fist of a raging giant wringing me like an old washcloth, squeezing gas and shit and blood out. She slid out from some place I cannot comprehend could be open.

It was not really happening.

A dolphin was pulled out of my behind.

There was crying somewhere in the distance and then the midwife asked if I would hold the bloody thing before I had even figured out whether I could move from my shuddering hands and knees. I said, "No, give it to Peter". There was a silence behind me – a lake of silence in a cavernous room. Then she passed it through my legs and made me take it. I lifted the towel to see what it was and it was a little girl who was looking at me. I was shaking violently by then and the midwife gave me Arnica and Rescue Remedy. But nobody touched me except medically. My belly was pushed so that the damned blood would pour out. I was stitched up.

It was all going on somewhere else. I travelled in and in to try and find a safe place, but outside felt ransacked and violated. It was as though my body had turned against

'I Gave Birth to a Dolphin'

Psychiatric Liaison Midwife

Viv Axon

Independent Midwife

me, turned inside out and expelled my heart.

Will I ever feel intact again? The bland and smiling faces of mothers in the supermarket belie this secret wound that I feel. A lake of tears collected in this wound – unshed tears in an unhealed wound.

My recently vacated body remains like a wraith in the delivery suite. Giving birth was a loss, not a gain. What was important left my body and my body was just a disposable container. I felt I died. The baby was my heart. The baby is the future and I am the past. But I am still here.

I see this spectre of myself on the bed in the delivery room that looks so innocuous now, so small and solid. The midwife writes up her notes on the delivery and Peter carries round his trophy in wonderment. This semblance rallies and talks to parents-in-law on the phone overseas while she is being stitched up between her legs. Then she is shown to the shower where she nearly faints and asks in an apologetic voice if someone would mind helping her dry herself.

When I look in the mirror after giving birth, I expect to be the way I was before I got pregnant. I thought that my belly would be taut and my legs and arms slender. I was not prepared for the bloodless and flaccid, used-up woman that greeted me. I was hurt, bewildered, shocked and guilty but it all went underground, to keep me awake for night after night, months later, mixed up with other traumas that I have not come to terms with in my life ... 'When we are tired, we are attacked by ideas we conquered long ago' (Friedrich Nietzsche).

The voice in myself I know as the part of me who would die rather than be a nuisance tells me I'm melodramatic: 'Don't be ridiculous, women have always given birth. It's painful. So what? It's part of nature. Just put it behind you and get on with your life.'

Do other women all just flow with the change, after being broken and put back together again and then immediately expected to care for a demanding infant 24 hours a day, seven days a week? Do they not have bruises and scars that persist after the physical healing has finished? I abandoned the body that felt smashed and vacated, because there seemed to be no place for those feelings. I've done that before, when the feelings I had from an experience were not what I expected or wanted. I expected giving birth to be joyous and empowering, but it actually felt like being raped from the inside.

In my imagination, I recreate the scene in the delivery room, I would like to see the birth attendants bend over the woman after she has given birth, unfazed by the blood and shit, to hold her gently and murmur soothing words. Then I would like to see her carried to her room, a victorious queen on a velvet bier, swathed in silky curtains. I would like to see her gently stroked, encouraged to cry, to laugh or to talk about her experience if that is what she needs to do. I would like to see her washed with warm soothing water and spoon-fed with delicious and strength-building foods. I would like to see the woman cherished as though she was the baby for she is, each time she gives birth, she is newborn among mothers.

The newborn dolphin has become a little girl called Sylvia. She expresses herself without fear, her demands are loud and vociferous and her laughter is glorious. As she sucks her life from me, giggles and waves her arms and legs around, exploring her world, I love her for her shamelessness. I want, above all, for her to remain lusty and unquestioning of her right to experience her world fearlessly.

It has been difficult to admit to myself how much it hurt, that giving birth was not as I expected or wanted. I found I could not make a connection between that birth experience and motherhood.

I found that once I let myself express my grief and disappointment over Sylvia's birth, I felt more strongly bonded with her.

Psychiatric Liaison Midwife's Role

The role of the psychiatric liaison midwife was formulated to co-ordinate service provision for women with a history of or a current psychiatric issue. The midwife also offered a service to those women who were thought to be suffering postnatal depression. A women's support group was set up within National Women's Hospital and women joined in anywhere along the childbirth continuum, i.e. antenatally – postnatally. I worked in the role for 18 months after establishing it.

I want to share with you some of the main points I learned during this time.

In summary:

1. The power of normalising and legitimising women's feelings, experiences and reactions is extremely powerful in healing. The group reflected this now and again.
 2. Our socio-cultural norms are out of 'sync' with the 'real' norms for women in childbirth.
 3. There is no such thing as 'postnatal' depression. Clinical depression exists and, in the puerperium, depression is the same as any other time. What is different is:
 - a dependent baby and
 - our culture only recognises childbirth as a 'happy' time.
 4. When labelling women as having 'postnatal depression' we decrease the responsibility family and society play, and by stating 'pregnancy and hormones' are the cause. Women then doubt their own responses and bodies – as a reaction to being seen as sick.
- In reality, it is perhaps the expectations we as a society have of women who are sick and women's responses are healthy responses to these inappropriate expectations.
5. The inextricable cycle of women as mothers as children means that where there are problems, if not dealt with appropriately and constructively, they repeat again and again through the generations. I have seen many examples of mothers and mothers-in-law, trying to use their daughters' pregnancies as a catharsis for themselves with negative consequences on their daughters.
 6. I learned about midwives using their personal experience of childbirth as the definitive professional practice.

7. I have reflected much over the uniqueness of midwives and childbearing women. The obvious partnership which, for whatever reason, doesn't always result.
8. The amount of advocacy women needed demonstrated how often the 'nursing hierarchy system' is used to intimidate and medicalise. Women often felt that they were being punished for deviating from the 'norm'.
9. I learned also about the sisterhood of midwives, I had been excited at joining; good sisters, bad sisters, ugly stepsisters.
10. I looked at the institution and watched:
 - dysfunctional families
 - doctors playing 'Dad' – only there part-time and when he is there needs pampering, placating and instant needs response.

The midwives are great mothers and midwives – looked after Dad's needs first and defined themselves by their relationship with him.

The woman/babies were the children. 'Naughty' if non-compliant. Needs attended to, were secondary to the staff's. If something needed to happen which the midwives knew the doctors would be unhappy about, they did it quietly without informing them.

Then independent midwives quickly mirror those mothers who abandoned their families by going out to work in the 1960s and 1970s. Economic rivalry and competitive force in the job market. Interesting to note is the Northern RHA's latest response to Section 51 negotiations, which effectively decreases pay and sends midwives back to home/hospital where they belong.

I digress. The huge issues of grief and loss which accompany and ensue from a 'normal' pregnancy are even more amplified for already vulnerable women, e.g. those with sexual abuse issues and psychiatric issues have the power dynamic of those situations replayed once they enter the institution. Their vulnerability is heightened and exploited as we view compliance as 'good' behaviour.

It became rapidly apparent that when women's health is run by business men, not only are the cultures different, but the agencies are obviously different. Women's culture is diverse and by necessity hidden. It really needs to become overt to be allowed to talk, but this can't happen when the power of an institution is from a separate culture and differing agendas.

