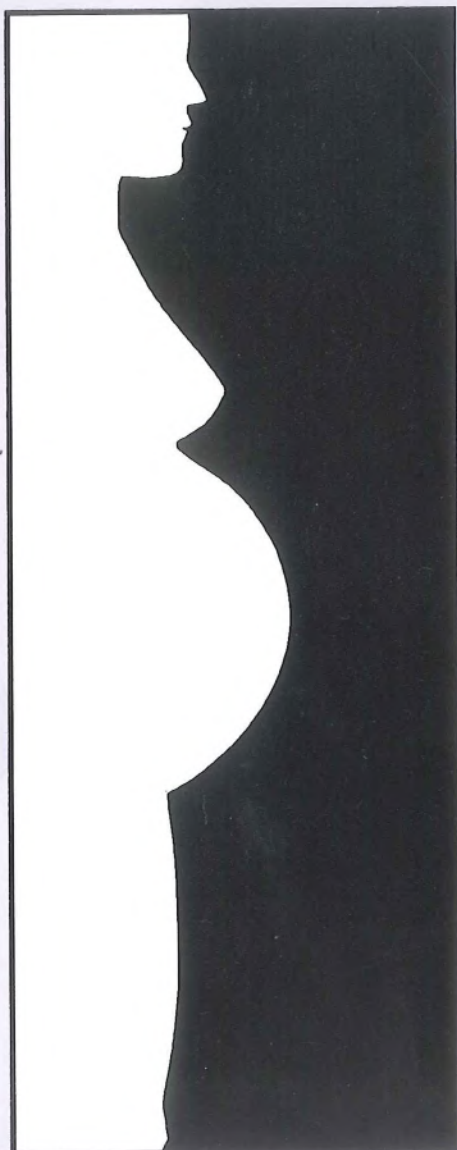




# JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, OCTOBER 1996







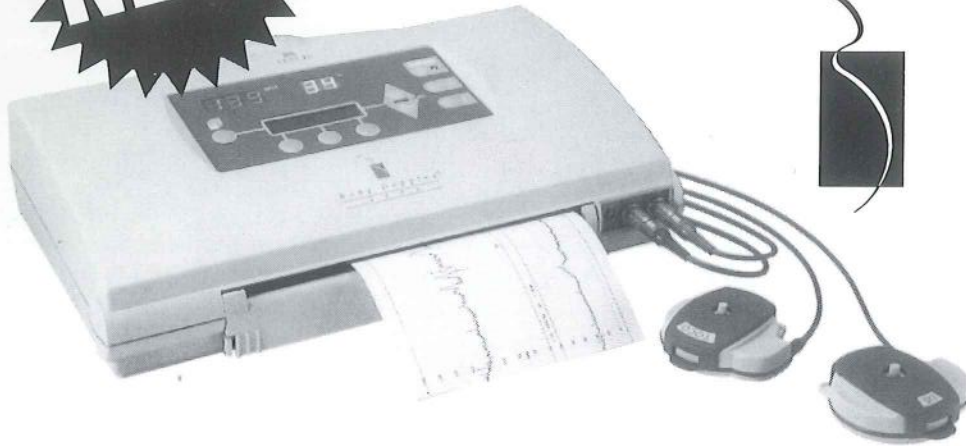
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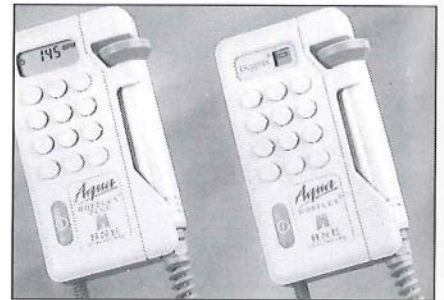
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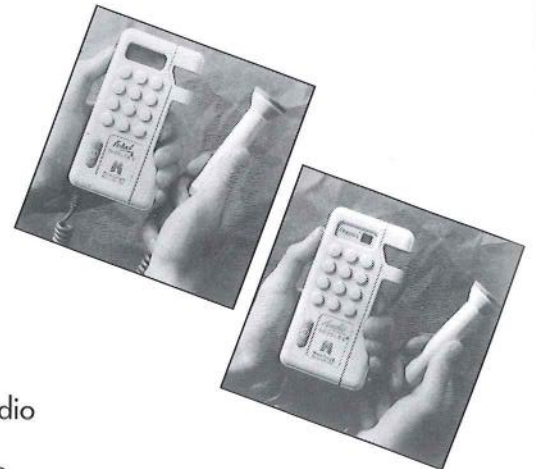
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- \* Promote women's health issues as they relate to childbearing women and their families.
- \* Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- \* Provoke discussion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

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#### Information for Authors

These notes are intended as a brief guide for contributors.

