



# JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, APRIL 1996



FOURTEENTH ISSUE



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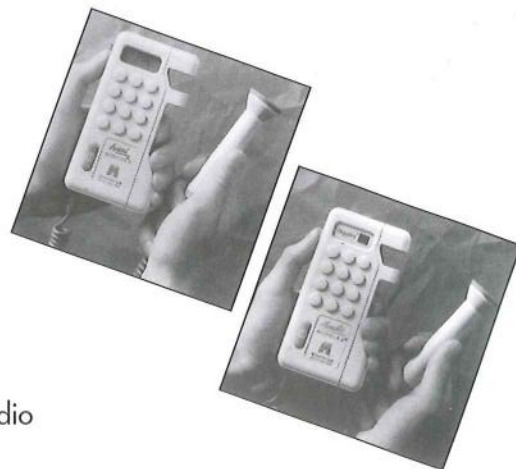
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- \* Promote women's health issues as they relate to childbearing women and their families.
- \* Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- \* Provoke discussion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

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**– December 1995**



## LETTERS TO THE EDITOR

### Vaccination Awareness

Dear Editor,

Under the new vaccination schedule children are given eight combination injections and three polio shots containing a total of 25 vaccines including boosters between the ages of six weeks and 15 months, with six more vaccines to follow at the age of 11 years. Our government promotes this taxpayer-funded insanity through *Immunisation 2000*.

Viera Scheibner, retired principal research scientist for the NSW government and author of the book *Vaccination - The Medical Assault on the Immune System*, reminds parents that:

... vaccination is not compulsory and that everyone has the right and the choice to reject this highly invasive, dangerous and ineffective medical procedure which is simply a big money spinner ... vaccines contain substances which are so noxious they should not ever be injected into human beings.

These substances are chemicals such as mercury, aluminium and formaldehyde and modified viruses or bacteria which are cultured on animal tissues (such as chicken eggs, monkey kidneys) or on human tissues (e.g. the cells of aborted fetuses). This viral/bacterial matter and contaminants from these cultures are foreign proteins which, when injected into the tissues of children, have direct access to the organs via the blood and the lymph, exactly what the immune system is there to prevent. They can cause anaphylaxis, that is a shock to the organism which can be fatal, or auto-immune diseases and other disturbances such as juvenile arthritis, asthma, allergies, eczema, glue ear, cancer, leukaemia, multiple sclerosis, chronic fatigue (ME), etc.

Vaccines damage the immature nervous systems of babies and young children, sometimes resulting in paralysis or sudden infant death. In most cases however, physical development appears to carry on as normal. It is not until later that the consequences of brain damage of various shades of severity may become apparent: disturbed mental/intellectual development or personality changes such as speech or learning difficulties, autism, epilepsy, hyperactivity and other mental or physical handicaps. Most parents don't even suspect vaccine damage; if they do, doctors usually tell them that such disturbances are 'purely coincidental'.

Canadian Dr Guylaine Lanctot MD disagrees:

The medical authorities keep lying. Vaccination has been a disaster on the immune system. It actually causes a lot of illnesses. We are actually changing our genetic code through vaccination. In 10

*Continued on Page 28*

Dear Editor,

Thank you for sending me the monograph, 'The Midwifery Partnership' that Karen Guilliland and Sally Pairman wrote.

The monograph is beautiful. Indeed, I would consider it unique. The concept of a true sharing of all information with the non-professional member(s) of the relationship upsets all the traditional concepts of a profession in which power is maintained by the jealously guarded expertise of the professional.

The midwifery partnership is not only a model for practice, it can serve as a model for profession/client relationships in all fields. Would that its example were to be widely emulated.

I would not consider the above two paragraphs to be a review of the monograph, but it is a sincere reaction to it.

Murray Enkin

### The Demystification of University

Dear Editor,

I would like to thank Stephanie McLean for presenting the courses offered at Massey in such an honest and objective way in the October 1995 issue of the *NZCOM Journal*.

Encouraged by Dr Valerie Fleming, a former lecturer in the Department, the Department of Nursing Studies made a commitment to the development of a midwifery programme. As a sign of its commitment, the Department changed its name to the Department of Nursing and Midwifery.

The separation of the academic disciplines of nursing and midwifery is, however, an evolutionary process which 'takes time'. In order to speed up the evolutionary process we need the support of practising midwives who are willing to work with us to see that this happens. Being able to offer additional papers in midwifery is dependent upon there being sufficient midwives interested in enrolling in these papers. (That said, I would like to acknowledge the support given to us by those midwives already enrolled in a Dip SocSc (Midwifery) and the Masters and PhD programmes.) We need to know how many midwives are interested in further study and what their particular needs are.

As part of our strategic plan we have undertaken to investigate the feasibility of introducing a Masters of Midwifery programme and to develop four distinct midwifery papers at the masters level by the year 2000. The first paper will commence its development this year by means of the Advanced: Practice Midwifery paper (68.416) which is being offered as a block course of four days in July and four days in November. Midwives who have an undergraduate degree or equivalent and two years of clinical experience may like to consider joining me in exploring aspects of midwifery via this paper. Interested midwives should complete an application form for graduate studies in the Department of Nursing and Midwifery.

This form is available by telephoning (06) 350 4331 or writing to the Administrator, Department of Nursing and Midwifery, Massey University, Private Bag 11222, Palmerston North. I look forward to hearing from any interested midwives.

Comments/suggestions from interested midwives in hospital or independent practice regarding the midwifery programme are sought and welcomed. A curriculum review document, 'Pathways to Progress', produced by Sally Shaw is available for anyone who would like to know what students, professionals, CHE managers and others have had to say about the Department of Nursing and Midwifery. We have taken note and are working on a number of issues raised in this document.

My congratulations go to those midwives who have made such a major contribution to the development of midwifery in New Zealand. Let us continue to work together on strengthening midwifery.

Dr Cheryl Benn  
Senior Lecturer (Midwifery) and Graduate  
Studies Co-ordinator  
Massey University, Palmerston North.

## EDITORIAL

### Plus ça change encore la meme chose\*

How bright the world looks when the sun shines - each day bringing a new beginning; a new generation will be born today.

Information is a primary need of these new parents in pregnancy and childbirth. People in our society often grow up knowing little about childbirth and generally are accustomed to giving all the responsibilities to the health professionals. Because of fears, lack of knowledge, embarrassment or other strong feelings about childbirth, many are afraid to trust their own feelings and accept their own judgments, especially if they are in conflict with the 'experts'. As 'standard practice in childbirth' is increasingly questioned, we don't always have the right answers, in fact, more often than not, it creates more questions.

In this issue this theme becomes glaringly obvious - posing questions of change, that will leave you to wonder how far we really have come.

We are indebted to those of you who share your thoughts with us, it does take time and a great deal of effort, but it is a vital step in improving our practice.

\* The more things change, the more they remain the same.

Helen Manoharan

# Documentation: The Front Line in Midwifery Risk Management

Jackie Pearse

Midwife Lawyer

A midwife came in the other morning and said, 'It's terrible since you started telling me about professional liability, I document everything. Like this morning; I got a phone call from a woman and normally I would write "X rang - advised". Today I documented why she rang, what we discussed, our decisions, and that she must ring back if there was no improvement. Do you think I'm overreacting?'

It is certainly not an overreaction to document scrupulously, although for the midwife who is used to operating with minimal recording it can require a major change in thinking. An unfortunate reality for today's midwife is the need for comprehensive records, as when it comes to a situation where she needs to defend her practice, the unspoken motto is that if it is not written, it did not happen. This was illustrated in the case of Yates.<sup>1</sup> This midwife was found guilty of professional misconduct because she did not write on the client's obstetric record, did not write a birth plan and did not record details of the labour, either immediately or within a reasonable time of delivery. There was no question that records were taken, they were recorded on her personal record, it was just they were not written in the chart until the following day. The Preliminary Proceedings Committee commented that the implication was that if recordings were not charted they had not been done.<sup>2</sup>

If an investigation commences against a midwife and there is not a written record then it becomes an issue of credibility. When it is a lone midwife's voice against possible combinations of women, their partners, support people and doctors, the sheer number of dissenting opinions may be the determining factor in a finding against the midwife.

Traditionally, concern over careful documentation has been largely limited to drug records, client records and notes. The changes to midwifery practice have extended that concern to many other areas:

- Prescription writing (see *Medicines Regulations*, 1984, s41)
- Laboratory tests
- Referral letters
- Phone calls
- HBL claims
- ACC claims and disciplinary hearings
- Midwifery Standards Review.

The standard of documentation at all times is the 'reasonable (not perfect) practitioner'. This is gauged by asking, 'What would a reasonable midwife, in compliance with her legal requirements, document in this situation?' Failure to meet this standard may result in the midwife under scrutiny being judged as negligent.

## Legal Requirements

### Obstetric Regulations 1986

**Section 9** states the type of clinical records and documents that must be kept, in respect of maternity clients attended by a midwife in domiciliary practice.

**Section 10** states that every entry *shall* be:

- legible
- indelible (preferably black ink)
- written as soon as practical.

Records should be kept for at least three years after the date of the last entry. They should be signed, dated and timed.

**Section 41** has the above requirements as well as the need for the prescriber's address and phone number, the details of the client, the name, strength, route of administration, total amount and supply details of the medicine. There are also other limits on prescribing within the regulations.

### Health Act 1956 (reprinted 1993)

Defines personal information and states when disclosure of health information is permitted and when a holder can refuse to disclose.

Under Section 229 any person who has claimed payment for services must make records available for notes to be taken on them or for them to be copied or inspected by an authorised person from the PHC or the RHAs. Generally this would be a representative of HBL. HBL also have certain obligations to practitioners and clients regarding this inspection of records. There are specific notification points and the midwife has the right to be present.



Under Section 121A the holder of health information must protect all such information against loss, damage, destruction, access, use, modification, disclosure or misuse. Midwives may need to consider whether they provide adequate protection for the client records in their care.

The privacy principles of the Privacy Act 1993 and the Health Information Privacy Code 1994 also regulate how health information can be collected, utilised, corrected, disclosed and retained.

The S51 Draft Advice Notice in Clause 7.1 states that every practitioner who provides any maternity services for which payment is claimed under this Notice shall keep a comprehensive and readily accessed daily record.

### General Documenting Principles

Midwives avoid many documenting difficulties by giving the woman a copy of her notes and encouraging her to also write in them. An example is when a woman first feels fetal movements. This can be independent evidence of the accuracy of a midwife's EDD estimation. The notes should record the holistic assessment of the woman (not just physical data), explanations, issues discussed, concerns raised, advice and decisions made. If a woman's choice is contrary to the 'best practice' recommendation of the midwife this should be also recorded and in some instances countersigned by the woman. This encourages her to take responsibility for her choices and further protects the midwife from adverse comment.

Notes should be accurate, factual, objective and detailed enough to decrease any possibility of misinterpretation. Sloppy notes, inaccurate spelling, lack of clarity and objectivity, inadequate and ambiguous statements all lead to an inference that the midwife is incompetent. It is pointless to try and later argue lack of sleep or

work pressure to try and mitigate your documentary inadequacies.

### HBL and Claim Forms

Maternity Services Claim Forms are causing real concern as a number of anomalies are being identified during HBL audits. Many midwives get into strife because they fill in claim forms weeks or even months after the event. They often lose sight of the whole picture and their diaries and client records are an insufficient check for the close scrutiny of HBL. One example that has arisen is where a midwife was claiming for conduct of labour but actually went across to the antenatal ward to visit a client. She claimed both without checking times and dates and was adjudged by HBL to be 'double dipping'. Other examples have been overstated hours or mileage or simply insufficient evidence of why there was a sudden change; wrong dates, claims for visits that did not occur, inadequate documentation to prove the establishment of labour, no car running sheets and claiming each service in isolation. A midwife needs to constantly overview her claims to ensure that the times and numbers match up and do not overlap. If she visits an antenatal client during labour, she should suspend her COL claim for that time.

### Conclusion

Most midwives would consider that they document reasonably well but unfortunately exposure to ACC, Nursing Council and HBL is highlighting the fact that this can be a flawed perception. Midwives need to look objectively at their notes and ask if they could be improved. Do they tell the whole story? Would they adequately protect and disclose the midwife's decisions and practice if they came under scrutiny? Would they provide documentary evidence that she meet a reasonable standard of care? If it comes to an investigation the midwives notes can become her best defence or her worst indicter.

### Notes

1. Yates v Nursing Council of New Zealand Ltd, H.C. Wellington, AP, 174-91, 117/93.
2. See Oborn v Nursing Council of New Zealand Ltd, H.C. Wellington, AP, 174-91, 117/93. This decision was overturned on appeal but illustrates the importance that Nursing Council places on accurate and proximate documentation.

### References

- Chappell, A. (1994), 'Protecting the Public', *Kai Tiaki Nursing NZ*, August, p. 29.
- Walmsley, Jo (1995), 'Getting the Record Straight', *Kai Tiaki Nursing NZ*, April, p. 28.

# Advertising

Jackie Pearse

Midwife Lawyer

It has been noted in recent advertisements that some midwives use as part of their endorsement the fact that they are members of the New Zealand College of Midwives. All current members are entitled to advertise their membership but we would like to point out that this carries certain obligations.

The member should adhere to objectives of the College and participate in Midwifery Standards Review. The Constitution states that 'NZCOM members practice by the "... standards of Midwifery practice, service and education ..." Standard 8 in the *Midwives Handbook* for Practice relates to the midwife evaluating her practice. Part of this evaluation is that ...' she participates annually in the New Zealand College of Midwives Standards Review process Midwifery Review is becoming a major component of reflective practice. Consumers require midwives to be accountable and to maintain a level of practice that correlates with the standard of a reasonable practitioner. There is a growing expectation by consumers that review is part of this accountability.

Reviews also have the advantage of being a consultative means of identifying areas where a midwife needs improvement, of strengths that she has and of assuring external investigative bodies that she monitor the care that she offers. In recent ACC and Nursing Council decisions the fact that a midwife voluntarily undertook NZCOM Standards Review was a factor in her favour.