When women need nurturing and finance is an agenda, the nurturing has to be cheap, i.e. cost effective.

When women want their needs responded to, their needs have to be cheap and cost effective. I could go on. The points are made.

As long as women's culture is seen as unworthy, it will be lost, ignored and unknown. It is up to midwives to acknowledge this and move to reveal issues in women's culture. We need to know ourselves first and then work in partnership with other women to know about *all* of women's culture.

Surely we can't be safe practitioners otherwise.

Burwood Continuity of Midwifery Care Scheme

Chris Hendry

**Practice Manager
Burwood Birthing Services**

On 26 September 1994, the Burwood Birthing Service initiated a 'Continuity of Midwifery Care Scheme' based in the Burwood Birthing Unit at Burwood Hospital, Christchurch. Seven midwives offer continuity of care to all women birthing in the Unit who have not engaged the services of an independent midwife. Burwood Hospital is situated 10km from the centre of Christchurch and about 550-600 births take place in the Birthing Unit annually.

Background

Historically, midwifery care in the Burwood Birthing Unit has been provided on a nursing/medical model, with the midwives working eight-hour shifts. This meant that a woman in labour may have had two or three different midwives providing her care. The Unit was staffed by two or three midwives and an aide per shift, regardless of how busy the Unit was. Most women had GPs or independent midwives as their primary caregivers and only visited the Unit once prior to birth. The childbirth classes were run five times a year with as many as 60 people attending. The workload in the Unit was very dependent on independent practitioners' recommendations. Most primiparas were encouraged to birth at the Base Hospital.

In early 1994, the plans commenced to introduce a midwifery caseload model of maternity care. Successful negotiations were carried out with the NZNO for a variation to the nurses contract enabling the midwives to work more flexibly and carry a caseload of clients rather than working shifts. By August, a Practice Manager was employed to facilitate the move to the case management model. In September, seven midwives chose to take part in the 'Continuity of Midwifery Care Programme'. A smaller number of 'core midwives' chose to work eight-hour shifts to cover 'core duties'.

Preparation for the Scheme

Changes were needed in the Unit in preparation for the new scheme. A computer was installed which, among its many functions, had a paging system enabling staff in the Unit to type messages into the midwife's pager. Booking-in systems, filing systems, communications and routines were all reorganised, enabling a workload reduction and a reduction of midwives to one midwife per shift.

A self-service breakfast system was also introduced enabling women to arrange the morning to suit themselves.

Midwives

The midwives who chose to stay in the Unit became 'core midwives', work on shifts and provide midwifery coverage and backup support in the Unit 24 hours per day, for both continuity of care and independent practitioners accompanying women in labour. Birthing Unit assistants are employed to work during the daytime hours, one per shift.

The 'Continuity of Care Midwives' self-selected into two teams in order to organise relieving, childbirth education classes and back-up support. When a woman books into the Unit to birth and does not have her own midwife, she will have her midwifery care provided by a Burwood midwife. As the scheme is becoming better known, women are requesting Burwood midwives on booking. The woman may or may not have a medical practitioner involved in her care, but the scheme ensures that all women who are booked to birth in the Unit have their own midwife. Once the booking is allocated to one of the teams, the team decide which midwife is allocated to the woman as her primary midwifery caregiver, unless the woman has requested a specific midwife. Each midwife has a maximum caseload of six women per month (including an even distribution of 'shared' care and 'total midwifery' care, based on the full-time equivalent status of the midwife).

Each team of midwives meets weekly to discuss allocation of cases, organise a roster, and generally debrief from the previous week's work with their colleagues. There are no appointments made on Fridays from 12.00 noon to 3.00 p.m. The Unit meetings, clinical practice meetings and

continuing education sessions are held every Friday from 1.30 p.m. to 3.00 p.m.

Midwifery options now include:

- Total midwifery care from pregnancy testing to care after birth up to six weeks postpartum.
- Shared care with a doctor who practises obstetrics.

The 'Continuity of Care' midwives offer:

- Antenatal visits at the Unit or in the woman's own home.
- Antenatal classes are offered, both for first-time mothers and refresher sessions.
- Labour care at home or in the Unit, particularly in early labour when assessment can be made when to be transferred to the Unit.
- Delivery of the baby in the Unit and daily postnatal care for mother and baby.
- Following discharge, visiting the woman in her own home.

To improve access to the midwives, one of the midwifery teams is providing a midwifery information and assessment service from the Aranui Plunket Rooms.

Practice Manager

This role is distinct from that of a Midwifery Manager: it is purely a management role with no clinical input. The midwifery philosophy of self-responsibility, autonomy and accountability for professional practice, is incongruent with the role of midwifery 'specialist' or supervisor. Each midwife is responsible for their own practice, which includes negotiating, consulting and referring to others on their own behalf.

The Practice Manager's role is to facilitate the midwives' practice. This involves ensuring that personnel, equipment, environmental, marketing and communication issues are managed efficiently and effectively. Many of these issues are identified by the midwives themselves and having someone cope with organisational issues allows the midwives to concentrate on the practice of midwifery.



Clerical Support

Good clerical support is a crucial element to effective management in this type of practice. The woman is usually in the Birthing Unit for an average of three days within the total five to six months of midwifery care. This means at any

one time, a full-time midwife could have up to 36 women in her care. With seven midwives, that is the equivalent of 250 'outpatients'. With 50 per cent of women using our facility with their own midwife, there is an even greater number of women potentially wanting to have contact at some stage with the Unit.

An efficient communication system with at least four to five different telephone lines has been necessary, as has the development of a good computer system, with word processing, database, rostering, paging and printing facilities attached.

Clear marketing messages need to be presented to potential consumers. Having one main person giving out technical information about the service, making appointments and arranging visits/admissions increases the efficiency and prevents mistakes.

Clear information in written form is also crucial: brochures, booking forms and posters all need to provide as simple a message as possible about the service, giving a 'user-friendly' approach.



Women and Families

The number of women choosing to book in to birth in the Unit has increased, both with contracted midwives and with the Burwood midwives. The number of women choosing midwifery care rather than sharing with a doctor has increased from 16 per cent to 45 per cent.

There is an increase in use of the Unit by Maori women and the self-referral rate has doubled. The number of first-time mothers birthing in the Unit had been decreasing over previous years, but the numbers booking in to birth recently are increasing.

One byproduct of this community-based service is the early identification of women with social needs, and the use of social work services has increased.

Initially, there was a need for the midwives to familiarise themselves with community agencies so that they could direct women to the most appropriate social support.

Transfer rates to the Base Hospital have remained similar at 8-12 per cent. The induction rate has fallen, perhaps as a result of the negotiation that now takes place between the woman, the midwife and the doctor over the birth plan.

Staffing

The most significant change is the feeling that the Unit is running more smoothly. If it is busy there are enough staff, if it is quiet there are no staff sitting about. With each woman in labour

being cared for by her own midwife, birthing is a very discrete event in the Unit. Women appreciate the privacy as there are no staff running from one room to another.



The use of relieving staff has fallen dramatically. The cost of replacing staff on leave has been cut. The continuity midwives reduce their caseload to go on leave and a colleague covers for them. The continuity midwives relieve the core midwives if they are sick. Annual leave is planned in advance and spread over the year and the continuity midwives relieve each other and the core midwives.