#### Articles

Manuscripts submitted for publication should not have been published previously in any form. Ideal length is between 1,500–4,000 words plus figures, tables and references. Authors should use concise headings and subheadings to identify sections of the article. Diagrams should be supplied as computer generated or as high quality line illustrations drawn in black ink. Photographs should be of high quality. All illustrations and tables should be captioned. All pages should be numbered consecutively, beginning with the title page. Manuscripts should be submitted typewritten and double-spaced on A4 paper (one side only) with 2.5 cm margins all around.

Abbreviations should be written in full followed by the abbreviation in brackets for its first use, e.g. World Health Organisation (WHO).

Preferably the manuscript should be accompanied on a computer disk either Macintosh or IBM compatible.

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#### Author Details

Please provide the following details:

- Name(s)
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- Address for correspondence (this is not printed).
- Current telephone and fax numbers where the author can be reached.

#### References (Harvard system)

In the text, cite the authors' names followed by the date of publication, e.g. Bowers and Thompson (1996). Where there are three or more authors, the first author's name followed by *et al.* will suffice. Style should follow:

- Bowers, A.C. (1996). *Clinical Manual of Health Assessment*. 4th ed. London: Mosby.
- Bloch, S. and Harari, E. (1990). Family therapy: conceptual empirical and clinical aspects. *Current Opinion in Psychiatry*, 3 (3), pp. 359–367.



## EDITORIAL

Great speeches are certainly not a thing of the past. Speeches packed with data, which were defiantly optimistic, uplifting and buoyant were plentiful at the NZCOM Conference recently held at Lincoln University in Christchurch.

Barbara Katz Rothman with her marvellous, witty, tumbling oratory presented a thought provoking speech – setting the scene for what was to follow. (We hope to publish Barbara's presentations in following issues.)

At the start of the Conference a Powhiri was held by the Tangata Whenua for registrants reaffirming our partnership which was celebrated by 400+ women participants.

Sally Pairman's opening address was faultless in its presentation filling the air with anticipation and electricity (of the human kind).

The New Zealand women can take great pride in the calibre of the political and professional women who have stood to represent us – Rt Honourable Jenny Shipley (Minister of Health) and the Rt Honourable Helen Clark (Leader of the Opposition) paid tribute to the midwives who had ensured implementation of a maternity service which reflects today's society.

Mention must be made of 'Midwifery through Time in Aotearoa' a dramatic presentation, heart-wrenching and tear-jerking, a creatively put

together history of New Zealand midwifery which lead us through to the present date.

Over the four days of the Pre-Conference Workshops and Conference, over 60 speakers presented workshops and papers – we owe a lot indeed to the Conference organising committee and the speakers for so willingly sharing their skills and expertise with us – thank you.

**Strong Women – Strong Midwives Indeed!**

*Helen Manoharan*

## LETTERS TO THE EDITOR

### Partnership Model

Dear Editor,

My background is science and it would be fair to say my bias has always been towards the quantitative end of the research spectrum. Recently however, I have been exposed to the exciting possibilities of the qualitative methods of enquiry. I believe a multi-method approach to research is very important. It was therefore with some concern I read the article by Mairi Lauchland (April 1996) on 'Models in Midwifery Practice'. While an interesting article which raises valid points she has used qualitative research to quantify her argument and this is simply not valid. Indeed it brings qualitative work into disrepute.

I have read both Guilliland and Pairman's monograph on Partnership and Fleming's original unpublished thesis where she interviews five women and five midwives and interprets their narrative in a thematic way. Any attempt to generalise or transfer the views of Fleming's interviewees onto any other population than those five is not possible. The danger of using extracts rather than returning to the original to make our analysis of the literature is apparent when Fleming herself says 'for the midwives and clients in this study partnership was a key issue'. This is in contrast to Lauchland's generalisation and interpretation. Fleming's thesis rather than contradicting the Guilliland and Pairman model complements it. Even so, neither Guilliland and Pairman's nor Fleming's work proves anything and Lauchland is right when she agrees with those authors that more research is needed before we move from the theoretical. Misusing the work that is available however, does nothing to further midwifery's quest for evidence-based practice.