The College would therefore encourage midwives who advertise themselves as members to be members in fact and not just in name. To do less undervalues the NZCOM standards, short changes the consumers expectations and prevents the midwife fully participating in her profession. ■



# How Useful is Bioscience Knowledge in Midwifery and is it Necessary for Safe Practice?

**Bronwyn A. Hegarty**

**Midwifery Lecturer and Clinical Tutor  
Otago Polytechnic**

**Zab Franklin**

**Independent Midwife**

This article is an abridged account of third-year midwifery students' experiences and opinions about the usefulness of bioscience knowledge and its relationship to safety in their practice. The information was gathered in 1994 and 1995, as an informal evaluation exercise, to determine the educational needs of third-year midwifery students.

The study of bioscience is an essential component of the curriculum in the three-year direct-entry Bachelor of Midwifery Degree programme offered at Otago Polytechnic, New Zealand (*Midwifery Curriculum Document*, 1995). Students are taught several aspects of bioscience applicable to midwifery: the anatomy and physiology of normal pregnancy, labour, the puerperium and the neonate; development of the embryo and fetus; physiological rationale for common clinical manifestations of reproductive and pathophysiological conditions; key concepts, e.g. inflammation, fever, dehydration; abnormal maternal, fetal and neonatal physiology; pharmacology. Bioscience is allocated a relatively small proportion of this course's teaching hours (320 hours over two years) and is not formally taught during the third year when students spend the largest proportion of their time in clinical environments.

There was no equivalent direct-entry midwifery programme offered in Australasia until 1995 (Auckland Institute of Technology, NZ), therefore, the performance of these graduates is under scrutiny and followed with interest by educationalists, midwives, nurses and doctors.

Direct-entry midwifery training is not a new innovation, but historically these midwives were regarded by the medical profession as inferior to obstetric nurses and nurse/midwives (Domiciliary Midwives Society of NZ, 1992; Tew, 1993). The 1983 Nurses Amendment Bill prevented the employment of direct-entry midwives in the Domiciliary Midwifery Service in New Zealand. Gradually, since the New Zealand College of Midwives was formed in 1989, the status of midwifery has rocketed, a change illustrated both financially and in the type of responsibility expected of midwives, e.g. prescribing rights and independent practice (Domiciliary Midwives Society of NZ, 1992). Consequently, the type of midwifery training offered has changed to reflect this improved status and to parallel the new midwifery philosophy, one which is not illness-oriented (Domiciliary Midwives Society of NZ, 1992; Radford and Thompson, 1994; Tew, 1993).

The philosophy of midwifery practice in New Zealand is to protect and promote women's wellness in a holistic way and is seen to encompass several areas of women's reproductive health; social, emotional, cultural, spiritual, psychological and physical (*NZ College of Midwives Handbook*, 1993). Bioscience relates primarily to the physical component of this philosophy, why? and may also help explain emotional and psychological aspects of women's reproduction.

Bioscience is regarded by some students, initially, as an unnecessary scientific component of midwifery training, one which may conflict with the holistic nature of the profession (second-year midwifery students, Otago Polytechnic, *pers. comm.*, 1994) and link midwifery with interventionist obstetrical management (Tew, 1993). Lecturers in bioscience have concerns about the inability of students to integrate bioscience knowledge with their clinical practice (Allnutt and West, 1994; Green, 1994). Whether this is due to an antiscience attitude or due to some other factor is not clear. There is evidence, however, to suggest that students can only make theoretical links once they have concrete clinical experiences (Robertson, L., 1995).

In the feedback from formal nursing and midwifery student evaluations in the third year of study, it was overwhelmingly stated that there was a need for bioscience input which is closely linked to clinical practice. Therefore, students may initially have some resistance to learning bioscience, but come to realise the necessity for this knowledge once their clinical practice hours increase.

There was a common consensus among all the students who responded that bioscience knowledge was essential for safe practice and gave them confidence when entering into a concentrated period of clinical practice during the third year. One student stated: 'I think bioscience knowledge is extremely important and very necessary for safe practice. I use it practically every day, now that we are out and about, basically working as midwives, I am consolidating my knowledge.' Professional competency and autonomy is not achievable unless the educational curriculum for nurses is oriented towards the specialised area of nursing knowledge (Akinsanya, 1987a). The same applies to midwifery, though there has been limited research to support this statement.

Research in this area has focused mainly on continuing midwifery education rather than student midwifery experiences (reviewed by Robinson, 1991). In a study conducted by Robinson (1991), educational experiences of student midwives

in Britain and their opinions about the preparatory value of the teaching for midwifery practice were examined. Classroom and clinical teaching were considered adequate but many students found teaching during clinical experiences was contradictory, therefore unhelpful in preparing them to practice (Robinson, 1991). The same situation was encountered by the third-year midwifery students in the survey at Otago Polytechnic, in relation to bioscience. Midwives supervising students on clinical placement were often unable to explain unusual phenomena in physiological terms and some became defensive when students asked questions. The contribution of science in nursing education affects individual nursing practice, quality and accountability of that practice in relation to the safety of the nurse and the client (Cameron-Traub, 1992). The demands made on all these aspects of nursing practice are increasing as nursing roles diversify and this is equally true of midwifery practice; midwives in New Zealand have prescribing rights while nurses do not, as yet.

Midwives must have professional competence and autonomy to practice as independent midwives. A recent trend away from hospital only obstetrical care is due to the development of New Zealand's Independent Midwifery Service since 1990. Women can now choose a midwife as the primary practitioner for either home or hospital births with general practitioners or obstetricians contracted in where the pregnancy or birth is not regarded as normal.

The response to the survey indicated that the students found it difficult to transfer scientific knowledge into terms easily understood by their clients. Is the language easier to translate as the understanding of bioscience improves, or does this enhanced understanding occur with experience and repeated use of bioscience as a tool? There is no easy answer to this question. Students learn to assess clients as part of the midwifery process and bioscience knowledge may not gel successfully with some views of what constitutes holistic care. Students are working alongside experienced midwives who were taught in an education system in which students learned facts without being given the underlying physiological explanations; that depth of knowledge was left to the medical profession to attain.

Students on clinical, therefore, are supervised and trained by people who use a language which often does not include scientific terms. It is no wonder that the language of bioscience gets in the way.

Scientific knowledge has long been associated with scientific management of birth where various interventions were used to hurry the natural process (Tew, 1993). Procedures were used for the convenience and prestige of the practitioners rather than for the safety and comfort of the woman and her baby. Tew (1993) also states that obstetrical procedures became fashionable through repeated use and were not evaluated using scientific research, nor were they

based on physiological reasoning. Current teaching practices in nursing and midwifery mean that degree students are given more indepth information and encouraged to question, practice independent learning, utilise critical thinking and seek information from current research (*Midwifery Curriculum Document*, 1995).

Midwives with adequate indepth bioscience knowledge can make common-sense judgements for themselves regarding physiological advantages and disadvantages of procedures, e.g. advantages of mobilisation during labour, disadvantages of the lithotomy position; they can also back up their decisions with findings from research.

Students do value bioscience learning and this is illustrated by these comments: 'If we didn't have bioscience, we would be having to remember facts with no background understanding. If we didn't understand it ourselves, we couldn't explain to women, or act as their advocates.' Another student said: 'Knowledge about bioscience makes me feel more confident to talk to other practitioners. Knowledge is power and any information that I can pass on to my clients, empowers them also.'

All respondents expressed the necessity of having an integrated knowledge. This is where bioscience plays an essential role, as the key to intellectual understanding of clinical conditions and this gives power to the recipients whether they are midwives or their clients.



Remembering concepts is certainly made easier when there is understanding of the underlying principles; this is evident in exam papers when they are being marked. Students tend to attain better marks in topics closely related to common clinical conditions.

Female midwives in seventeenth-century Britain developed their skills through practical experience, but were illiterate and unable to obtain technical qualifications associated with anatomy, physiology and pathology, available to male midwives (Tew, 1993).

Education was seen to guarantee better service, therefore male midwives (later known as obstetricians in nineteenth-century Britain) were more valued by the upper classes. Midwives now graduating are in a very powerful position; they have the advantages of a degree education and broad standards of practice designed to nurture and empower their women clients. Midwives of today are a force to be reckoned with, not trampled on.

There is a problem, however, when theoretical knowledge exists without first-hand experience to consolidate the learning. One student stated: 'I understand the scientific principles but have never seen either of these

things, so I have to keep reminding myself that these conditions are really serious and need to be avoided. Midwives who have seen a woman fitting, really, really understand the realism of the effects of high blood pressure leading to eclampsia.' Students realise that some conditions such as eclampsia are really serious and should be avoided, but would remember more easily if the knowledge was imprinted through direct experience. 'Once seen never forgotten' ties in well with a sound foundation of key concepts in bioscience. In the ideal world the gap at the theoretical and practice interface would be narrow and not clearly defined.

There are a few studies where the role of the biosciences in nursing practice and the associated educational requirements have been examined (Akinsanya, 1987b; Akinsanya and Hayward, 1980; Casey, 1994; Courtenay, 1991; Trnibranski, 1993). There do not appear to be any equivalent studies related to midwifery, though debate on a model for competency in midwifery practice is being sought (reviewed by Worth-Butler *et al.*, 1994).

Worth-Butler *et al.* (1994) suggest a competency model of midwifery should include capability, a concept where the expert practitioner has the ability to integrate intellectual, personal and clinical skills.

The present paper addresses some of these issues; there is clearly a place for bioscience knowledge in midwifery practice and this knowledge needs to be more closely integrated with the acquisition of practical experience during the education of student midwives.

Student midwives are novices in the field and the following comments illustrate the uncertainty confronting students:

Only two things to watch, is that too much bioscience knowledge doesn't make us unnecessarily paranoid or overcautious and that we retain our trust in pregnancy and birth as a normal, healthy event and in women's ability to give birth.

Another student stated: 'What I know makes me nervous!'

Midwifery promotes the image of wellness in relation to women's health with the expected outcome of birth as a normal, healthy event, unlike the pathophysiology of conditions associated with nursing.

There is, however, always the possibility of abnormal situations in midwifery and students found that a sound knowledge of bioscience principles enabled them to anticipate problems and act appropriately; this was vividly illustrated by one student's statement: 'I knew when to go and get the resuscitation trolley.' Some found it difficult to 'wait' during prolonged labours and became paranoid about the possible negative outcomes. These responses are natural in the novice practitioner and should change as the level of expertise is raised (Benner, 1984).



## Midwives

Guess what? I was selected to join the special needs programme for gifted children at our school, the first for an intermediate school. So I chose to learn more about what a midwife is and does!

Did you know that there is a big difference between midwifery and nursing? Well, nurses usually work with sick people but midwives usually work with healthy women and their babies.

Midwifery isn't just a job you can go to, you have to have a special training, which takes three long years.

I also learned that midwife means 'with women' - isn't that cool?

There are heaps of other things I learned. New words, like dilatation, which means to open up, and ultrasound, which they don't know yet if it is safe. Midwives don't feel so good about it.

And did you know that if you have older children, you might want them at the birth. But you've just got to know your own children and if they can handle it. When everyone comes round to see the new baby you need to remember your other kids and give them presents and do things with them.

Wow, there is so much to it. You can even choose where to have your baby. We went to see Robin, who is going to have a home birth. Well, that was special. I am definitely going to have a home birth. But do you know what? First, I am going to be a midwife. I can't imagine anything more special than that!!!

Fiona Spencer

Form 2, Longburn Adventist College  
Longburn.



Sent to us by Ruth Martis Midwife in Palmerston North, who is doing an excellent job in preparing the next generation of midwives.

Thanks Ruth.

The emphasis of degree education in nursing and midwifery in New Zealand means that students no longer soak up existing knowledge, they are stimulated to question assumptions within the professions and to seek out new knowledge. Teaching is based on current research and up-to-date information, therefore students are trained to be enquiring practitioners. 'Practices' which are used because they have worked in the past are not necessarily safe unless there are scientifically proven studies to support them (Enkin, 1990; McKinley, 1994). Students have every reason to be cautious.

They are novices and rely on problem-solving rather than experience to interpret subtle physiological changes in their clients; this requires a detailed store of knowledge. Safer motherhood is regarded as a midwifery challenge world-wide and therefore the number of independent, autonomous and competent midwives practising needs to be increased. Such midwives would have a wide range of skills including epidemiology knowledge, research, teaching and management and act as advocates for their clients (Alexander *et al.*, 1993). Midwives today are entering practice in a rapidly changing era of technology and need an appropriate level of knowledge to compete in the present environment and to ensure safe practice.

Third-year midwifery students have been unanimous in their opinion that bioscience knowledge is an essential tool for their practice.

Bioscience principles are more easily remembered when related closely to experiences in practice. There is a convincing argument that some facets of bioscience teaching in the education curriculum need change. Primarily, that more hours be allocated to teaching bioscience during the third year when clinical practice is most intensified.

Third-year students have learned the skills of enquiry and continue to seek information from the literature. They still need reassurance, however, from lecturers adequately trained in bioscience in two important areas. First, that their interpretations of current research are correct and, second, that they understand the physiological processes underlying the health of women and their babies whom they encounter during practice.

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# Caring for Sexual Abuse Survivors During Pregnancy and Beyond

Sandy Cotman  
and Vivienne Axon

Midwives

She laboured and had the baby but was completely spaced out through it. She just never said anything through the whole labour. She was just one of those people who you think are wonderful in labour except they weren't there ...

These women are off the head of the bed by the time you're at their ankles ... . No matter how gently or how much of a trust relationship you feel you've built, the minute you start touching them there, they're gone.

My body is my enemy because it is the one who let it happen and my mind is my ally. And that it (my body) was helpless . I couldn't know then and who allies with the helpless anyhow?

During the childbirth continuum women might reasonably expect to have their emotional difficulties responded to with as broad a range of options as occurs in their physical care. The impact of prior or current sexual abuse on a woman, during her childbirth continuum, has in the past received little investigation. Midwives are uniquely placed to facilitate positive, cathartic experiences for women with histories of sexual abuse, because of the intimate relationship and mirroring of the cultural positions shared by women and midwives.

Childbirth has been identified as a potentially positive experience for an abused woman, if the woman can feel empowered and in control of her childbirth experience and if this is supported by a sensitive woman centred caregiver. However, the potential for reproducing the dynamics of the abuse and therefore the abuse itself and its negative sequelae is also present. Midwives are in a privileged position to address these issues with the woman both as a professional involved in the care of the woman and her sacred space, and as a woman in our society today.