The greatest challenge with this new service has been to get the message across to women and their GPs. The most effective way has been for the midwives to make personal contact with GPs to explain the new way in which they practice, pointing out it is the individual midwife that they discuss care of the woman with, and not the Practice Manager.

Inductions and any other procedures are arranged directly with the midwife who then makes arrangements with the woman and the Unit.

Independent midwives were anxious that our 'Continuity of Care Scheme' would impact on their use of the facility but, in fact, the feedback has been positive. They have developed a collegial relationship with the Burwood midwives and appreciate the reduction in conflicting advice that women receive, their care plans are followed by the core midwives.

The Future of the Service

We see ourselves as a community-based service and intend to further develop in order to better meet the needs of women in the surrounding community. As over 50 per cent of our consumers are Maori or Pacific Islanders we need to ensure that our service is appropriate. We also need to ensure our service is accessible for women. As a large number do not have their own transport, we need to offer our service within their community.

We also have a commitment to professional development, health promotion and education. We have developed a variety of childbirth preparation options for women and their families. We also facilitate access for midwifery students to gain experience within the midwifery teams. Continuing education opportunities are provided monthly for our staff and contracted providers and we also have clinical practice meetings monthly to give our midwives a forum for discussion of specific clinical practice issues with colleagues and the Professional Midwifery Advisor.

Breastfeeding

Joan Donley O.B.E.

Independent Midwife
Auckland

When I was working 'inside', the emphasis was on labour and delivery. However, as a domiciliary midwife it didn't take too long to realise how important postnatal care is to the wellbeing of mothers and their babies. This is the time when women get to know their babies and adapt to the change in family dynamics – in-laws, siblings, who can be less than enthusiastic about the competition. It's the crucial time when breastfeeding is being established – while new mothers cope with sleepless nights, tender nipples (like putting your nipple in a mousetrap, according to one of my colleagues), engorged breasts and after pains. It is also the time to debrief from the labour. It is a time when a woman needs support and TLC if she is to parent effectively and breastfeed long term.

Once upon a time when we could make up to 12 postnatal visits we had a breastfeeding rate of 98 per cent – long term. When we were booked for the next birth we would find that the previous baby had been breastfed for at least one year and often longer. Of course, one could say these were committed homebirth women.

Today, as a response to the Standards Review Evaluation forms, there is still a relationship between the number of postnatal visits and the breastfeeding rate. These are mainly women who birthed in hospital and went home early – under the care of an independent midwife (IM).

In Auckland, the women whose IMs make 12 postnatal visits have a breastfeeding rate at six weeks of 98 per cent.

The women whose IMs make seven or fewer postnatal visits have an 80 per cent breastfeeding rate.

The IMs who provided 12 postnatal visits did not receive negative comments on their evaluation forms, while 10 per cent of the midwives who made seven postnatal visits received negative comments. That is, these are dissatisfied customers!

Gary Henry, NWH Manager of Women's Affairs, believes that customer satisfaction is the most important factor in this market-oriented competitive environment. Nevertheless, the latest sum for the postnatal care module is \$350 for an anticipated average of six visits. Its been calculated on averages by male bean counters – not on the needs of women as satisfied customers nor the health of their babies.

Economics is the basis of every decision made by the current health gurus. Yet, this is an economically short-sighted decision. There are long- and short-term costs of failure to breastfeed – higher incidence of SIDS, more hospital admissions, milk allergy, eczema and child abuse.

This is backed by UNICEF which wrote to physicians for help and leadership in promoting World Breastfeeding Week. It pointed out:

... there is increasing awareness that breastfeeding plays a far more crucial role in the survival and healthy development of children than we ever before imagined. Study after study now shows, for example that babies who are not breastfed have higher rates of death, meningitis, childhood leukemia and other cancers, diabetes, respiratory illnesses, bacterial and viral infections, diarrhoea diseases, otitis media, allergies, obesity and developmental delays.¹

There are also long-term costs for the education system. In five studies, artificially-fed children have shown lower cognitive scores than breastfed children, even after adjustment for mother's education and social class.²

World Breastfeeding Week 1995 was 1–7 August. World Alliance for Breastfeeding Action (WABA) called on governments and NGOs to use this week to raise public awareness on the need to improve conditions of women so as to enable them to breastfeed successfully. It also highlighted the 'empowering nature of breastfeeding culture on women'.

WABA presented a five question National Report Card on Breastfeeding. Ten marks = 100 per cent for each question.

Q.1. *How long are babies exclusively breastfed?*

A. WHO recommends exclusive breastfeeding to six months of age. New Zealand has no national survey. Dr Birkbeck of the Nutrition Foundation claims mothers 'so often fail to continue to breastfeed for more than a few weeks'.³

When one considers that mothers are encouraged to give their babies solids early, according to the WABA scale we would merit – Marks 1.

Q.2. *Is there a national breastfeeding policy and a national committee and co-ordinator to encourage its implementation?*

A. Last year when the WHO Code on the Marketing of Breastmilk Substitutes was resurrected 'to stop irresponsible advertising of Breastmilk substitutes' PHC senior policy analyst Jenny Reid claimed, 'We want to promote a culture in which breastfeeding is the norm'.⁴

This, despite the fact that four months earlier Jenny Shipley confirmed that the



Photo: Jane Scotts

Ministry would not provide ongoing funding in order to achieve the aims of the Code. The taskforce set up to encourage breastfeeding in hospitals was denied funding, being told to go out and find their own.⁵

Marks – 1 for paying lip service to the formation of the taskforce.

Q.3. *What percentage of maternity facilities fully practice all Ten Steps to Successful Breastfeeding and are considered 'Baby Friendly'?*

A. None.

Babies are still given bottles even against the expressed wishes of their mothers. On evaluation forms many women comment on the difficulties they have in establishing breastfeeding due to conflicting advice. North Shore Parents Centre received complaints about the breastfeeding policies and practices at North Shore Hospital.⁶

Marks – 0

Q.4. *Is the International Code of Marketing Breastmilk Substitutes in effect?*

The Innocenti Declaration called for all governments to take action to implement the Code and supplementary resolutions approved by WHO.

A. If the Code is in full force as a law – full marks!

However, the Code has been adopted only as a voluntary measure and the marketing of breastmilk substitutes has been separated from promotion of breastfeeding. Birkbeck pointed out that 'The adoption of the Code is only a facade unless a breastfeeding promotion is also in place'.³

Marks – 3 maybe – for a voluntary Code being contracted out.

Q.5. *Is there legislation to provide adequate maternity leave for breastfeeding mothers? WABA points out this includes International Labour Organisation (ILO) standards:*



- 12 weeks' maternity leave (six weeks before and six weeks after the birth) with a salary of at least two-thirds of regular earnings;
- no dismissal during maternity leave;
- two half-hour breastfeeding breaks during each working day.

A. ... Shipley has acknowledged that the government had no plans to introduce paid parental leave.⁵

Birkbeck claims very few New Zealand workplaces provide any facilities for breastfeeding women in their workplace.³
Marks - 0

TOTAL MARKS 5 out of 50 = 10 %
Big Deal!