Epidemiological studies suggest that up to 38 per cent of women in the general population have had unwanted sexual contact before 18 years of age. Research on the sequelae of sexual abuse identifies long-term effects as including the diagnosis of depression, anxiety, low self-esteem, substance abuse, sexual dysfunction, intimacy difficulties, eating disorders, chronic tension, chronic headaches, dyspareunia, pelvic pain, vaginismus, urogenital and gastrointestinal complaints, sleep disorders and severe premenstrual syndrome. Seng and Peterson (1995) identified a range of psychological consequences including multiple personality disorder, addiction and compulsive over-achievement, through to panic attacks.

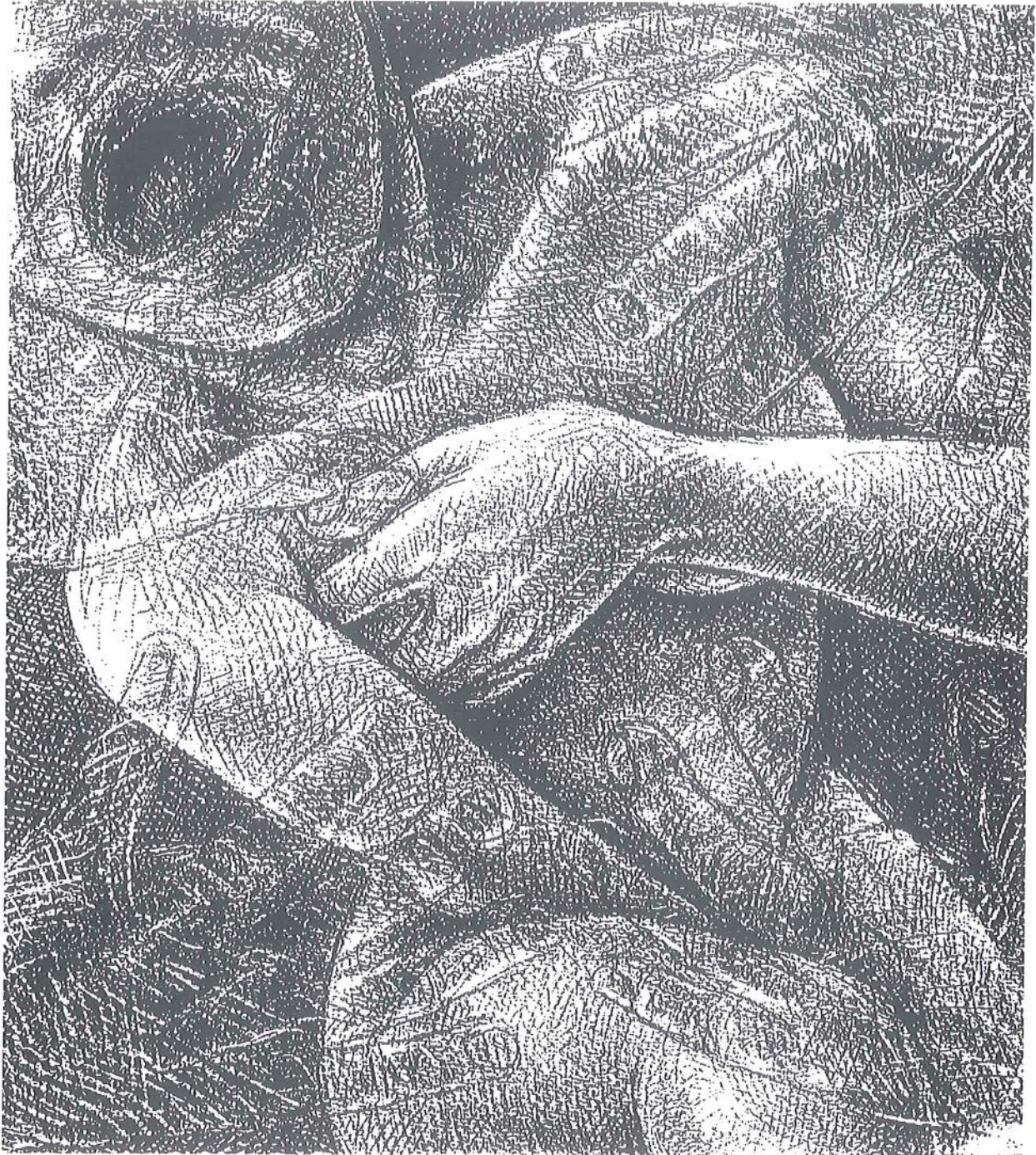
In maternity institutions, examinations and care combine nakedness, touching, intrusion, pain/discomfort and powerlessness, as well as depersonalisation, reproducing the dynamics of sexual abuse and leaving the woman feeling humiliated, dirty, violated and/or alienated. The power dynamics and the other aspects of labour and birth experiences may parallel those of an abusive relationship. Abused women may fear that midwifery/obstetric examinations, labour or birth procedures through to breastfeeding will trigger flashbacks and negative body memories or that she will lose control and be embarrassed.

Kitzinger (1990) identifies women's feelings of being objectified and exposed, as recurring descriptions of abuse and acknowledges that whatever the actual nature of the treatment, obstetric/maternity events still raise concerns for some abuse survivors because they carry intense psychological meanings. Being exposed or having unwelcome people present may re-enact pregnancy/birthing woman's vulnerability and inability to protect herself. The pain of birth itself or the process of initiating breastfeeding may feel like the pain from abusive sexual contact.

Rosser (1994) discusses the disassociation of a woman from her pain ... the obsession with control as shown in the attachment to a meticulously worded birth plan ... the closing of her legs as the baby descends and the sensations of loss of control become overwhelming.

Menage (1993) lists comments from women about their obstetric procedures:

- Degrading and distressing ... no account was taken of my feelings.
- My opinions were dismissed as irrelevant although it was my body which was being invaded.
- I cried and shouted but was held down and told to stop making a noise.
- I felt abused like a piece of meat on a slab.



- I was offered no information whatever, hence my extreme fear.
- It felt undeniably like rape.

Vaginal examinations can be traumatic in themselves, but particularly so when there is a history of sexual abuse. Authority figures, e.g. white male obstetricians, are often seen as having tremendous power because a woman in the dependency role of seeking help may regress to a childlike mental state and the way in which she sees the 'father figure' will depend on past experiences. This is known as transference and is important for male doctors to understand that women can see them as an amalgamation of all other male authority figures in whose power the woman has been.

Twenty years after the event a sexual abuse survivor recalls the connection between abuse and labour:

The birth terrified me. I thought I was going to die. I felt like that during the sexual abuse. When you get in a situation where you feel like you've been violated or you feel like your life is in danger, or someone has so much power over you they can do anything, you're out of control ...

That's terrifying and that's the feeling I remember when I was giving birth. I was going to die and there were no two ways about it.

This is referred to throughout the literature on the subject as post-traumatic stress syndrome, which can less obviously continue to affect women during the postpartum period. The puerperium is an issue for abuse survivors because it raises concerns about the child's safety:

Oh my God! It's a girl ... I can't bear it if she has to go through what I've been through.

Many women are concerned that their male partner might abuse the baby.

My Mum didn't know my Dad would abuse me, how do I know my husband won't turn out like that?

Whilst other women have voiced anxiety to the point of experiencing panic attacks because they were themselves abused and therefore cannot possibly be 'good mothers' or that they might even sexually assault their own children. Other women describe an inability to breastfeed their newborn because they have learned to distrust the sensual, warm feelings that are aroused. One woman specifically identified the horror of 'white liquid' coming in spurts and 'freezing' at the thought of putting it in her baby's mouth.

During pregnancy, birthing and the postpartum, women are highly sensitised with their feelings about their body – how it looks and

whether it is 'good' enough. Women often report feeling that their body has been deformed or ruined by abuse, or that it has betrayed them by attracting the abuser or sexually responding to his touch. Childbirth may either confirm or challenge these perceptions. In fact, this can be an opportunity for women to relate to their bodies in new ways and to experience them as powerful, competent and creative. Childbirth could be the catalyst for a woman to take pride in her body as good for something other than sexual use and abuse.

Midwives have a vital role in ensuring that during her time with women experiencing pregnancy and beyond, the midwife counteracts rather than reinforces the dynamics of sexual abuse as far as possible.

This is a special time for a woman to learn, not only about her body but to begin making choices and taking control over her physical wellbeing. Because labour is viewed as a painful process, extremes of behaviour are not surprising. Fighting labour is often perceived as an extreme of an expected behaviour as opposed to seeing it as a sign of sexual abuse. When a woman is stoic in her reaction to labour, she is viewed as a paragon of motherhood who bears her pain bravely. Women who surrender or retreat are easily overlooked and given approval for their quiet compliance.

Rhodes and Hutchinson (1994) state irrespective of whether caregivers are aware of a history of sexual abuse, they should attempt to avoid triggering traumatic memories. They recommend keeping the woman focused and grounded in the labour experience to minimise the memory or re-experience of sexual abuse.

The midwife can guide the woman through each contraction using her voice to help the woman visualise what is happening in her body and what her baby is doing. Sensations need to be defined for the woman and the experience reframed, e.g. 'What you're feeling is your baby ...'.

The woman needs to be involved as much as possible in all decision-making, facilitating feelings of control. Privacy is extremely important as it permits control and concentration.

By keeping the woman focused on the birthing process encourages the woman's sense of accomplishment. This positive focus on sexuality can counteract past negative associations. Relating to her body in this new way lessens the sense of estrangement previously felt as a result of sexual abuse. It is the role of the midwife to facilitate this reconnection for the woman. Midwives then need to feel comfortable with their own sexuality as women in society before they can begin to provide appropriate care on a professional level, as midwives with other women.

Midwives must be aware of their own feelings and be prepared to confront any issues in their practices. This is an important topic which needs further incorporation into midwifery curricula and continuing education programmes.

Although the effects of sexual abuse cannot

be erased, they can be diminished. Midwives are often the first people to hear an abused woman's story. If they are sensitive, comfortable and perceptive they are able to provide a crucial link in the process of recovery.

The body not only seeks truth, but also, for want of a better word, it stores truth. When we're ready, our body may provide us with clues about painful truths that our conscious mind has repressed. Many of us receive the precious gift of memory through the body first.

(Lerner, 1993)

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# Routine Pregnancy Testing

Joan Donley O.B.E.

Independent Midwife

According to Charles Essex<sup>1</sup> 50 per cent of first trimester spontaneous abortions and one in 200 neonates have a chromosomal abnormality.

This provides the rationale for the proliferation of routine pregnancy tests (RPT) which are an extension of the medical model of maternity care.

The question I want to address is:

*Is this really in the best interests of either women or midwives?*

## Medical Model

- \* Based on the steadfastly held concept that 'no birth is normal except in retrospect'.
- \* It is crisis-oriented, based on the masculine concept of exploiting and dominating nature.
- \* It is focused on the medically independent fetus struggling to survive in the hostile maternal environment, supported by those who 'speak' on its behalf.
- \* It is technologically intensive, controlled by white middle-class technocrats supported by a bureaucratic structure.

## Midwifery Model

- \* Based on belief that pregnancy and birth are normal healthy processes. It is therefore:
- \* Holistic, preventive and supportive, based on working with nature.
- \* It is *woman-centred* and recognises that the mother and fetus are one.
- \* It is a labour-intensive social model with control based on *equal* partnership between women and midwives.

Since RPT is based on documented technological assessment and medical opinion, it undermines midwives unique knowledge and skills, suppressing their intuitive insights, to say nothing of their clinical assessment skills. This can lead to loss of confidence in birth as a normal process. With that loss, midwives could easily slide back into the role of politically unaware and inert doctors' handmaidens – no further threat to the status quo. They can easily become victims of what Marsden Wagner refers to as a 'global witch-hunt' against midwives. He claims it is staged by doctors as part of a global struggle for control of maternity services, the 'key underlying

issues being money, power, sex and choice'.

For women, the picture is even bleaker. While being conned into believing that they are making choices women are encouraged to have unrealistic expectations such as 'painless birth' and a 'perfect' baby. Robbed of confidence in their body: ability to function normally, their medically induced fears become self-fulfilling prophecies. In the long term, this passive reliance on medical opinion deprives them of the opportunity to develop intuitive awareness of fetal wellbeing which can later undermine their parenting abilities.

## The Perfect Baby

Aside from who defines 'perfect' the 'perfect baby' is based on what is currently called 'quality control' which grew out of the 'eugenics' movement of the nineteenth century. Quality control is ensured through RPT with termination of a defective fetus or fetal surgery and/or genetic engineering.

Two forces are at work here.

1. In our market-led economy, the fewer babies born with congenital abnormalities or disabilities, the more 'cost-effective' our health services will be seen to be.
2. A very expensive technological super-structure has been established supported by universities, the medical profession and the pharmaceutical companies. These not only determine the service in their own vested interests, they also have the power to shift the responsibility for 'quality control' onto the victim. This despite the fact that *the majority of congenital defects are caused by random mutations – genes damaged by chance occurrences and/or environmental factors.*

These factors can include industrial pollutants such as dioxins, PCBs, heavy metals such as lead, cadmium, mercury (environmental and medical), and nuclear radiation. Then there are the so-called public health measures such as chlorination and fluoridation of water, preservatives and additives to food to preserve shelf life. Finally, there are the deteriorating social conditions, the result of local and global economic policies.

According to U.S.A. National Institute of Health Papers (1993):



Photo: Jane Scotts

Never before in the history of mankind has there been such a vast multiplicity of environmental risk factors.<sup>2</sup>

A later (1994) article in *NEMJ* claims 'strong, if indirect evidence ... suggesting that important environmental teratogens have yet to be discovered.'<sup>3</sup>

To clean up the environment and improve social conditions would be unprofitable for the perpetrators of the problems. Neither is this option supported by our National government. Under its Treasury-driven 'Environment 2010 Strategy', voluntary industry codes are referred to national environmental standards. Direct environmental regulation should only be used as a last mechanisms and voluntary measures were ineffective or cost too much.<sup>4</sup>

International standards for minimal human intakes of chemical residues are set by WHO's Codex Alimentarius. According to Meriel Watts the aim of Codex is 'to minimise disruptions in the international food trade caused by the presence of pesticide residues in food'.<sup>5</sup> New Zealand's 'standards' for fruit and vegetables are even higher, for example New Zealand's proposed 'safe level' for dioxin is more than 1,000 times higher than the U.S. Environmental Protection Agency (EPA) safe dose.

As well as higher 'safe levels' and leaving interpretation of 'public health' to the manufacturers, company profits can also be ensured by shifting the responsibility to the victim. Australian Dr Kate Short claims that where there has been a baby's death or a newborn's imperfection due to suspected pesticides, genetic counselling (damage control) has been more palatable remedy than proper investigation of the cause.<sup>6</sup>

Marsden Wagner explains that even from the early 1900s the industrialised countries recognised that both environmental and health factors were to blame for the health of the child and his mother. The state chose to address individual rather than environmental factors for complex reasons including the politically more acceptable approach of blaming the victims (the poor) rather than the state. ... The choice of the individual approach set the pattern of health services for children and their mothers in the twentieth century.<sup>7</sup>

Eventually, just as kidney dialysis patients are prioritised, it is not too far-fetched to believe that any woman who refuses RPT, then termination or genetic engineering of a defective fetus will be expected to assume the costs of care and treatment. Hobson's choice!

Therefore it is very important for midwives and women to understand these political/environmental factors when discussing RPT. Not only that. Since interference with the biological process can occur during the critical first month of fetal life, it is important to take a detailed and well documented history as early in the pregnancy as possible while the woman can recall contacts with environmental pollutants. History should also include occupations of both parents, geographical area at time of conception and early weeks of pregnancy and possible chemical exposures.

RPT is NOT the answer to the increasing incidence of congenital abnormalities. It is merely another ambulance at the bottom of the cliff. But, do midwives have the courage to challenge this powerful, well-entrenched bureaucracy? To initiate action when their documented histories correlate with an abnormality? To caution parents of the dangers?

With an election in the offing, ask your aspiring MPs for their stance on cleaning up environment pollution. Also, remember who passed the legislation to give midwives back their autonomy!

## Environmental Factors

### Ionising Radiation

- Nuclear testing.
- Nuclear power.
- X-Rays.
- Irradiated foods – new radiolytic products.

### Heavy Metals

- Lead – car exhaust, batteries, tobacco smoke, lead crystals, some ceramic glazes, old lead-based paint, old lead water pipes.
- Agricultural chemicals.

### Cadmium

- Superphosphate fertilisers, alloys, solders, welding, aluminium smelting, alkaline batteries and pigments.
- Cigarette smoke, ceramic glazes.

### Mercury

- Mercury vapour is quickly absorbed.
- Fetal brain concentrates mercury at twice

the maternal rate and retains 30 per cent more than red blood cells do. Passes into breast milk.

### Industrial Sources

- Chlorine production, coal burning.
- Anti-fouling – fungal paints, slime inhibitors, exterior latex.
- Paints, paper manufacture, discarded electrical equipment, aerosols, fish concentrate mercury 3,000 to 5,000 times New Zealand children, pregnant and nursing women are advised not to eat old large fish and those taken downstream from geothermal or volcanic activity.<sup>8</sup>
- Fish meal is fed to animals and fowl.

### Medical Sources

- Medical equipment – thermometers, sphygmometers (70 per cent are in unsealed containers).
- Dental amalgams, mercury also released during cremation.
- Thiomersal in vaccines and anti-D (Rhogan).
- Calomel.
- Volcanoes.

### Organochlorines

#### Bioaccumulative

- Chlorine – is a halogen which also includes bromine.
- Fluorine, iodine.
- Sources – Bleaches, solvents, disinfectants, chemical intermediates.
- e.g. trichlorethylene – degreaser, carbon tetrachloride – cleaner, (both form phosgene gas when heated).
- Industrial synthetic chemicals produced from chlorine can cause genetic mutations.

- \* Chlorinated phenols = phenoxy herbicides obtained by heating chlorinated benzene with methyl alcohol and sodium hydroxide at 160–180°C. The byproduct is DIOXIN.
- Dioxin bioaccumulates, especially in animal fats.
- Decreases thyroid function and disturbs calcium metabolism.
- Sources: DDT, lindane, dieldrin, aldrin, Agent Orange, 2-4-D. The most commonly used form of 2-4-D in New Zealand is made from butyl ester which is almost 20 times more volatile than that made from the amine ester.<sup>9</sup>

- \* Chlorinated plastics + chlorine + petrochemicals
- PCBs (polychlorinated biphenyls) now banned but are still present in water, earth and food chain.
- In breast milk, placenta and can be transferred genetically.
- Sources: electrical insulation, transformers, pumps, compressors, brake

linings, varnish, fluorescent lights.

Anti-fouling paints.

PCP (pentachlorophenols) used in the softwood timber industry to prevent sap stain. Produce dioxin. Banned in 1991, but there are still more than an estimated 600 which would cost up to \$175 million to clean up.<sup>10</sup>

PVC (polyvinylchloride) – vinyl.

Plastic wraps (absorbed by foods high in fats), drug containers, surgical tubes, hoses, blood and IV bags.

Coatings, polyurethanes, epoxy resins, neoprene. (Polyurethanes and water-based paints contain isocyanate. The Bhopal disaster was due to methyl isocyanate.)

(Both production and disposal (burning) releases lead, cadmium, dioxin. Medical waste incinerators are one of the largest contributors to dioxin in the air.)

Polyethylene – milk, softdrink, food containers.

## Anaesthetic Gases

Chloroform (halogenated hydrocarbon)

Halothane

Nitrous Oxide prolonged exposure as midwives working in delivery units – teratogen.

## Drugs

*Thalidomide:* Jim Sprott noted the similarities in molecular structure between benolate/benomyl and thalidomide.<sup>11</sup>

*Tranquillers:* Chlordiazepoxide (Librium) noted in about 11 per cent of exposure in the first 42 days of pregnancy; chlorpromazine (Largactil) – lower rate.<sup>12</sup>

*Diethylstilbestrol (DES).*

*IVF – clomiphene citrate:* Of the 8.6 per cent of successful IVFs, there is a 2.3 per cent rate of congenital abnormalities compared to 1.5 to 1.7 per cent in the general population mainly, neural tube and cardiac.<sup>13</sup>

*Lithium:* Heart, brain, spine, fetal goitre in 8–9 per cent of exposures.<sup>14</sup>

*Anticonvulsants:* Heart, lungs, eyes, ears, fingers, CDH, absent thyroid.

Carbamazine, Phenytoin, Primidone abnormalities occur in 10 per cent of exposures. Divalporex Paramethadione, Trimethadione, Valproic acid abnormalities occur in 69 per cent of exposures.<sup>15</sup>

Retinoid – isotretinoin (Acutane) – CNS, neural tube, heart blood vessel, no thymus. Occurs in 40 per cent of exposures.<sup>16</sup>

*Warfarin:* Skeletal, heart, facial, eye, brain – occurs in 35 per cent of exposures.<sup>17</sup>

*Decongestants,* expectorants, bronchodilators, antihistamines can also cause congenital abnormalities.

## References

Available on request. ■

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# When should we change our practice? When should we be cautious?

Suppose you find an article by Bloggs which outlines a comparative study of 50 women eating marshmallows and 50 women without marshmallows and found that the women with marshmallows requested and used less analgesia during labour than those women without marshmallows. Would you adopt the use of marshmallows as part of suggestions for women in labour? Your answer might well be 'Yes it sounds good and it is not likely to be harmful'. What if we then add the information that this group of women were Hispanic Americans, under the care of obstetricians and obstetric nurses? You might then feel that the client group, culture and obstetric practices could differ to your own practice and clients. If we then add that whilst these are the overall results, in Table 1 of results we have the following finding. Does this make any difference?

**Table 1: Women in both Study Groups and Use of Analgesia**

Analgesic	Group A (n = 50)	Group B (n = 50)
	<i>Women in labour with marshmallows</i>	<i>Women in labour without marshmallows</i>
Use of Entonox	4 (8%)	15 (30%)
Use of pethidine	10 (20%)	5 (10%)
Use of epidurals	5 (10%)	2 (4%)
Total using analgesics	19 (38%)	22 (44%)

First, it is clear that the difference between the groups is a matter of only three women more in Group B having analgesia. Second, it is clear that in fact Group A (eating marshmallows in labour) have used more invasive analgesics which have greater risks and side-effects than Group B, where the majority of women have used Entonox. Whilst the statement that fewer women used analgesics in Group A is true, it does not tell the whole story. A fact which is true of many research articles where abstracts or conclusions present the interesting or simplistic version of the research without the wider picture. So, maybe we would read the article by Bloggs with interest but would want more research to clarify the effect of marshmallows in labour on the use of analgesics before we leapt in and made changes to our current practice.

The process we went through in the section above has a grand research term, namely, critiquing. It means that we read the article, weigh up the strengths and weaknesses of the article and also consider how it relates to actual practice. Before we look at this further, we need to be clear that there are different types of research which are done for different reasons. There are two main approaches which we tend to meet in midwifery; the quantitative (positivist) approach and the qualitative (interpretive) approach. There are many other branches of research but we will focus on these two. With quantitative research the intent is often to provide information which looks at cause and effect, or association relationships with recommendations for changes to practice, e.g. the New Zealand Cot Death Study. With interpretive research the emphasis is often on raising awareness of an issue with no intention that the findings can be directly transferred and applied to other people, e.g. a phenomenological study of four women's experience of postnatal depression.

**What are some of the points to be aware of when reading a research article and deciding whether to base changes in your practice on it?** [Most of the following points relate to reading quantitative research.]

- *Is it recent and therefore reflecting current practice?*  
Studies published even in the 1970s and 1980s are likely to reflect a different climate of practice to that of 1996.

Alison Stewart

Senior Midwifery Lecturer  
Otago Polytechnic



- *Does the way in which the research was conducted seem appropriate/logical to you?* For example, a study of pain relief in labour using the pain of squeezing of the big toe of men as analogous to the pain of uterine contractions does not seem an appropriate choice of sample (people) or methods (what is being done and measured).

- *Do the practices and people studied seem similar to your practice and clients?*

This inevitably means that research undertaken outside New Zealand needs to be considered in terms of how the country and the people may be the same or different to New Zealand. In the case of YES, they are similar, you *might* be able to apply the results to your practice, but be careful to study the outcome of any changes since there might be unexpected side-effects from any change you make. If NO, then the research can raise your awareness of the issue studied and you might decide to do a similar study in your own area.

- *How many people/places have been studied?*

This is an issue if we want to apply the results of another study to our practice. For example, an experiment using lavender oil versus salt baths to remove postnatal perineal pain, with 10 women in the study (five in each study group). Comparing 10 women in two groups is too small to show valid, reliable differences and the results could be skewed if, for example, the five women in the lavender group were all more stoical about pain. Hence, the more people in the study, the more likelihood that individual differences (such as pain levels) will be equally distributed with people with high and low tolerance of pain in both groups.

- *Is it clear what is actually being studied?*

For example, if we decide to advocate the use of lavender oil in baths for perineal discomfort is it clear exactly how much lavender oil in how much water should be used? Without this detail we could be recommending a concentration of lavender oil which has not been studied.

- *What about ethics?*

There is the issue of whether to use research which does not indicate how the rights of participants have been recognised. For example, how did people join in the study? Are they volunteers or were they coerced to take part or did they not even know that they were part of a study as in the case of the cervical cancer study at NWH (*Report of the Cervical Cancer Inquiry*, 1988). If an article does not tell you about ethical aspects of the research do you use the results in your own practice? Certainly, to use findings which may have been gained unethically would not seem to fit with philosophies such as a

woman's right to informed choice. However, we should be aware that there is a distinction between an article and a study and that many studies are ethically sound but have not given details of this in the article. If interested you could always write to the researcher to find out what measures were taken.

Finally, remember that our research-based practice can only be based on the current state of knowledge and knowledge is not stationary nor does it apply to all situations – research is context and time specific. I became very aware of this in 1990 when working in the county of Avon (U.K.) in a study of the potential causes of cot death. The 1980s had seen the prone sleep position advocated for all babies by paediatricians who were applying the findings that prone sleeping was beneficial to small, preterm babies (Martin *et al.*, 1979). The cot death rate rose dramatically in the 1980s in Avon with over 50 babies dying in some years. A case-control study (Fleming *et al.*, 1990), comparing the history and environment of babies who died with babies who lived, identified some of the same findings as the New Zealand Cot Death Study data (Mitchell *et al.*, 1991). One of which was that prone sleep position greatly increased the risk of cot death. These research studies highlighted that an action which may be beneficial to some babies cannot be assumed to apply to all babies.

As we claim to base our practice on research, it means that we all are reading and discussing research to a greater extent than ever before. In the words of the old adage, 'All that glitters is not gold' and all research that is published is not necessarily suited to our practice. Using our common sense with questions such as those above, it is possible to rapidly identify studies which may be relevant to our practice and studies which might influence and change our practice.

### Further Reading

Most research texts provide chapters on critiquing research articles with handy hints and examples on reading articles and how to assess them.

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## Chinese Infant Massage (Paediatric Tui Na)



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# Birth in the '90s: A Student Midwife's Lament

Jenny Edgecombe

Midwife

Strong and beautiful woman  
you nurtured yourself for nine months  
while your baby grew strong and safe  
within the cradle of your womb.  
Your first baby, you waited  
in nervous anticipation  
for him to push his way into the world.  
You are strong, and you glow with life and health –  
Both of you.

Labour came to you hard and fast.  
A gush of waters then sweeping waves of pain  
that swirled you away  
into a stormy sea of contractions  
with barely space to catch your breath.  
You were magnificent  
(you and your man) –  
you welcomed them for what they were  
your baby was coming!  
Catching breath only to whisper  
"I love you, I love you, I love you"  
to your man.  
While, deep within, your baby's heart  
beat strong and safe  
in the cradle of your womb.

Transition came  
(in went the fingers – "Just to check")  
nine centimetres!  
Well done – in only four hours!  
and your first baby, too.  
You are awesome and lovely in your power.

Pushing came  
(in went the fingers – "Just to check")  
Oh no! An anterior lip! No, don't push yet!  
Just breathe them through, that's right,  
that's great, you are wonderful.

Fighting desperately not to push,  
as fingers dip in and out of your vagina  
three more times.  
At last – thank God – you are allowed to push.  
(How generous we are with this power  
that we hold over you)  
"Up you come – onto this lovely birth stool  
we have here".  
(So high on the bed now that I can  
barely reach your face)  
"Push! No, PUSH!!"  
Not into your legs!  
Don't waste it in your legs – into your bottom,  
just where my fingers are,  
deep breath, now PUSH!!".