If the incidence of breastfeeding is not to deteriorate further it is essential that more has to be paid for the postnatal module. The question is, how to achieve this?

The health reform (mis) managers respond to profit-oriented 'incentives'. It's highly unlikely they would respond to breastfeeding empowering women! Also, most of the advantages of exclusive breastfeeding are long-term, therefore will show no immediate monetary gains to their share of the maternity budget.

However, the government with its questionable majority is insecure. Lobby your opposition MPs to ask questions in the House.

Government is also sensitive to international opinion. Bring our situation to the attention of WABA (an NGO): WABA Secretariat, P.O. Box 1200, 10850, Penang, Malaysia. Fax 604-872655.

WABA will also provide you with background information you can use to gain media attention.

Visit your local maternity hospital to discuss strategies to becoming a Baby Friendly Hospital. Encourage your media health reporter to accompany you.

Monitor maternity hospitals and antenatal clinics to ensure that the International Code of Marketing Breastmilk Substitutes is being adhered to.

This requires that:

- No free samples of formula are given to mothers, or to health workers,
- Formula feeding is not promoted in health care facilities, e.g. babies given bottles at night against a mother's wishes,
- Posters and advertising do not idealise bottle feeding.

Mothers and midwives together can reverse the 'collateral damage' (to use free-market jargon) being done to babies and mothers. One mother reported on her evaluation form that she was able to resist the conflicting advice in hospital by having had a 'breastfeeding plan' developed by herself and her IM.

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Personal Note

I would like to express my appreciation to all who sent loving messages of concern while I was incarcerated - especially the mothers and midwives and student midwives in Auckland who organised a roster so that I had 24-hour support and TLC while in hospital. It made me feel very cherished and humble, and still brings tears to my eyes.

Issues of Power and Control Within Women's Experience of Breastfeeding Following Childbirth

Abstract from Masters thesis

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In this study, six primiparous women who had some difficulty with breastfeeding tell of their experiences of breastfeeding following childbirth. Their stories are discussed using the feminist poststructuralist theory of discourse analysis.

Quotes from the women's stories are used to identify and examine discourses surrounding breastfeeding, and examine influences on those discourses.

The stories reveal a wide range of experiences, including conflicting discourses, many of which relate to issues of power and control. Some of these issues focus on knowledge of breastfeeding, birthing and breastfeeding, power and control over breastfeeding, the context for breastfeeding, and satisfaction with breastfeeding. Issues of the medicalisation of childbirth and breastfeeding which contribute to the oppression of women who breastfeed are discussed. The study concludes with a discussion of what women want for their breastfeeding experiences following childbirth.

Full details of this research will be published in midwifery journals at a later date. Meanwhile, if you have any questions please contact Orma at the address above.

Decision-Making in Midwifery Practice

Rosalie Parcell

Midwife

A decision can be defined as an 'act of deciding; settlement (of issue, etc.); conclusion come to, resolve made; decidedness of mind' (*Oxford Dictionary*, 1983). Just how do we arrive at the decisions we make?

I intend to examine the process of decision-making with the focus on midwifery practice, exploring briefly whether we make our decisions the same way each time or use different pathways dependent on the situation, i.e. are they always consciously made?

I will then move on to present two different 'Models of Decision-Making' and use example scenarios from my practice to demonstrate reaching a decision following these models. In the interests of confidentiality, all names used in these scenarios are fictitious.

An examination of the things that can influence our decisions will then be discussed. Finally, I will then attempt to consider the question of accountability for decisions made in practice.

Decision Pathways

When first considering decisions made in midwifery practice my immediate focus was on those made in emergency situations. However, on further reflection it 'dawned' on me that decisions were made every day, even every minute, when practising midwifery. From whether the woman who is requesting your service falls within your scope of practice, to when the next antenatal visit should be, or what investigations to offer her. In fact, I feel that perhaps the more time one has to make a decision, the harder it is to be satisfied that you have made the right one!

For example, Lucy was a midwifery-only client having her first baby. When booking Lucy we discussed the 'routine' investigations, including swabs and smears. These had not been done on first contact with her General Practitioner (GP). The decision was made not to have the swabs and smears done, based on the fact that Lucy had had regular cervical smears that were all normal (the most recent 12 months prior) and her husband had been her only sexual partner.

The issue of the smear was not a large concern as this practice in pregnancy has begun to be questioned, particularly in women who have them regularly. Being the primary caregiver was still a new experience (as was the Continuity of Care team) and throughout the rest of the pregnancy I grappled with the 'what if's' – what if there was a Group B Streptococcus present and what if the baby contracted it and became ill?

It was not until after the birth that I could sigh with relief and feel comfortable with my decision. The overwhelming fear that not performing this one investigation in the early part of pregnancy could have potential effects on the outcome was great. This fear was due to moving outside the security of the status quo. As my confidence grew in my practice within the Continuity of Care team, I was less fearful of decisions that differed from the 'routine' and was not so worried about others' opinions.

I wonder whether we are always 'consciously' aware of making a decision. McKay and Roberts (1990: 266) state that practitioners 'often rely less on assessment data obtained from vaginal exams and electronic instrumentation and more upon what is seen and heard'. I recall assisting a GP at the birth of Kay's second child. She had had an episiotomy with the first child (performed by the same GP) which had taken months to heal. I knew that she wanted to avoid one this time. Close to 'crowning', the GP asked me to prepare some local anaesthetic in preparation for an episiotomy.

There was no urgency required and the situation was not a stressful one. However, I dropped the syringe on the floor once I had prepared it. By the time I began preparing a replacement, the baby was born and Kay had an intact perineum. I believe that on a subconscious level (or intuitive) I had decided that the procedure was not required and I uncharacteristically fumbled with the syringe. The GP was unable to act on the decision she had made as by not supplying her with the equipment I had become an outside influence.

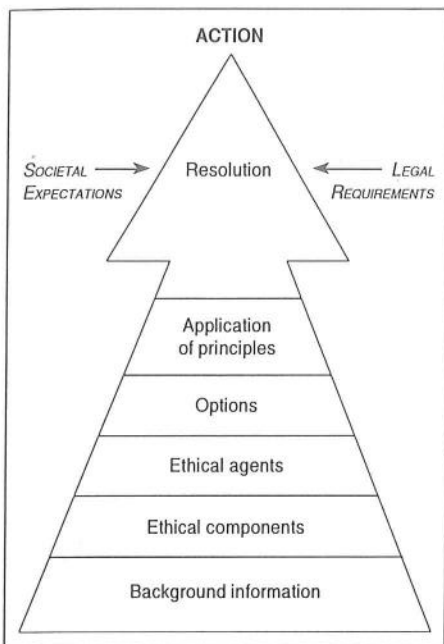
Models for Decision-Making

The 'act of deciding' can be difficult when trying to determine right from wrong in cases where guidelines are not clear. This is described as an ethical dilemma and Stuart and Sundeen (1987: 237) state that it 'exists when moral claims conflict with one another'.

Within midwifery practice the health, safety and needs of both mother and baby are considered. It is because of this that the 'ethical decisions are particularly difficult ... and there are times when maternal and fetal rights conflict' (Johnson, 1992: 121).