Desperately, you try to please  
straining with each contraction,  
near bursting with the effort.  
(The second stage clash is on – the mothers  
of all babies not born within thirty minutes  
will be severely frowned upon)

On goes the heart monitor to listen  
to your beautiful baby's heart beat.  
"Damn – can't pick it up".  
(Well maybe this baby is so deep now  
that he is hiding from our ultrasonic waves)  
No, no – not good enough.  
On goes the scalp clip.  
Oh shit – came off again.  
On goes another one.  
our man withdraws into himself  
while you turn yourself almost inside out  
in your efforts to please us  
and get this baby born.

Panic strikes as the heart monitor goes haywire.  
(Is the clip on properly?)  
"Look – late decelerations!  
(Oh no they're not – is that clip on properly?)  
Quick, summon the Great Doctor  
that He might save us from ourselves".  
(But if we changed position, pushed gently –  
and if we have to have a clip then please  
check its on properly?)

No time. No time.  
The Doctor is here  
and He will rectify the situation.

In came the Doctor, in came the nurse  
(in came the lady with the alligator purse)  
"Hmmm" says He, "Tsk tsk, tut tut  
I'll have to make a little cut  
and then, my dear, with the greatest of ease,  
and the help of these salad tongs  
if you please –  
your babe will be born.  
Now, now, don't be sad  
HIS HEART RATE IS DIPPING AND THATS  
REALLY BAD".

So, sobbing now, contractions strong and long,  
we lay you down upon your back  
and put your legs up in the air.  
A shot of Lignocaine and then scissors cut you  
in that most tender and private place.  
Forceps forced inside, they grasp  
your baby's head.  
(What – with only local in your perineum?)  
Screaming now with pain and fear.  
The Doctor tugs and pulls "Hmm, this is a tricky  
one"  
as beads of sweat break out on His brow.  
Your man shrinks by your side.  
Baby Doc stands by her gleaming Ohio,  
while I hold gas over your face – that's right  
breathe deeply, breathe through it.  
(Breathe through it? Breathe THROUGH it?)  
I must be bloody mad.)

Minutes later your baby boy is dragged  
screaming into this world.  
(Yes, screaming, this poor compromised infant  
with late decelerations)  
Baby Doc whisks him to her gleaming Ohio  
to be poked and prodded into shape.  
Apgars 9 and 10.  
Thank God for modern medicine.

Sobbing now with joy and shock  
amazing, strong woman,  
talking to your mother on the phone  
as your placenta is pulled from your womb.  
And the Doctor settles Himself between your  
legs  
to fix what wasn't broken until he broke it.  
"Oops, episiotomy extended a bit there,  
see the damage from the forceps?"  
Your baby son is returned to you  
swaddled so tight that he looks more like  
a cocoon than your precious baby boy.  
He fights a hand free of his bindings –  
at least you can count the fingers of one hand –  
in wonder.

Stitched up, swabbed down,  
at last you get to hold him to your breast.  
He pulls away  
bewildered baby boy  
with bruises on his cheeks.  
You hold him close  
with tears in your eyes.

Up for a shower – no time to waste  
it's 3 a.m.,  
(and this is the fifth baby that the midwife  
has delivered in the last six days you know).  
You stagger to your feet  
faintness washing over you.  
Estimated blood loss 600 mls.  
Hot water soothes your aching body,  
tired ... tired ... tired.

Up to the ward  
cold ice upon your wound.  
The Ultimate insult awaits ...  
Tucked up at last in your bed with your son  
son your man beside you.  
"... Have to change this baby's label"  
he is whisked from your side  
relabelled and firmly wrapped  
(My God, this baby has hospital corners!)  
to be placed with utter finality  
in his fish tank alone –  
and facing the other way.



# HELLP Syndrome

Joyce Cowan

Midwife

For the last 18 months HELLP Syndrome has had a very big effect on my life. I have become driven to study this fascinating and complicated condition. It seems a strange subject to interest a midwife who is mainly involved with normal birth and who has a strong commitment to home birth but in March 1994 an encounter with HELLP Syndrome had a profound effect on my life and has led not only to a fascinating study but to the setting up of an organisation to provide support for women with pre-eclampsia and to promote public awareness and better detection of the condition.

In March 1994 Wendy Roberts gave birth by emergency C/S to a son, small but healthy, just over five weeks early and weighing 1.8 kg. This little boy named Finn continued to thrive as his mother fought for her life, while her body succumbed to almost every possible complication of severe fulminating pre-eclampsia and HELLP Syndrome. I would like to present some of the information I have gathered about HELLP Syndrome and then with the help of Wendy and her husband Evan tell you what happened when Finn was born. We would also like to share with you the news about NZAPEC (New Zealand Action on Pre-eclampsia) which was established as a charitable trust in September 1995.

## HELLP Syndrome

The study of HELLP Syndrome is both confusing and fascinating. Controversy surrounds almost every aspect of it.

### Terminology

A review of the literature highlights the confusion concerning the terminology, incidence, cause, diagnosis and management of this syndrome. Searching through midwifery and obstetric texts produced little information but I discovered a wealth of knowledge waiting for me in the journals. I found the first article published in 1982 by Weinstein, who coined the term HELLP. He described 29 cases of severe pre-eclampsia complicated by thrombocytopenia, abnormal peripheral blood smear and abnormal liver function tests. He suggested that this collection of signs constitute a separate entity from severe pre-eclampsia.

Over the next decade the term HELLP, representing *Haemolysis, Elevated Liver Enzymes and Lowered Platelets*, was to be investigated and discussed at length. In fact, although Weinstein<sup>1</sup> was the first person to name the Syndrome, he was not the first to recognise it, as he admitted in his article. The HELLP Syndrome entity was previously described by Pritchard and associates in 1954. In 1972 McKay published four cases of the HELLP Syndrome, all occurring in eclamptic patients. Goodlin in 1976 and 1978 and Killarn and Associates in 1975 all presented cases involving the classic components of HELLP. These early authors all concluded that the entity is more common than had been previously realised and that prompt delivery is mandated regardless of gestational age. They were also aware that hypertension does not have to be severe in HELLP Syndrome.

Looking back even further, the components of HELLP were reported in the literature over 100 years ago by Schmore in 1893, according to Chesley.<sup>2</sup>

Since the defining of HELLP, obstetricians have had different opinions over what constitutes the syndrome. Terminology and diagnosis have varied Weinstein considered HELLP to be a unique variant of pre-eclampsia Goodlin<sup>3</sup> considered it to be an early form of severe pre-eclampsia. McKenna *et al.*<sup>4</sup> considered it to be misdiagnosed pre-eclampsia. It has also been considered to be mild DIC (Disseminated Intravascular Coagulation) that had been missed because of inadequate laboratory investigation. However, the role of DIC in HELLP is controversial. DIC is diagnosed when there is thrombocytopenia prolonged prothrombin and partial thromboplastin times and low fibrinogen concentration. In the largest well-defined study group of patients with HELLP in the medical literature, Sibai *et al.*<sup>5</sup> found that only 21 per cent of patients with HELLP had DIC. The majority of these also had abruptio placentae, peri-partum haemorrhage or sub capsular liver haematoma This would fit with the statement by an author<sup>6</sup> on DIC who says that this condition is never primary but always secondary to some general stimulation of coagulation release of pro-coagulant substances into the blood. In Sibai's study, excluding the women whose DIC followed such an event the incidence was less than five per cent.

More recent opinion on the terminology may lead to the disappearance of the concept of HELLP Syndrome as a distinct entity. According to Brown<sup>7</sup> (1995), 'this term should probably be abolished so that this syndrome is not viewed as anything other than a severe form of pregnancy-induced hypertension'. Even more recently, the Australasian Society for the Study of Hypertension in Pregnancy have recommended that 'the term HELLP Syndrome should be abolished so that abnormal liver function, thrombocytopenia and haemolysis are not viewed as anything but manifestations of severe pre-eclampsia'.

According to Redman, Roberts<sup>8</sup> 'Diseases can be diagnosed but syndromes can only be recognised. Screening for the development of a syndrome is, at best, imprecise and always, in terms of logic, unsatisfactory'.

It seems then, that Weinstein's theory about HELLP being a separate entity from pre-eclampsia may not be correct. Most authors agree with Poole<sup>9</sup> who states that HELLP Syndrome always occurs in tandem with pre-eclampsia. The fact that HELLP Syndrome's symptoms may become apparent even before pre-eclampsia classic triad or findings may lead to faulty or delayed diagnoses, putting the mother and fetus at risk. In fact the syndrome has often been misdiagnosed as the symptoms can be similar to many medical conditions such as acute hepatitis and gall bladder disease.



## Symptoms

The symptoms of HELLP Syndrome include epigastric pain, nausea and/or vomiting, or even non-specific virus-like symptoms. Visual disturbances, headache, bleeding, jaundice, neck or shoulder pain also may occur. According to Sibai,<sup>10</sup> 90 per cent of patients will give a history of malaise for the past few days before presentation. Sibai recommends that, as some patients with HELLP may have a variety of signs and symptoms, none of which may be diagnostic of severe pre-eclampsia 'all pregnant women having any of these symptoms should have a complete blood cell count and platelet and liver enzyme determinations irrespective of the maternal blood pressure level'. Schroder<sup>11</sup> found that incorrect interpretation of abdominal pain was the major cause of misdiagnosis.

## Incidence

It is widely accepted that pre-eclampsia can affect 10 per cent of pregnancies. How many of these pregnancies will be complicated by HELLP Syndrome? According to Poole<sup>12</sup> HELLP may affect 12 per cent of the pre-eclamptic/eclamptic population. Sibai<sup>13</sup> found the incidence amongst patients with severe pre-eclampsia was 18.9 per cent. He commented that the high percentage may have been due to the high number of cases referred to his specialist centre from five different states in his region.

## Diagnosis

It is clearly important that HELLP Syndrome is diagnosed early. There is, however, no agreement in the literature regarding the type and degree of laboratory abnormalities to make the diagnosis. A major reason for the controversy surrounding HELLP Syndrome is the lack of standardised diagnostic material used to diagnose it. At present there are few published studies with an adequate sample size to describe the syndrome. However,

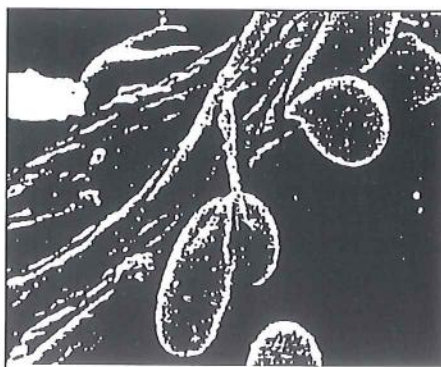
Sibai studied 442 women with HELLP over 15 years. Sibai based diagnosis on the clinical diagnosis of pre-eclampsia and all the following laboratory abnormalities: characteristic peripheral blood smear, serum lactic dehydrogenase >7600 U/L or total bilirubin  $\geq 17.2 \mu\text{mol/litre}$ , serum aspartate aminotransferase >70 U/L and platelet count <100,000/mm<sup>3</sup>. Routine laboratory evaluation included serial measurements of liver function tests, complete blood cell count, coagulation profile and renal function tests. I found no other reference to specific levels of test results at which diagnosis was made. Other authors described the peripheral blood smear, the effects of HELLP on the liver and other organs and the changes in platelet numbers.

## Haemolysis

This is diagnosed mainly on the abnormal peripheral blood smear although it will be found that the haematocrit which may have risen as a result of the developing pre-eclampsia, will drop as the red blood cells are destroyed. Haemolysis, defined as the presence of micro-angiopathic haemolytic anaemia is the hallmark of the HELLP Syndrome. It is thought to result from the passage of red blood cells through the small blood vessels with damaged endothelium and fibrin mesh deposits. This leads to the appearance on the peripheral smear of damaged red cells such as – triangular cells, burr cells, spherocytes and schistocytes.

Cunningham *et al.*<sup>14</sup> used scanning electron microscopy to study the RBCs of women with severe pre-eclampsia and eclampsia. They found changes in the red blood cell membranes that were more pronounced in patients with liver dysfunction. They suggested that alteration in the cell membrane may increase the susceptibility of the erythrocytes to microangiopathic haemolysis.

Spherocytes appear spherical rather than circular due to damage of cell membrane in haemolysis.



Scanning electron micrograph. Red cells are 'clothes-lined' over fine fibrin strands; *in vitro* model. Other cells, moving past these trapped erythrocytes, may cause their fragmentation. Thicker fibrin strands in background do not cause this injury.

Bull, B.S. and Kihn, L.H. (1970), 'The Production of Schistocytes by Fibrin Strands', *Blood*, 35, p. 104.

Burr cells have a prickle-like appearance. They are also known as echinocytes. The rough surface is the result of cell damage.



Schistocytes are cells with 'bites' out of them. They appear small and irregularly shaped on microscopy.



Bilirubin may increase after the disease is severe, however, Sibai's level for diagnosis would not apply in New Zealand as our upper level of normal is 20  $\mu\text{mol/litre}$ . LDH is not used universally as a diagnostic test, in fact it is seldom used in Auckland as it is not highly specific and as it is a very sensitive test, tests may not be reliable. LDH is raised in liver disease and haemolysis.

Haptoglobin is used in New Zealand to test for haemolysis. Free haemoglobin released by haemolysis combines with haptoglobin to form a complex which is removed by the liver. Free Hb is toxic and can cause kidney damage  $N = 0.7-3.8\text{g/L}$  Reduces as used up.

Schrocksadel *et al.* studied the haemolysis markers LDH, haptoglobin, bilirubin in the serum and wine, fragmentocytes and free haemoglobin in the 166 patients with various degrees of hypertensive disorders of pregnancy and 179 non-hypertensive pregnant controls in a weekly screening programme.

In the diagnostic sensitivity, they found that haptoglobin and to a lesser extent LDH were superior to other haemolysis parameters.

They found that a decreasing platelet count also is an indicator of impending haemolysis.

Subclinical haemolysis was associated with poorer fetal and maternal outcome. They concluded that, with the aid of haptoglobin, LDH and platelets and incipient HELLP Syndrome could be recognised 1–2 days before the complete clinical picture became apparent.

An interesting case was presented by Jones *et al.*,<sup>15</sup> describing a case of HELLP Syndrome at 38 weeks.

The condition was diagnosed when the patient presented with acute, persistent gum bleeding after toothbrushing. Her platelet count was  $26 \times 10^9/\text{L}$ .

Bleeding gums have rarely lead to the diagnosis of this syndrome, no such severe case has ever been presented in the literature. Although the patient had been hospitalised 48 hours earlier with non-specific viral-like symptoms, she was discharged after treatment with IV fluids for rehydrations. Re-examination of her laboratory tests obtained during this time revealed thrombocytopenia. This case emphasised the important of maintaining a low threshold of suspicion for HELLP Syndrome.

## Elevated Liver Enzymes

There is no consensus in the literature over which liver function tests should be used for diagnosis of HELLP. As already mentioned Sibai uses a raised AST of 770 U/L (N = 0.45). Liver damage tends to be a fairly late feature of the disease. As the disease worsens the damaged liver swells, stretching its protective capsule. This causes pain which can also be aggravated by bleeding under the capsule.

In Auckland standard liver function tests include:

### Liver Enzymes

Alkaline phosphatase	ALP N = 25–120 U/L
Gamma glutamyl transpeptidase	GGT N = 0–5 U/L
Aspartate transaminase	AST N = 0–45 U/L
Alanine amino transferase	ALT N = 0–40 U/L

AST and ALT are hepato-cellular enzymes

– both increase in response

ALP and GGT are cholestatic enzymes

– response to liver damage

Bilirubin	N=5–20 µ mol/U/L
Serum albumin	N=35–50 G/L
Serum Globulin	N = 18–34 G/L

Acute or chronic liver failure shown by low albumin.

The classic lesion in the liver is an area of necrosis, in which large hyaline deposits of fibrin-like material can be seen in the sinusoids. Immuno fluorescence studies usually reveal the presence of fibrin microthrombin and fibrinogen deposits in the sinusoids in areas of hepato-cellular necrosis as well as in the sinusoids of histologically normal parenchyma. These findings may be responsible for the elevated liver enzymes and epigastric pain mentioned above. On rare occasions the pressure within the liver results in haemorrhage and subcapsular haematoma formation and possible rupture.

## Lowered Platelets

It is likely that the platelets are involved at a very early stage. The cause of platelet involvement at an early stage is not clear but could be connected with poor functioning of the placenta which is known to occur in pre-eclampsia.

Another hypothesis is that an imbalance of thromboxane and prostacyclin may be responsible for part of the problem. A study from Michigan State University found that in a normal pregnancy the placenta produces equivalent amounts of thromboxane which tends to activate platelets constrict blood vessels and stimulate uterine activity and prostacyclin, a related substance, with opposite effects. The pre-eclamptic placenta

produces more thromboxane and less prostacyclin than normal. This helps to explain the increased constriction of the blood vessels, enhanced platelet activity and reduced placental blood flow which are characteristic of the condition.

According to Poole,<sup>16</sup> arteriolar vasospasm damage the endothelial layer of the small blood vessels, forming lesions. These lesion sites allow platelet aggregation and the formation of a fibrin network. Circulating platelets adhere to collagen at damaged endothelial sites and as the platelets are consumed, thrombocytopenia occurs. New platelets which may be produced more rapidly than normal appear larger, hence the increased mean platelet volume notices in pre-eclampsia. Normal platelets levels =  $150-450 \times 10^9/L$ .



## Management

On the subject of management there is general agreement! *Deliver*. Whereas conservative treatment of mild or even moderate pre-eclampsia has caused a marked improvement in perinatal outcome, according to Weinstein<sup>17</sup> conservative management may be detrimental to maternal survival. Over the years since 1982 no one has disputed that fact, particularly if the woman has reached 34 weeks, or if there is evidence of fetal lung maturity or maternal jeopardy before that time. According to Sibai<sup>18</sup> women remote from term need referral to a tertiary care centre and initial management should be as for severe pre-eclampsia. Maternal condition has to be assessed and stabilised, particularly coagulation abnormalities. Platelet transfusions may be given prior to delivery. Fetal assessment is carried out continuously.

There is no cure for HELLP Syndrome except for delivery of the baby but in some cases the syndrome has presented postpartum.

Various therapies have been used to treat or reverse HELLP Syndrome including plasma volume expansion, antithrombotic agents, immuno-suppressive agents. However, it is doubtful that limited pregnancy prolongations gained will result in improved perinatal outcome, especially when maternal and fetal risks are substantial the only definitive treatment is delivery regardless of gestation. Pregnancies complicated by HELLP are associated with poor maternal and perinatal outcome.

Reported maternal mortality is up to 24 per cent and perinatal mortality may be as high as 60 per cent.

Redman and Roberts agree the need to deliver is urgent.<sup>19</sup> In conclusion, although HELLP Syndrome complicates only a small number of

patients, the effects can be devastating, possibly fatal. HELLP, like severe pre-eclampsia, is a multi-system disease and may lead to failure of major maternal organs, i.e. liver, kidneys, lungs, heart, brain, and may affect vision, sometimes permanently. Effects on the baby through poor placental function or hypoxia may be equally devastating.

For a midwife, the first signs of HELLP may present at a routine antenatal or between visits through phone contact. It is important that the varied and often subtle ways in which the syndrome may present are understood.

Good client education is also important as many women would attribute symptoms such as nausea and vomiting to something unrelated to the pregnancy. In most cases they would be right to make such an assumption but misdiagnosis can have tragic results. With the trend to reduce routine antenatal visits it is important that safety is not sacrificed in order to be 'cost-effective'.

Perhaps in the future a screening test will alert us to those clients who are 'at risk'. At the present time all health professionals caring for pregnant women need to be familiar with HELLP Syndrome and its clinical and laboratory findings in order that they may obtain appropriate care quickly and effectively.

The study of HELLP Syndrome has been challenging and fascinating. I still have unanswered questions and my literature search will continue.

## Acknowledgements

Grateful thanks to Wendy and Evan for openly sharing their thoughts and feelings.

## References

Available on request.

## Notes

### Action on Pre-eclampsia (NZAPEC)

In 1991 APEC was founded in the U.K. September 1995 saw the founding of the New Zealand APEC, a sister organisation with equivalent aims. In the short term, APEC wants to ensure that every parent-to-be appreciates the risks of pre-eclampsia and the need for antenatal screening; that every doctor and midwife understands how to diagnose and manage the condition; and every sufferer gets the support and information they so badly need.

To join APEC the annual membership is \$25.00.

Contact: APEC, 54 Karaka Road  
Beachlands, Auckland.

# A Travel Report and a Look at Vaccination

Erwin Alber

## Vaccination Information Network

Dr G. Buchwald MD, one of the speakers at the International Vaccination Symposium in Auckland last April, has for the past 30 years been the medical adviser for the German Parent Association for the Support of Vaccine Damaged Children. Last year he invited me to come along on his tour of 11 lectures around Germany, at which he warned that vaccines do not protect against diseases and cause harm.

Vaccines contain chemicals such as aluminium, formaldehyde and mercury. Of even greater concern to Dr Buchwald are, however, their viral and bacterial components, as well as the contaminants from the animal and human tissues vaccines are cultured on, such as chicken eggs, monkey kidneys, the cells of aborted fetuses – all of which are foreign protein. Dr Buchwald says that their forcible introduction into the organism causes problems similar to those resulting from blood transfusions before it was known that blood types had to be matched. The quantity of foreign protein involved in the injection of a vaccine is of course much smaller, but is nevertheless capable of causing allergic reactions which, in some cases, can cause a shock (anaphylaxis) severe enough to be fatal.

In his experience this foreign protein deranges the immune system and is responsible for much of the increasing incidence of auto-immune diseases and other disturbances such as juvenile arthritis, asthma, allergies, eczema, neurodermitis, inner ear infections, etc. as well as damage to the immature nervous systems of babies and young children, including sometimes paralysis or cases of sudden infant death. Autopsies usually reveal no signs of nervous system damage because swelling of the brain caused by a vaccine is usually only temporary. In most cases physical development appears to carry on as normal, however, and it is not until later that the consequences of brain damage (encephalopathy) of various shades of severity may become apparent. These may be disturbed mental/intellectual development, or personality changes such as speech impediments, learning difficulties, autism, epilepsy, hyperactivity and other mental or physical handicaps. Most parents don't even suspect vaccine damage; if they do, doctors usually tell them that such disturbances are 'purely coincidental'. It is only when children approach the age of three, says Dr Buchwald, that their nervous systems are mature enough to react to vaccines with an inflammation of the brain (encephalitis). A causal link with vaccination is more obvious at that age also because children at that age – unlike six-week-old babies – can verbalise their discomfort.

I came across several cases of vaccine damage at Dr Buchwald's lectures, including a young man and a young woman, both severely mentally handicapped. In Paderborn a very upset mother related how her baby was (and still is) paralysed as a result of a recent polio sip. In Eschenbach a

mother (we were later told) was silently crying throughout the lecture because her baby had suddenly died following vaccination. Near Nuremberg we visited a solicitor who works full time to obtain compensation for vaccine damage on behalf of parents in the German courts. One of her recent cases involved of a child who became paralysed from the neck down – including the tongue – as a result of a vaccination against hepatitis B.

In Paderborn Dr Buchwald debated the pros and cons of vaccination with Professor Koch, Germany's top official responsible for vaccination. Though an advocate of vaccination, Professor Koch admitted that the BCG-vaccine – still recommended for (and given to) those 'at risk of TB' – is ineffective. He also felt that vaccination against polio should be reviewed. Polio cases in Germany have been virtually nil for the past decade. The vaccine, however, causes about 50 cases of paralysis in Germany every year. In 1993 there were 19 deaths (in a population of 80 million) from infectious diseases commonly vaccinated against in Germany – but over 2,000 claims for compensation for serious vaccine damage. The real figure is much higher and the link to vaccination of less severe instances of illnesses and disturbances caused by vaccines – like elsewhere – almost completely ignored.

Dr Buchwald spoke to audiences ranging from between 100–200 people. In Berlin he talked to about 900 people at the 75th Congress of the Berlin Biochemical Health Association. Dr Hertel from Bern, Switzerland, who is the president for Europe of the World Foundation of Natural Science, also spoke at that congress. He is very concerned about genetic engineering which he says is resulting in biological chaos and a degradation of life including human life wherever it is carried out. It serves, he says, not humanity, but money and power. Like Dr Buchwald, Dr Hertel is also concerned about the continuous injection of foreign protein into our children's organisms:

Vaccination is dangerous – to humans and animals – for a variety of reasons, one can look at it whichever way one wants. It is certainly foreign protein which is introduced into the organism. Just as in organ transplants here too the immune system reacts to reject it because its function is to keep its own protein and that of its species pure. The injection of foreign protein via vaccines is in violation of this biological integrity, resulting in an immune reaction. The organism is permanently burdened with pathological information in the form of proteins, viruses, bacteria and fungi it then tries in vain to get rid of. Vaccination in this manner influences the genetic code in a destructive manner, just as inappropriate

ways of life, industrial poisons and radiation do. Vaccination has nothing whatever to do with self-generated immunity. Vaccination with genetically engineered substances harbours the additional danger of burdening the human organism with modified, abnormal pathological combinations of genes against which the body may not be able to resist because it is not programmed to recognise such unnatural substances.

The new vaccination schedule promoted to New Zealand parents recommends that children receive 25 vaccines including boosters via combination injections and sips between the ages of six weeks and 15 months, with six more vaccines to follow at the age of 11. If the conclusions Dr Buchwald and other independent researchers have arrived at are correct, it may well be the health department policies (such as *Immunisation 2000* which are the most serious threat to our children's health and wellbeing, not measles or polio, etc.

The vaccination issue is one which has become of world-wide concern. There is an International Vaccination newsletter (published by Dr Kris Gaublumme MD in Belgium), which links organisations, in about 20 countries, of parents who share information. All of these organisations have come into being independently from one another, but are motivated by the same concerns.

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# Postscript: One Year On ....

Erin Morton

Direct Entry Midwife

I practise midwifery on the West Coast of the South Island having graduated from the Direct Entry Midwifery programme at Otago Polytechnic in December 1995. My practice is 100 per cent midwifery only care and 75 per cent home birth. Since my first client in July 1995 I have had 15 clients deliver.

When I first started as a new graduate I felt like a fraud. All I had which separated me from a student was a piece of paper and a star badge. And then it hit me. Total responsibility for people's lives. The buck stops with me. I thought being a student was 'enormous' but that's just a drop in the ocean when compared to being a midwife. This job has consumed me. 'Erin the woman' has been replaced by 'Erin the midwife'. I feel like I'm in over my head, like I'm drowning. Last month I was completely washed out to sea, but this month I'm much better and fully resuscitated!

This is a silly job! It's so up and down – an emotional rollercoaster.

So they want a review of my first year of practise. What are some of the significant aspects of my practice?

## Mentorship

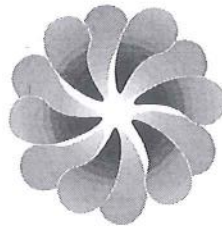
Without a mentor I could not practice in the manner I am currently doing. Unfortunately 'mentorship' means different things to different midwives and I think as a College we need to inform and support midwives regarding membership. I have got a wonderful mentor – Elinor Stratford. She has a wealth of experience and support which is shared openly.

## Experience

You see – it's a lack of experience. My head is full of textbook knowledge and I've not yet got the experience to counter balance it – so my practice is heavily tipped toward conservative. Personally, I think that it is just how it should be and half of my clients agree. However, the other half know exactly what they want and how they want it and intimidate and bully me! A wee example:

Primip – bleeding three days per vagina at term after intercourse (95 per cent sure there is no A.P.H.) I really, really want to do something. C.T.G.? Speculum? Scan? 'No!!' She says, 'I feel everything is fine

– lets wait and see Erin'. So I watch her across the fire on the beach, that calm summer's night. And I lean back against the house bus that she'll deliver in and wonder what will I do now. So I do what I do best. Document – pages and pages and pages. As I drive home I realise I'm the luckiest midwife in the whole world. This woman has no fear of childbirth and no understanding of why women have babies in hospital if nothing is wrong! She had a lovely home birth the next day.