A model of Ethical Decision-Making has been proposed by Curtin (Figure 1) which depicts the decision process in a succession of steps which direct the practitioner towards resolution into action.

Figure 1:



The scenario:

- * First baby.
- * Induction of labour for increased blood pressure (pregnancy notes and labour recordings did not reflect this, private obstetrician had stated this as the reason).
- * Clear liquor.
- * Continuous fetal monitoring, via fetal scalp electrode.
- * Following four hours of syntocinon augmentation, no further dilation of cervix or descent of presenting part.
- * Fetal heart decelerations with contractions and occasionally late (possible early signs of fetal distress?).
- * Epidural.
- * Obstetrician, on being called in, wished for syntocinon to continue and at a higher rate; charge midwife agreed with management.

Using Curtin's Model

1. Background Information

This step entails gathering pertinent information surrounding the problem from sources such as patient, family, progress notes and other health professionals.

In the scenario:

- * Nan and Mark had not been fully informed that the decelerations could be an early sign of distress.
- * Nan had been in labour for more than 12 hours now, with slowed progress.
- * Fetal heart did improve when syntocinon stopped or decreased significantly, however, deteriorated if infusion recommenced and/or increased.
- * Obstetrician and charge midwife satisfied to continue, however, no physical assessment had been undertaken by the Obstetrician which may have sourced other signs of distress.
- * Midwife's assessment of situation appeared not to be taken into account by Obstetrician (he chose to ignore this information source).

2. Ethical Components

The components to consider in this step are those of informed consent, the patient's right to refuse treatment and preservation of life.

In the scenario:

- * Nan and Mark were informed by myself that I was concerned (enough to call the Obstetrician and the charge midwife into the room to assess). However, I felt that they had not been given enough information in order to refuse or agree as planned by the Obstetrician. The preservation of fetal life may have been under threat if the signs were ignored or played down.

3. Ethical Agents

This refers to all those individuals involved in the decision-making. Johnson (1992: 121) states that 'the primary decision-maker in any health care setting is the patient'.

In the scenario the agents were:

- * Nan and Mark.
- * Midwife.
- * Obstetrician.
- * Charge midwife.

Who acts as agent for the baby is an ongoing debate within the maternity and legal services.

4. Options

In this step all options are explored recognising the rights and responsibilities of everyone involved. Even when the best option is taken the practitioner may still feel that it is 'inconsistent with personal beliefs and values' (Johnson, 1992: 124).

In the scenario the options were:

- * Obstetrician acknowledge midwife's concerns and assessment and perform his own, e.g. fetal scalp pH.

- * Syntocinon infusion remain off to give baby a 'rest period' especially if all other parameters remained normal.
- * Expedite birth.
- * Midwife to remove herself from management if she continued to disagree.

5. Application of Principles

This step entails applying the four principles of Autonomy, Non-Maleficence, Beneficence and Justice, in order to select a suitable option.

Autonomy – defined as 'the right to self-determination ... individual choice' (Johnson, 1992: 124).

In this scenario:

- * Nan's individual choice has not been recognised until she is given all information.

Non-Maleficence – defined as 'the duty to do no harm' (Johnson 1992: 124), and Beneficence – defined as 'the duty to do good and actively prevent ... harm' (Johnson, 1992: 124).

In the scenario:

- * Instead of being proactive and not acknowledging possible early signs of distress, ignoring could result in trauma or loss of life and practitioners would then become reactive.

Justice – defined as 'the duty to treat the patient fairly' (Johnson, 1992: 124).

In the scenario:

- * Being honest with Nan and Mark with regard to the whole situation while not disagreeing about management in front of them.
- * Playing down possible early signs of distress is not, I believe, being fair to the parents.

6. Resolution

In this step the practitioner should now be prepared to make a decision and implement it, i.e. action it.

In the scenario:

- * Reassessment by the Obstetrician was not undertaken and he requested that the infusion rate continue to increase.
- * Nan and Mark were not fully informed of possible consequences of this decision to continue.

7. Action

I chose to hand over care as I disagreed with the proposed management.

The outcome:

- * Nan went on to have a caesarean section with thick meconium and the baby went to the Special Care Baby Unit with respiratory distress.

On first examining Curtin's Model, I wondered whether resolution was reached in all cases. Since using the model to work through the process using the above scenario (with much more time at my disposal), I have realised that by choosing not to participate in the care is, in fact, still resolution into action. If I had continued to provide midwifery care and ignored my feelings of unease in order to appease the Obstetrician I would have also achieved resolution. I would not, however, have felt comfortable with it. Neither decision would have been wrong essentially, just as the choice I did make may not have been right for another individual.

I was totally comfortable with my decision to withdraw from care as I felt I could not morally sit and observe the fetal heart response to increasing the syntocinon infusion. Although I suffered a few negative opinions from colleagues, I would do the same again.

In a different approach, Greener (1988) provides an overview of four theories of decision-making pathways that practitioners can journey through to assist when making clinical judgements. The theories she describes are – Concept Attainment Theory, Rational Decision-Making Approach, Utility Theory and Information Processing Theory.

I will use the Utility Theory in order to work through another scenario that occurred during my practice. Greener describes this theory as involving 'the construction of a matrix or decision tree' (1988: 262).

It is similar to Curtin's model in that it follows a process which leads towards a decision/choice being made. In using the 'tree' concept the conditions, information, alternatives and outcomes can be displayed.

The scenario:

- * Couple having second baby. Couple stated that wanted vaginal birth this time following forceps delivery with first baby.
- * Mary's mother Fran present.

- * Presenting part on view Mary began getting distressed and requesting a forceps birth.
- * Epidural beginning to wear off.
- * Jim very supportive and verbally encouraging.
- * Fran visibly upset and requesting I 'help her daughter'.

In Figure 2, Branch 1 was attempted but had no effect so I then moved to Branch 2. However, the introduction of the charge midwife (for epidural top-up purposes) redirected the journey directly into Branch 3, where we proceeded to do what Mary wanted us to do.

I recall feeling angry at Mary with her choice of an operative delivery versus a vaginal birth. Charonko (1992: 73), states 'our role ... is to provide them with knowledge and awareness so they can make informed choices. We may not always agree with the choices ... and we do not have to'.

The source of my anger at Mary's choice was due to having experienced an operative delivery myself. I had wrongly assumed that if it was possible to give birth vaginally, then this would be preferable to all women.

'In addition to our personal biases, we also develop professional biases' (Charonko, 1992: 76). I had taken my values and beliefs with regard to vaginal birth and incorporated them within my practice. I had projected this bias in the above scenario. I am now careful that I leave these assumptions/expectations out of my practice, and remind myself that it is not my birth experience.

Influences

I have diagrammatically depicted what I feel to be those things that are influential on a decision being made (Figure 3).

The midwife (accompanied by her belief, values and biases) is central as she grapples with 'the decision'. The indirect influences, in my opinion, are those that are always present during

the decision-making process but are unconsciously considered. These may change from time to time, e.g. new research, updated hospital policies.

The direct influences, in my opinion, are those that are present at that precise moment of making the decision. They are not necessary participants in coming to a decision, i.e. the midwife may choose not to seek their opinions. If they are utilised I feel they are perhaps more influential than the indirect influences because they have the greatest potential to sway the midwife.

The mother and the baby have a direct influence on the decision being made by the midwife. They are also specific to that decision only. The mother's family may or may not influence the midwife in her decision but they may be an influence on the mother.

Surrounding all of these influences is the expectation of society, that decisions will be made by practitioners that ensure safe, effective and appropriate care.

Considering the numerous influences that can effect a decision, I am amazed that we can actually make them in our practice and feel comfortable with them.

Accountability

It is my opinion that the individual practices of health professionals can impact on birth outcomes. As our practices are a result of the decisions made, we therefore need to begin being accountable for those decisions.

Bergman (1981: 54) defines accountability as 'being responsible for one's acts and being able to explain, define, or measure in some way the results of decision-making'.

On some occasions following a birth (always with the benefit of hindsight) I have questioned whether the outcome would have been the same if an alternative decision pathway had been taken. Or if the outcome would have been one that the midwife could feel more comfortable with.

For example, Sally was a midwifery-only client having her second baby. She had had a straightforward labour and birth the first time. At 39 weeks' gestation Sally contacted me and stated that she was experiencing painful tightenings and felt 'unwell'. In the assessment area of the hospital she presented with a temperature of 37.5°C and was having regular contractions. Following discussion with the Obstetrician, investigations for the source of an infection were performed and Sally transferred to the delivery unit. Sally had voiced her wish to continue with labour as she wanted to 'end' the pregnancy. No antibiotics were commenced and all results showed no infection.

After four hours contractions were still present but had not established in strength or length. After discussion with

Figure 2:

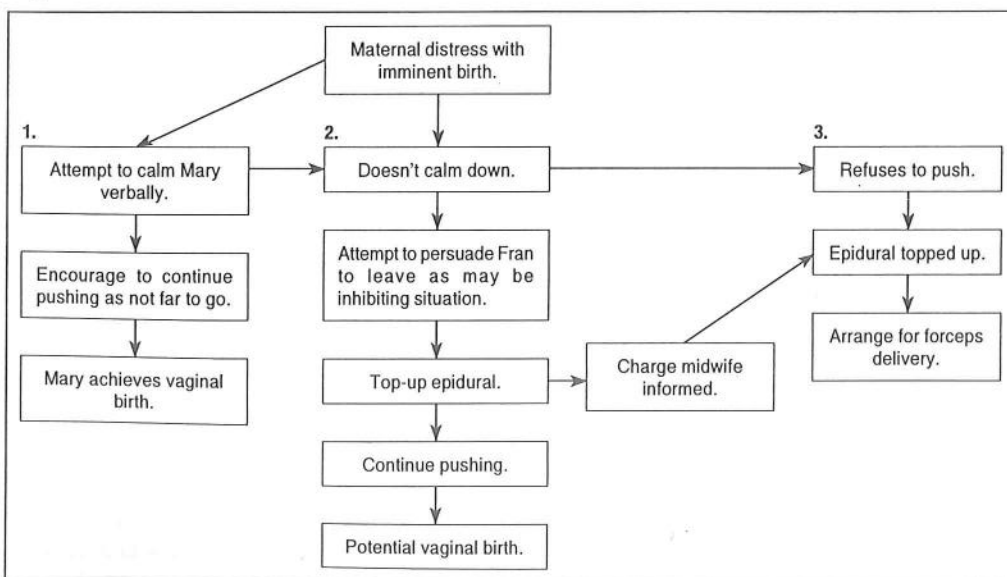
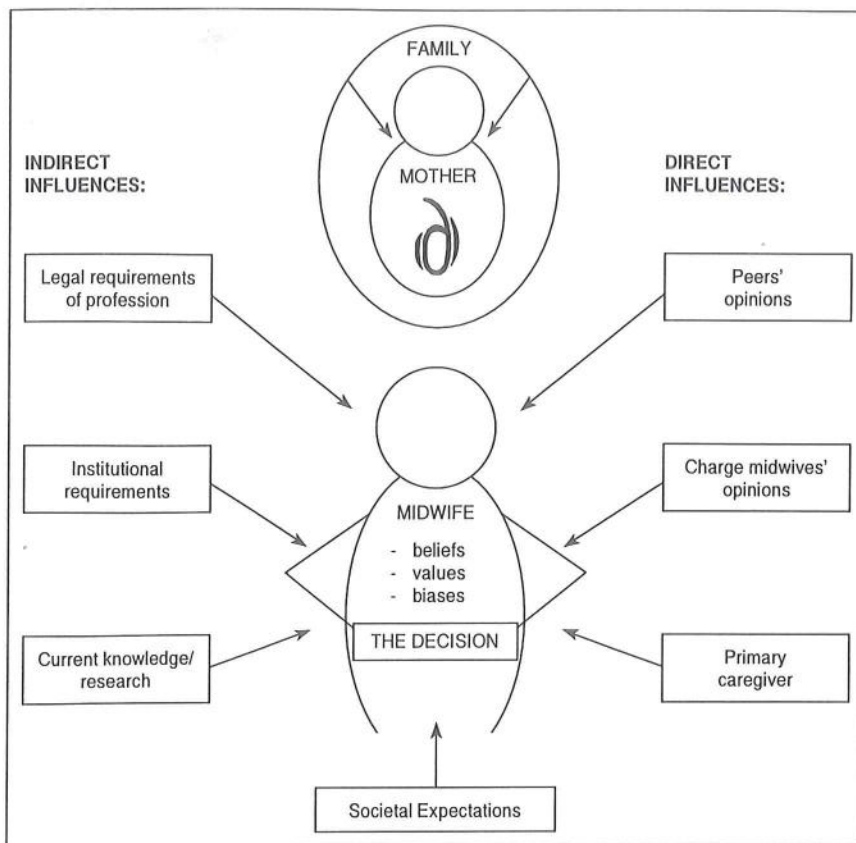


Figure 3:



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Sally and the Obstetrician it was decided to artificially rupture membranes and continue with the labour. Sally's temperature remained high, the fetal heart had now developed tachycardia, and labour had not progressed. The Obstetrician decided to perform a caesarean section.

I wondered afterwards whether it would have been better to admit Sally to the antenatal ward, commence antibiotics and wait and see if contractions stopped. I also wondered whether I should have been more assertive and suggested this alternative to the Obstetrician at the time the other decisions were being made and we just may have avoided a caesarean section. I guess I felt guilty that a woman who had a previous vaginal delivery this time had to have a caesarean section.

In this situation, I could easily blame the doctor and say 'he became the primary caregiver and what he decides is what happens'. Perhaps instead of being accountable to Sally by communicating to her a possible alternative, I became accountable to the source of power. 'Whilst we say our primary accountability is to them (the patient), we really give it to whatever we see as the source of power in our daily situations ...' (Robinson, 1979: 39). For example, doctor, charge midwife, supervisor, etc. Robinson (1979: 39) then goes on to state that 'it is people who make decisions and are accountable, not systems'.

The big question is accountable to whom? There can be many answers to this question, but for me being accountable is taking responsibility

for what I do in my practice, for the decisions I make ensuring someone else is involved if I am unable to provide appropriate midwifery care, e.g. when management moves outside my scope of practice.