## Support Networks

These are significant in my practice. I discuss different scenarios with a variety of practitioners and then find out where I fit in to it all. I read 'Heart and Hands, Beishcher, Myles and Enkin, Kierse and Chalmers'. Then I go back to my client and discuss what's happening to her. Sure enough nine times out of 10 she goes off on her own tangent and I'm back where I started ... cursing my lack of experience!

Another example where I spent hours on the phone and searching for research. Para 8 wants a home birth one hour from base hospital and I can't guarantee back up. I tell her the risks and the potential impact of my lack of experience, she says 'No Erin, it gets easier as you have babies', I did nothing to install trust in her – only my fears. She had total trust and I had NONE! Hardly surprising she had a BBA, eh?

I ask so much from my clients in our partnership. I demand they acknowledge my lack of experience and the impact it has on my practice. That I'm in a mentorship and frequently consult with other practitioners and that my practise is conservative.

\* What drives my practice?  
Trust, fear and women.

\* What impacts on my practice?  
1. Lack of experience  
2. Family (my own)  
3. Women  
4. Politics – I'm not going to discuss it – it's too ugly!

My lack of experience *really* bugs me. I'd give my wisdom teeth to have been a midwife for five years. I feel like it would be so much easier. Would it?

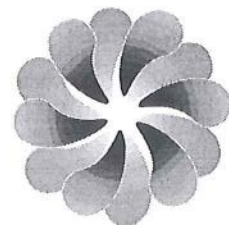
If you had to choose to describe your practise what would you choose? Mine would be:

1. Stress
2. Women
3. Stress
4. Stress
5. Stress.

I do sometimes wish I was back in a supermarket stacking shelves.

But it's nothing like anything in life – put nothing in you get nothing out. The job satisfaction is tremendous – but at what cost? Please tell me it get easier!!!!

Erin wishes to thank all midwives who given her support in her practice – to whom she she will always be indebted.



## Editor's Note

We need lots more midwives to write in about their practice – by sharing your thoughts we all gain insights and understanding. Please consider writing to us. Thank you, Erin.



# The Shared Journey: Models in Midwifery Practice

Mairi Lauchland

Midwife

Childbirth is a journey through a significant life event. Childbearing women share it with their families, support people and the midwife. The journey is essentially linear, culminating in a changed life for the woman and her family. For a childbearing woman, the quality of her experience is intimately connected to the people who surround her and the events that occur during her journey. The paths this journey may take now in New Zealand are various, yet the essence of the journey is the same for all women. In this article I offer a model of the shared journey set into its social context, showing the collaborative working relationship between childbearing woman and midwife, and showing some of the events along the way. I comment on different models and aspects of partnership, postulating that partnership is based on reciprocal trust, and acknowledging that research into partnership is just beginning.

The New Zealand College of Midwives (NZCOM) states that a clear social ethic exists within midwifery, reflecting the society in which midwifery operates (NZCOM, 1992: 1). The effect of this social partnership is an overlapping and a melding of the skills of the midwifery profession with ideas and philosophies of the women's health movement. The values of '... egalitarianism, co-operation, personal experience, holism, the demystification of health care, and empowerment' (Webster and Lipetz, 1986) affect women as both the consumers and providers of health care, describing many of the aspects of the midwifery partnership and mutual work in the partnership.

## The Use of Models in Midwifery Practice

The current model of midwifery practice in New Zealand is contained within the *Midwives Handbook for Practice* (NZCOM, 1992), produced by a process of collaboration between consumers and practitioners of midwifery care.

Guilliland and Pairman (1994) have recently expanded on this work. The *Midwifery Partnership* describes the professional status of midwifery in New Zealand from a feminist and political viewpoint (Guilliland and Pairman, 1994). The model is an interpretation and description of midwifery practice based on consumer surveys by various health authorities, submissions to various processes by consumers and midwives, and observations from the authors' and other midwives' practices. As the authors acknowledge, there is no 'documented analysis of what partnership means in actual practice ...' (Guilliland and Pairman, 1994: 6). Guilliland and Pairman have not carried out this analysis in their essay. The *Midwifery Partnership*, therefore, is an unresearched model of the professional status of midwives, not their clinical practice. This model, while worthy, must be treated with caution until the constraints within it have been tested by research.

Nursing models and the nursing process have been used and adapted for midwifery, generally within an institutional setting, but have been neither widely used (Bryar, 1988; Hughes and Goldstone, 1989) nor well understood (Murphy-Black, 1992). The models that have been used have tended to fall within an obstetric/medical model (Bryar, 1988). There is a need to research a model of care for midwifery that gives more emphasis to the 'wider social and cultural factors affecting pregnancy and childbirth than is found in many of the current models of nursing care' (Bryar, 1988: 116).

Missing in nursing models in particular were the close historical, social (Flint, 1986) and professional (Guilliland, 1992) links between midwives and women, the partnership and autonomy desired by both midwives and childbearing women (Guilliland, 1992; Guilliland and Pairman, 1994), the interlinking between women and their families/support networks with midwives and the larger health system that I have observed, and the wider social context of the process of childbirth (Barclay, Andre and Glover, 1989; Guilliland and Pairman, 1994).

The following model attempts to represent my personal philosophy and ideas of the process and context of midwifery care. It also represents a process of reflection on the bonds between theory and practice in midwifery during the childbearing process.

## Social Context of Birth

Society both influences birth and is influenced by birth (Barclay, Andre and Glover, 1989). Some influences affect the family more: such things are the social event of childbearing; culture, both the predominant culture in society and the childbearing woman's and her family's culture; and the role of women in society. Societal influences that affect the midwife more are; ethics, the politics of childbirth, disciplinary procedures, and the regulation of midwifery practice. Principles inherent within the Treaty of Waitangi, particularly *tinorangatiratanga*, both affect and are affected by the childbearing process, particularly if any person within the event is Maori.





## The Shared Journey

This model represents a midwife and woman partnership throughout the childbearing process. The important concepts are a working partnership, continuity of care and holistic care, all within the context of the woman's life, family and support network, and the healthcare system. All the different areas of family, health system and society interlink during the woman's childbearing; this concept is represented by broken lines between them.

The overlapping areas on the left in Table 1 represent the collaborative relationship between women and midwives. The overlap is greater for midwives than for women, showing the greater proportion of shared goals for midwives than women – childbearing women are the reason for midwives' existence.

There are elements of the relationship that are common to both, and which form the basis for a developing collaborative relationship. These are the politics of childbirth and the professional organisation of midwives, which I postulate are likely to be of more importance to the midwife than the childbearing woman in the clinical relationship. The major common element between midwife and woman is partnership. The partnership is based on reciprocal trust between the woman and the midwife.

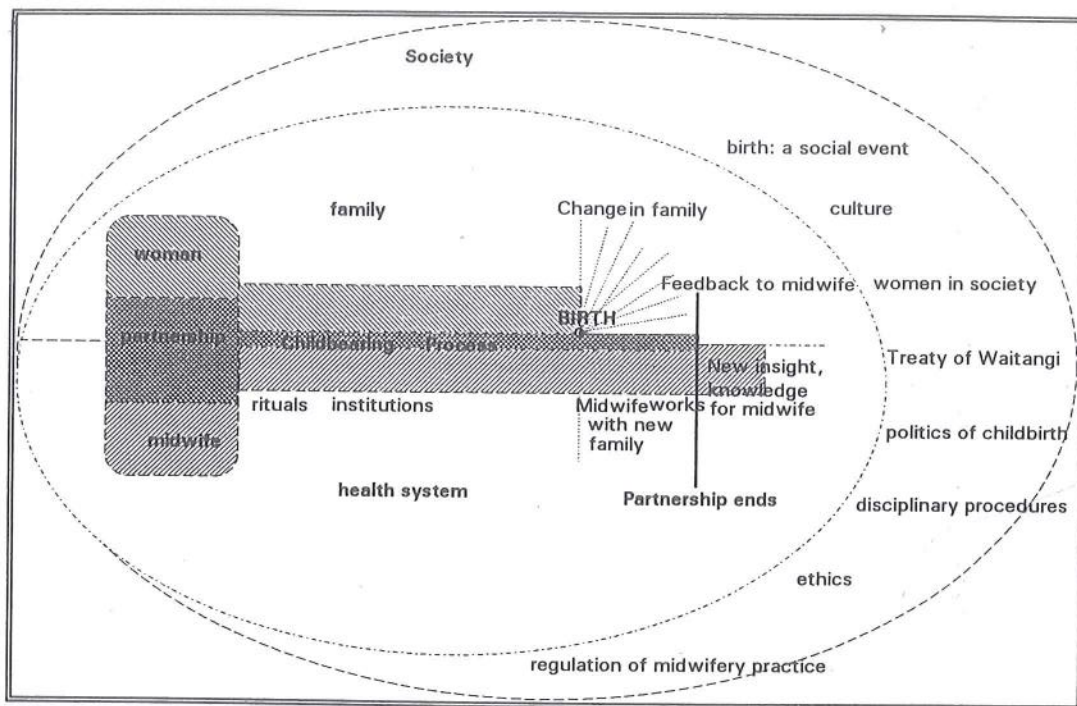
The midwife and childbearing woman each bring their experiences, culture and values to the relationship. The woman also brings her knowledge of herself, health and birth. She brings skills in staying well, self-care and may already have skills in parenting. The midwife brings with her midwifery skills, knowledge and education. She brings also knowledge of professional standards, ethics and midwifery review systems.

The partnership extends along the shared journey of childbearing between women and midwives, moving both through the course of childbearing.

Society surrounds everything, as childbirth is a societal event (Barclay, Andre and Glover, 1989) as well as a family, a female and midwifery event. The borders between the family, the woman, the midwife, the health system and society interlink and interconnect.

Surrounding and connecting with the midwife is the health system. Within the health system, midwifery and obstetric rituals and institutions, in which care is given, may have an effect on the shaping of the mutual journey together, whether or not the woman plans to birth in a hospital. Expectations from local and national bodies concerned with childbirth may also affect the way midwives will react in any given situation. Examples of these are NZCOM, Crown Health Enterprise Access Committees, local midwifery conventions and protocols.

Table 1: The Shared Journey



The journey changes at birth to incorporate the new family with the woman's care, the start of a changed life for both her and her family. Her family and support people surround and accompany her through her childbearing. The part they play is ultimately larger, more intimate and longer-term than the midwife, and this is shown graphically. At birth, lines reach out to the family as the family structure alters with the birth of the new baby. The midwife is now working with the new family.

The midwife's and woman's partnership ends, but the insights, new knowledge and feedback from the woman remain with the midwife, influencing her practice for the future.

### Partnership

Partnership in New Zealand is a cherished ideal, based on the collaboration between midwives and women's groups working on a political level, culminating in the 1990 Amendment to the Nurses Act 1977. Partnership continues at a political and organisational level with consumers having equal membership in NZCOM, along with midwives. The first standard of practice in *The Midwives Handbook for Practice* is partnership with women. Partnership has been extensively discussed and written about, yet the components of partnership and what it means in practice to childbearing women and midwives are only just starting to be researched.

Fleming, in an interview about her research on midwifery practice, talks about partnership and divesting of power being major issues, and a focus for midwives. Partnership with the midwife as a professional was important but not a focus for childbearing women. The midwife instigated decision-making on the issues that the woman needed to make a choice about, and the woman was less likely to be actively participating in major decision-making. She found also that total

continuity of care by a midwife was not vital to the woman, as long as they knew the midwife whom they could call on (Fleming in Gilkison, 1995).

Covenant is a term coined by Thompson to describe the type of relationship a woman and midwife may share, following a study of values midwives felt were important to their practice (Thompson, 1989). The original concept of covenant is biblical, describing mutuality, reciprocity and sharing in the context of a dynamic relationship. 'In its simplest form it involves three elements, an exchange of gifts, an exchange of promises and an alteration in the subsequent life of each partner' (Thompson, 1989: 195):

May (1975) in an unforgettable phrase, describes covenants as having 'a gratuitous, growing edge to them that nourishes rather than limits relationships'. He argues that the adoption of a covenant model frees the professional relationship from the one-sided paternalistic element of philanthropy inherent in codes of conduct or advocacy.

In Table 2, Thompson describes the midwife and mother moving through three stages of covenant together.

The negotiated partnership implied in covenant forms the basis for the partnership between midwife and childbearing woman. Covenant is an ethical construct, a framework that fitted a study of midwifery values. I have some reservations about the word 'compassion' with the connotations the word has of sickness or a traumatic event. A model of covenant has not been researched as it applies to midwifery practice and childbearing women. However, some elements of covenant have been researched in their own right, for instance, trust.

Table 2: The Three Steps of Covenant

<p>* <b>The exchange of gifts:</b> The mother offers trust to the midwife. The midwife offers competence, commitment and compassion to the mother.</p> <p>* <b>The exchange of promises:</b> The mother says 'I will share one of the most important events of my life with you'. The midwife says 'and I will help you live it fully and safely'.</p> <p>* <b>The shaping of subsequent life events:</b> Childbirth permanently changes a woman's life. The midwife's life, as well as her professional experience is enhanced by each birth she shares.</p>
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(Thompson, 1989: 195)

## Reciprocal Trust

Thompson asserts the basis of the relationship between midwife and childbearing woman is trust, supported by scrupulous promise-keeping (Thompson, 1989). Trust is defined as 'an attitude, bound in time and space in which one relies with confidence on someone or something. Trust is further characterised by its fragility' (Meise-Grochowski, 1984, in Morse, 1991). Further:

Trust is one of the most significant elements in health care relationships. It serves as a foundation for the kind of relationship that permits collaboration and co-operation ...

(Thorne and Robinson, 1988: 787)

Trust appears to be of fundamental importance to both the midwife (McCrea and Crute, 1991) and the client (Thorne and Robinson, 1988).

A health care relationship of reciprocal trust not only allows a collaborative relationship to develop, but enhances the client's self-esteem. The specific skills of:

... listening with intent, curbing preconceptions, soliciting the [client] perspective, and validating conclusions ...

(Thorne and Robinson, 1988: 788)

will help the development of reciprocal trust.

## Other Aspects of Partnership

In their essay on 'Midwifery Partnership', Guilliland and Pairman (1994) state that the formation and maintenance of the midwifery partnership depends on how well integrated into the relationship are the three concepts of individual negotiation; equality, shared responsibility and empowerment; and continuity of care. Most midwives would not disagree with these ideals, but I suggest that some of these concepts are not well understood. For instance, Guilliland and Pairman (1994: 7) state that '[i]ndividual negotiation is the method by which the woman and midwife work through issues of choice, consent, decision-making, power-sharing, mutual rights and responsibilities within the partnership'.