Conclusion

In summary, two Models for Decision-Making have been examined and then used to demonstrate the process of making a decision within my midwifery practice. A brief exploration of whether decisions are consciously made or not and an analysis of the many influences on decisions made has been provided. I have briefly explored the question of accountability for decisions made within midwifery practice.

To conclude, it has become apparent to me that perhaps we take decision-making in midwifery practice for granted. How often do we stop and reflect on how we arrived at a particular decision, what influences effected the decision and are we able to measure and define the outcomes of the decision made, i.e. are we truly accountable for the decision?

Now that midwives can practise independently it is important, I believe, that we take the time to reflect on our practice every day as we are now having to be increasingly accountable and responsible for our decision-making, not only to our employers and/or women, but to society as a whole.



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Cup Feeding

Jane Wickham

Midwife
Rotorua

I first heard about cup feeding when attending a breastfeeding study day run by the NZ Lactation Consultants' Association (NZLCA) in Hamilton in July 1991. Maureen Minchin was the guest speaker and she spoke at some length about nipple confusion. Following this, I think it was at the NZLCA Conference in Christchurch in March 1992, I watched a video available from UNICEF which showed tiny preterm infants being cup fed by their mothers with hand expressed breast milk.

For a long time I had been concerned at the number of babies whose mothers planned to breastfeed and yet who received, while on the postnatal ward, either industrial milk or expressed breast milk by bottle.

A survey carried out by myself of 41 randomly selected infants cared for in the postnatal ward between July and September 1991 (all babies whose mothers intended breastfeeding) showed that 23 of these babies (56 per cent) received at least one bottle during their hospital stay. Reasons cited for the giving of the bottles included mothers' requests during the night,⁶ sore nipples,⁴ jaundiced infant,² dehydration,² inability to latch baby,² mothers refused to breastfeed baby,¹ low blood sugar readings.¹

Since there is strong evidence that even one bottle during the early days can interfere with the establishment of breastfeeding, I was alarmed at this result.

I ordered plastic medicine measures in numbers so they were readily available and encouraged the staff of the postnatal ward to try them, especially for infants who seemed unable to latch on to the breast in the first day or two. It was encouraging to see staff expressing the mother's colostrum into these cups and cup feeding the infant. They, in turn, were encouraged by the infants' better attempts at the breast following these tempting meals. Gradually more and more staff became comfortable with cup feeding newborn infants and explaining to mothers why we used cups. Some mothers did not accept the explanation and they considered the use of cups very strange and insisted on the more familiar bottle, reinforcing that we do indeed live in a bottle-feeding culture.

Some staff were more reluctant than others to abandon the familiar bottle but eventually cups have become widely accepted and I have heard the admission that a cup feed takes no longer and often less time than a bottle feed.

I decided it was time to do a follow up study in June 1994 (actually it was long overdue). I selected randomly a sample of 47 infants who were cared for on the postnatal ward during March 1994 whose mothers intended breastfeeding. This time only five babies received extra fluids by bottle (10.6 per cent). Of these, two were given industrial milk by bottle at their mothers' request and three babies were given industrial milk by bottle because they came within the criteria for intervention for hypoglycaemia. Fourteen babies received extra fluids by cup – five received their mothers expressed breast milk, four received water, three received both industrial milk and expressed breast milk and two received industrial milk only. Reasons for the extra fluids by cup included hypoglycaemia,³ lack of interest in latching,⁶ jaundice,¹ dehydration,¹ unsettled,² no reason given.¹

It was clear that while there were still grounds for concern about the amount of industrial milk being used, we had made considerable headway in making cup feeding the preferred alternative method if breastfeeding was not possible. Challenges that lie ahead include:

- communicating the *NZ College of Midwives Breastfeeding Handbook*² as the accepted policy of our obstetric unit, and
- make rubber teats an option that is available only to the mother committed to using industrial milk to feed her baby.

There are still staff who are resistant to the use of cups and I think there is a need to explore other satisfactory alternatives to cup feeding when breastfeeding is either not possible or is considered unable to meet the infant's caloric requirements, e.g. in hypoglycaemia or prematurity. Such alternatives as finger feeding and the use of a supplementer system need to be trialled. Further research needs to be done to determine if our hypothesis that the avoidance of rubber teats correlates with an increase in breastfeeding duration is in fact correct.

When introducing cup feeding, I used as a reference the IBFAN statement on cups.³ This cites the following reasons why cups are better than bottles.

- CUPS have a simple shape and can be easily cleaned with soap and water.
- Open CUPS do not encourage storage of feeds or carrying them about for several hours.
- CUPS do not make babies unable or unwilling to suck at the breast.
- CUPS used in hospital and by health workers teach the community method which is safe to use at home.
- Using CUPS means that the small infant has some contact with the mother or another person during feeds.
- BOTTLES and teats have many awkward corners which cannot be cleaned except by boiling.
- BOTTLES encourage the unsafe storage of feeds, increasing the chances for germs to breed.
- BOTTLES teach babies to suck in a way which makes them less willing to breast-feed.
- BOTTLES used in hospital provide an example which cannot be safely or cheaply followed by mothers at home.
- BOTTLES can be propped up, depriving the baby of human contact.

I circulated this around the special care baby unit (SCBU) and the postnatal ward. One paediatrician told me he was not absolutely convinced and he felt that the 'statement on cups' was mainly 'oriented to a Third World scenario where bottle feeding is beyond the safe financial and hygienic constraints of the average family'. He was also concerned that mothers who elected not to breastfeed might be made to feel guilty.

My response to the first concern is that it would be naive to believe that we have no families in Rotorua who are living in a Third World type situation. Of course, the suggestion also was more related to avoidance of bottles within the unit to allow breastfeeding to become successfully established.

The second concern is one that the people often give whenever initiatives to promote breastfeeding are proposed: 'We mustn't allow anybody feel guilty if they elect to bottle feed'. I suggest that all health professionals have a responsibility to allow women to make an informed choice, in particular, relating to this issue, the information that the use of bottles is associated with a reduction in breastfeeding success. Failure to provide this information is more likely to leave a woman feeling angry when she is unsuccessful with

breastfeeding than leave her with a feeling of guilt.

The NZ College of Midwives Breastfeeding Handbook which was endorsed as the policy for this unit in 1992 clearly states: 'As an alternative to bottle feeding, give supplementary and complementary feeds by cup, spoon, syringe, eye dropper, nursing supplementer or nasogastric tube'. As well, in a copy I have of Draft 2 of the NZ Paediatric Society's Policy Statement on Breastfeeding, it is stated: 'We recommend that Paediatricians should (among other things) support the joint WHO/UNICEF Statement:



Protecting, Promoting and Supporting Breastfeeding, the special role of maternal services (WHO 1989)'.⁴ This also states in the Ten Steps to Successful Breastfeeding: No.9, 'Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants'. Both these statements clearly refer to all breastfeeding babies and do not make a separate case for preterm infants.

Sandra Lang⁵ makes a very good case for using cups in an article published in May 1994 in the *Midwives Chronicle*. In her cup feeding

guidelines she recommends that a cup can safely be used from 30 weeks' gestation.

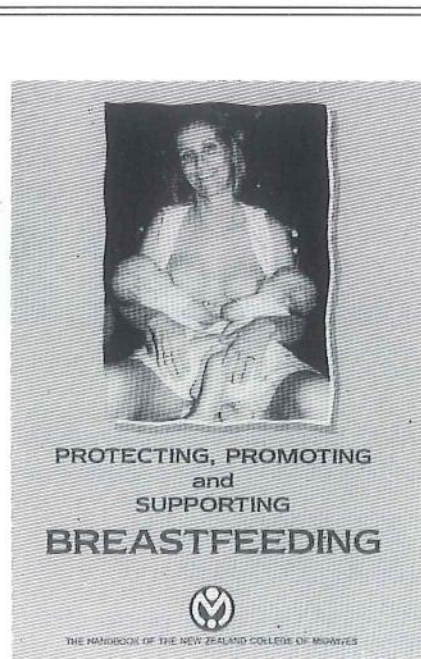
I have personally experienced frustration when trying to get babies to breastfeed following discharge from SCBU where they have had more experience with a rubber teat than a mother's nipple. It will take similar patience and perseverance to get the use of cups as well accepted there as they now are on the postnatal ward.

Elizabeth Jones⁶ from North Staffordshire Hospital describes the protocol that she used in the neonatal intensive care unit to get cup feeding accepted as the most appropriate way of feeding preterm infants before they were able to breastfeed. After the protocol had been used for six months, they did an audit and found that the number of mothers discharged from the unit and successfully breastfeeding had risen from one per cent (prior to the introduction of the protocol) to 58 per cent (six months after its introduction). This is a very powerful argument for cup feeding and it would be interesting to try and replicate this at this end of the world.

I have a commitment to see Rotorua Hospital achieve Baby Friendly Hospital status and shall continue to work to see rubber teats regarded as strange and cups as the logical alternative when an infant cannot be breastfed.

References

Available from author on request. ■



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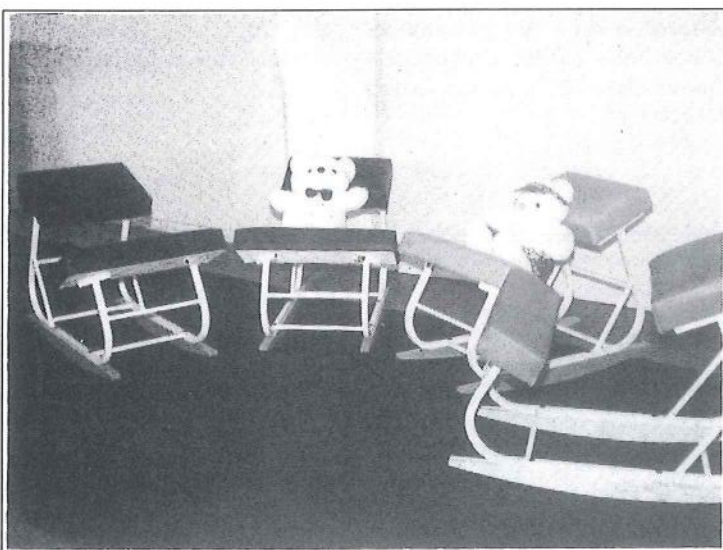
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The Demystification of University

Stephanie McLean

Midwife

I have just commenced my second semester full-time study in at Massey University where I am enrolled in a Diploma of Social Science (Midwifery) course. The DipSocSci is designed for experienced midwives who don't already have an undergraduate degree to fulfil entry requirements for the Masters programme. The Diploma of Social Science (Midwifery) consists of six 15-point papers. You can select any two 200-level and any four 300-level papers out of all of the undergraduate nursing papers available. Most DipSocSci students study extramurally completing one or two papers a year. I have found six papers more than ample, especially if trying to fit in some paid work, although this is considered a light full-time load. The DipSocSci is also available as a postgraduate qualification for people with an undergraduate degree, with a wider selection of papers from the 400–600 level.

Prior to my current experience, I had developed a barrier about tertiary study. This was partly due to an inferiority complex about being a polytech student, that is, not a university student. I could blame my socialisation as a girl being projected into something 'useful', or maybe the Nightingale Ethos that was generously passed down from mother to daughter. I developed the impression that university was for high-achieving scholars; this is one myth that I was quickly able to dispel. I now know that 55 per cent of university students achieve a C+ grade, 1 per cent of students achieve A grades. This valuable information reinforces what I already knew from my observation of friends, colleagues and family – university students are an average bunch, anyone can do it who has the time, money and, mostly, inclination.

Massey's Department of Nursing and Midwifery is making an effort with the 'and Midwifery' part of its title (since 1993). However, it is still essentially a nursing department. The information guidelines refer to the DipSocSci as the equivalent of an undergraduate degree major in midwifery. There are few absolute midwifery papers to enrol in: Human Milk, Lactation and Infant Feeding and Birthing and Early Parenting. There are other relevant and interesting undergraduate nursing papers such as Clinical Research, Ethico-Legal Dimensions of Nursing, Women and Health, Nursing in the Sociopolitical Context and Theory – Practice – Research, Integration in Nursing and Knowledge in Nursing.

I have easily negotiated and been encouraged to write essays on midwifery-focused issues in the nursing papers I have taken. I was asked by one tutor if I would prefer a midwife tutor to be involved in marking my essays, it could have been arranged had I chosen it. I have found essay writing a journey of soul searching, library searching, involving an immense amount of reading, both painful and rewarding. I have written a submission to a select committee about separate midwifery legislation, a research critique, academic essays using theoretical frameworks, a journal article, essays discussing issues such as stereotypes of femininity, abortion, professionalisation of midwifery, reproductive technology and many more yet to be written.

The dominance of nursing culture has been overwhelming at times – I have hardly met another midwife at Massey. The differences in nurses and midwives are not reflected at an academic level. I realise how I have developed my independence in personally in my philosophy about women and health. This has been reflected in my writing and has made me feel more independent and separate from my nursing colleagues. Massey has reinforced in me how midwives have their own culture knowledge and power, and how little it is represented at undergraduate level.

Many of my student colleagues are enrolled in the Bachelor of Nursing programme which can be completed in one year depending on previous experience and previous nursing programme, or in a Bachelor of Arts majoring in Nursing. I did not enrol in a Bachelor of Arts degree, which I could have completed with all the papers I am currently taking, because I believe in the power of titles. I want a DipSocSci (Midwifery), the only undergraduate programme with midwifery in its title. Of course there is the Master of Midwifery programme which allows for more independence and scope for individual interests, but somehow that really seems like a lot of reading.

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Aseta Redican

RHA Pacific Peoples Issues Manager

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Postgraduate Professor O&G

Ellamein Emery

Maori Birth and Te Kohanga Reo
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Issues: Sensitivity and awareness of the
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traditions

Contact: Birth in the 21st Century – Conference
Box 52 065, Kingsland

Auckland 3

Ph: 09-525 3437

Fax: 09-846 1801

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29–31 August – Conference

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Barbara Katz-Rothman

Contact: Judy Henderson

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Prof. John Hutton, Wellington

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Contact: Sue Peck

Convention Executive,

PO Box 474, Palmerston North.

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1996: Midwifery Today – Weaving a Global Future 11

29 February – 3 March 1996

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