If we take the issue of decision-making for instance, Fleming states she found that women were 'less likely to be actively participating in major decision-making' (Fleming in Gilkison, 1995). Nursing research shows that it is the positive encouragement and confirmation by the professional that helps clients involve themselves in decision-making (Kasch, 1986; Drew, 1986). In other nursing research, the professionals expressed trust in their clients' competence to make good decisions about their health helped clients develop the confidence to make these decisions. However,

... [t]he competence described by informants was not equivalent to independent decision-making or assuming total control of their health care. Rather it reflected their capacity to make, share or delegate decisions in such a way that their own best interests were protected.

(Thorne and Robinson, 1988: 784)

Individual negotiation seems not to describe reciprocal trust and the positive encouragement by the health professional that enables decision-making to be made confidently by the client.

The concept of a shared partnership and passage through a significant life event is pivotal in Christensen's nursing partnership research (1990). In Christensen's model of the nursing partnership, the client and the nurse work together to help the client through their health related passage, with the work of both focusing on the client; there is mutual work to achieve a negotiated outcome. The nursing partnership comprises a number of dynamic, evolving nursing episodes which form the basis of the patient's progress through the passage. The mutual work is an essential element that shapes the nursing partnership (Christensen, 1990).

The concept of a working client, and the concept of mutual work, fits well with current midwifery thinking. However, the mutual work as it is described by Christensen (1990) has limitations as applied to midwifery. A 'significant lack of balance in this relationship between nurse and patient ...' (ibid.: 30) is described. This is attributed to the fact that the patient's energies within the nursing partnership are focused on themselves, making sense of events and getting themselves through the health-related event. In contrast, the nurse focuses outwardly towards the patient circumstances at any given time, and nursing wisdom remains with the nurse as they assist the patient through their health-related passage.

The concept of midwifery partnership differs in several respects; most importantly, the current philosophy of equal partnership between the midwife and woman differs from the concept of unequal partnership that arose from Christensen's research. Midwifery partnership is often described in intimate terms, for instance: 'Midwives and women are intertwined, whatever affects women affects midwives and vice-versa - we are

interrelated and interwoven' (Flint, 1986). Guilliland and Pairman (1994: 7) state that 'within the partnership both partners have equal status. Knowledge and power are shared between the partners and must achieve a balance which is negotiated and mutually satisfactory'.

Is knowledge and power-sharing, then, also a prerequisite for midwifery partnership to occur? Partnership is a research finding in Christensen's work, an ethical standard in the *NZCOM Code of Ethics*, and a description of the professional responsibilities of the midwife in Guilliland and Pairman's work. The views are not easy to compare. How can midwives encourage an equal partnership to develop? Is this in fact possible?

More research is needed on the midwifery partnership in clinical practice.

## Conclusion

A major element missing in discussions about partnership in clinical practice is the childbearing woman's viewpoint. If a partnership exists, surely the woman must ultimately be the judge of that.

More questions surround partnership in clinical practice than have been answered. What is a partnership? Is it a functional working relationship between a midwife and woman, or is it and should it be more than this? Is partnership a function of a longer-term relationship or can it adequately occur in the context of a team approach or episodic institutionally-based care? How much continuity of care is sufficient for a woman to perceive continuity? What skills and attitudes can a midwife bring to the relationship that will enable the development of partnership? What skills and attitudes does a woman need? All of these questions require further research. Guilliland and Pairman say that '... [a]ny theory which arises from practice is accessible and meaningful to all practitioners' (Guilliland and Pairman, 1994: 9). I suggest that any un-researched theory remains just that - a theory. Without research into partnership, any discussions on partnership can only be regarded at best as optimistic assertions, at worst, dogma.


I have written my own personal view on the process and context of midwifery care as a woman and midwife share the woman's journey through childbearing. I have set this journey into its social context, described the journey, and described aspects of partnership, acknowledging that research into partnership is in its infancy. It seems obvious that partnership between a woman and midwife is fundamental to the shared journey they undertake. Exactly how the partnership is formed and how it can flourish needs further investigation.

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*The BabySitter* is a child seat that has been utilised in Australia for over 30 years and is now available in New Zealand. *The BabySitter* is used and recommended by the majority of New Zealand and Australian maternity and childcare hospitals for all babies, including premature babies and babies with heart problems or gastric reflux.

Hospital using *The BabySitter* include National Women's, Auckland, Waikato Hospital, Capital Coast Health Women's Hospital, St George Hospital, New South Wales, and Royal North Shore Hospital, Sydney.

*The BabySitter* is lightweight, weighing approximately one kilogram. It is made of polypropylene, with webbing carry handles and has a lap belt with a quick release catch which helps keep the baby safe. The handles enable the seat to be easily carried around the house, from house to car, shopping, to restaurants, beach, etc. This keeps the baby in easy contact with its caregiver at all times. *The BabySitter* is not an approved car seat.

The chair has three positions from lying back to sitting up. This helps with the feeding of babies, particularly those experiencing problems with gastric reflux. The flat back of the seat enables the baby to sleep in comfort and helps promote easier breathing in premature babies. The design of the seat back is also conducive to the development of good posture. Babies enjoy sitting in the chair to play with play gyms and other toys or chat to their caregiver. The comfort of the seat is ideal for healthy babies and those with heart problems or general illness. For young babies we recommend the use of a head rest or roll of soft fabric to help support their head when using *The BabySitter*.

The liner of the chair is 100% lambswool and is washable. It detaches from the chair easily and is ideal as a changing mat when out visiting.

The chair is currently available in five pastel colours - mint, mauve, lemon, pink and blue.

*The BabySitter* costs \$79.95 including GST, plus \$5.00 post and packaging and is available from Peet Holdings Limited, PO Box 97320, South Auckland Mail Centre. Telephone (09) 625 1401 Fax (09) 625 1402.

COMING EVENTS

The 4th National Conference of the New Zealand College of Midwives (Inc.) 28-31 August 1996 Lincoln University Conference Centre Canterbury, New Zealand

Theme: Midwifery: the balance of intuition and research

Home Birth Association National Conference 1 September 1996 Christchurch (venue to be advised)

Third Annual Midwifery Today East Coast Conference

3-6 October 1996 New York City, NY, U.S.A.

Theme: Midwifery: Reaching Beyond Our Goals

Midwifery Today New York Conference

28 August - Pre-Conference Workshop 11-13 October 1996 New York City, NY, U.S.A.

Theme: Keeping Birth Normal

\* \* \*

Contact: 541-344-7438, 1-800-743-0974 Fax: 541-344-1422 e-mail at Midwifery@aol.com or write to Midwifery Today PO Box 2672-500 Eugene Oregon 97402 U.S.A.

Continued from Page 4

years from now we will know that the biggest crime against humanity was vaccines.

(The Medical Post, December 1994)

When Dr Lancot published her book The Medical Mafia, denouncing not so much doctors as the system they have to work under and condemning the vaccination racket, she was asked to resign by the medical association. She refused. When the controversy hit the media her book became a bestseller and outraged parents formed groups to support Dr Lancot.

For more information contact: The Vaccination Information Network PO Box 149, Kaeo, Northland.

Yours faithfully, Erwin Alber



Midwives on the Web

If you have access to the World Wide Web, you'll want to visit the award-winning Online Birth Centre (URL: http://www.efn.org/~djz/birth/birthindex.html)

your gateway to birth at home and midwifery information available on the Internet. You'll find articles on home birth in England and Australia, articles from past issues of Midwifery Today magazine, information about Midwifery Today products and conferences, and links to useful birth, natural health, and breast-feeding resources from around the world.

Be sure to check the Midwifery Today Calendar Listings page

(URL: http://www.efn.org/~djz/birth/MT/conferences/calenhtml)

or the Midwifery Today Home Page

(URL: http://www.efn.org/~djz/birth/MT/Mtindex.html)

to find the latest conference information, including detailed information on the 1996 Hawaii conference!

For more information, e-mail us at:

Midwifery@aol.com.

or call: 541-344-7438, 1-800-743-0974 Fax: 541-344-1422 or write: Midwifery Today PO Box 2672-500 Eugene, OR 97402, U.S.A.

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Most of you will be aware of our FREE Maternity Gift Pack and feature item Baby and You. These have now been distributed to over 1 million new mothers over the past 30 years.

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The Cranmer Maternity Gift Pack PO Box 15041 Christchurch Phone: 03 365-8200 Fax: 03 365-8200

Contact: Barbara Halliday



## BOOK REVIEW

**Title:** *Baby Massage – A Practical Guide to Massage and Movement for Babies and Infants*  
**Author:** Peter Walker  
**Published:** 1995  
**Publisher:** Judy Piatkus Publisher Ltd, London  
**Reviewer:** Ruth Martis, Midwife  
**Price in NZ.:** \$29.95

This book is Peter Walker's second book on baby massage. Initially I thought that the above book was the second edition of *The Book of Baby Massage* by Peter Walker, as it uses similar diagrams and photos, but it is a new baby massage book in its own right, as it includes also soft flexibility techniques, assisting a child in his or her efforts to achieve balance and a wide range of versatile movements.

I have been involved in teaching parents baby massage for a number of years and more recently, in connection with women that are suffering from postnatal depression. Touch is a baby's first language and his or her first love.

'Being held, touched and caressed is like food to the baby, food as necessary as minerals, vitamins and proteins' says Frederick Leboyer, who is cited in the book.

This book has been written for parents who are interested in massaging their babies up to the age of 15 months. The contents are well laid out and the four chapters are accompanied by clearly defined and well-labelled diagrams. Full page coloured photos enhance the understanding of the pleasure that massage brings to baby's and children.

Chapter 1 introduces the importance of touch and the background of the healing art of massage,

this includes a section on 'the skin', 'vernix' and 'essential oils'.

Chapter 2 presents practical information needed to begin to massage babies. It looks at benefits of baby massage and contra-indications. A gentle routine is given for the newborn which leads into a full body routine for babies of two months onwards.

Chapter 3 combines massage with movement and flexibility exercises to help assist the child through the stages of sitting, crawling and walking.

Chapter 4 presents information on using massage to help babies and children with special needs (e.g. prematurity, born by caesarean section or with physical impairment) as well as to help cope with a variety of common childhood ailments.

This book is written within a British context, hence it is missing the New Zealand/Aotearoa Maori context, which is definitely a major draw back.

However, midwives owe it to the women in their care to have a sound knowledge base about baby massage and this is one book that goes a long way to providing that knowledge. I have found it very useful. The recommended reading list at the end of the book is also a helpful tool.

## VIDEO REVIEW

**Title:** *Chinese Infant Massage (Paediatric Tui Na)*  
**With:** Chi Ying Chun and Jenny Allison  
**Producer/Director:** Peter Marra  
**Reviewers:** Barbara Wright, Lactation Consultant  
Helen Manoharan, Midwife

Chinese Infant Massage or Infant Tui Na, is one of the methods of traditional Chinese Paediatrics, which is itself a unique branch of traditional Chinese Medicine. From the sixteenth century until this century, infant massage has been a popular treatment method in China. After almost disappearing earlier this century, it is now undergoing a big resurgence in popularity in the last 10 years.

Infant Tui Na has the advantage of being a gentle, safe and effective method of treatment, and is well tolerated by babies and young children. It is generally used to treat children up to three years of age, but is effective up to six or seven years. In clinic it may be used alone, or in conjunction with acupuncture and herbal medicine, according to the tolerance of the child and the condition of the disease.

This video demonstrates the practical application of infant massage very well, serving as a bridge to the many books on the subject, and making techniques accessible to the practitioner and parents. It includes common techniques and massage media, the locations, functions and indications of massage areas unique to paediatrics as well as of commonly used acupoints, some common pathologies (including glue ear, fever, etc.), and a massage protocol for health maintenance.

It was filmed on location in China, U.S.A. and New Zealand.

If infant massage is of interest to you, you will enjoy this video.

Further information can be obtained by:

Ph/Fax: ++64 6 753 9169

Or write to: PO Box 8103  
New Plymouth  
New Zealand

### Order your copy of the New Zealand College of Midwives **Breastfeeding Handbook**

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Available from your local region of the New Zealand College of Midwives, or the Midwifery Resource Centre,  
906-908 Colombo Street,  
PO Box 21-106  
Christchurch,  
☎ (03) 377 2732.

**\$19.95 (including GST). Add \$2.05 postage & packaging.**





# Proposals sent to the International Confederation of Midwives From the New Zealand College of Midwives – December 1995

## RESOLUTION PROPOSAL Nuclear Testing

That the ICM condemns nuclear testing and the use of nuclear arms throughout the world in the interests of present and future generations.

Under the ICM Code of Ethics – midwives are expected to:

1. Eliminate harmful practices within cultures.
2. Empower women to speak for themselves on issues affecting the health of women and their families in their culture/society.
3. Act as effective role models in health promotion.
4. Participate in the development and implementation of health policies that promote the health of all women and childbearing families.

Nuclear testing and the use of nuclear arms threaten the health and wellbeing of all societies and environments. Women and their babies are particularly vulnerable to the effects of radiation and midwives internationally should take an active role in calling for an end to the nuclear arms race.

## RESOLUTION PROPOSAL Indigenous People, Cultural Safety and Midwifery

That ICM promotes midwifery education and practice that works in partnership with women and their families; expresses respect for individual and cultural dignity; affirms that respect; and allows for the cultural expressions and concerns of indigenous women and their people.

Furthermore – ICM develops guidelines for midwifery association to encourage cultural safety in midwifery education and practice.

1. 1995 was the start of the United Nations Decade for the world's indigenous people.
2. Many countries do not provide for full participation of indigenous peoples in the development of policies, strategies, planning and service delivery to improve their health status.
3. The midwifery component of the health service involves close and personal contact with a wide range of women and their families receiving maternity services.
4. Midwifery can provide leadership in establishing and maintaining partnership with indigenous peoples to ensure maternity services are culturally safe, acceptable and free from discrimination.
5. Midwifery can recognise the impact of the midwives' culture on their own practice and promotes practices where the cultural identity of all pregnant and birthing women is protected and respected.





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