Diane Chandler

### Vaccination Awareness

Dear Editor,

Viera Scheibner, PhD, recently warned that 'a great number of cases of meningoencephalitis and serious respiratory infections in small babies and children can be linked to the administration of vaccines which have a high potential to be contaminated by amoebas', which, she says, 'further highlights the need for prudence on the part of health authorities who, for yet another imperative reason, should drop their national immunisation programmes'. In the *NZ Medical Journal* of 24/5/96 Dr B. Classen of Baltimore, U.S.A., comments about childhood immunisations and diabetes:

We found a large epidemic of diabetes, 60 per cent increase, occurred in New Zealand following the hepatitis B immunisation programme ...

The hepatitis B vaccine as well as other vaccines, can potentially induce insulin dependent diabetes. ... Based on this mechanism and our early finding that diabetes epidemics have followed the widespread use of the Haemophilus influenza B (Hib) vaccine, we expect a second epidemic of diabetes to follow the Haemophilus influenza B immunisation programme that was started in New Zealand in 1993/4.

Erwin Alber  
Vaccination Information Network  
PO Box 149  
Kaeo, Northland.

### Bioscience in Midwifery

Dear Editor,

Thank you for the article 'How Useful is Bioscience Knowledge in Midwifery and is it Necessary for Safe Practice?' in the April 1996 edition of the *NZCOM Journal*.

I am puzzled as to how bioscience could be considered any way other than necessary for safe midwifery practice. Perhaps some of the confusion is caused by the concept of holism/wholistic which is commented on in the article. It is more usefully and more often spelled 'wholistic'. Spelling the word as 'holism' causes confusion with the concept of 'holy' and gives rise to religious or spiritual interpretations where they are not meant. The word originates from the Greek 'holos', meaning whole or complete. According to the *Dictionary of Modern Social Thought* the 'w' is a late 14th century addition to the spelling (Bullock *et al.* 1988).

It seems, therefore, that wholistic/wholism means, to validate, or add up all the parts, or constituents, or relations of the whole – of the birthing woman of anything. Given this view, bioscience is, of course, one of the parts that constitutes the whole story and context of the birthing woman and of midwifery knowledge. 'She' nor her-story do not exist in isolation but in a **whole** social and environmental context.

The article also reveals some confusion and ambiguity that exists around the word 'science'. The social sciences study social systems and social structures. They examine political and economic processes and interactions with the intent of establishing knowledge that is capable of being tested. Often this social science is diminished in importance because the so-called 'natural' or 'hard' sciences (of which the sciences of obstetrics and medicine are included) hold the dollar power and thus – usually – bureaucratic and phallogocratic power. But, perhaps, in the end it is the social sciences that are the 'hard' sciences as there is never one answer. Context and story are the answers.

Jeni Bryant  
Midwife

*Continued on Page 19*



# Welcome to Conference

New Zealand College of Midwives  
Biannual Conference  
28-31 August 1996  
Lincoln University

**Sally Pairman**  
President, NZCOM

**K**iaora Tatou. I am delighted to welcome you all to the fourth biannual NZCOM National Conference. We come together today from all over New Zealand and from further afield; from America, Australia and the United Kingdom. We welcome our special guests:

**Professor Barbara Katz Rothman** has been an inspiration to many of us who have read her works and appreciated her very clear understanding of the issues of power and control facing both women and midwives in the maternity and health systems today.

Welcome to our two kuia, **Mina Timutimu** and **Joan Donley**. Mina continues to guide us with her gentle wisdom as we move forward on the path to biculturalism. Joan with her untiring energy and clear vision is an inspiration to us all.

Welcome to **Jane Burke** and **Learn O'Brien** our tangata whenua representatives, we are grateful for your warm welcome and your hospitality.

Welcome to **Dr Erihapeti Murchie** who has made such a huge contribution to the health of Maori women. She has led by her example of partnership in practice and we applaud her support for nursing and midwifery's journey towards cultural safety.

Welcome to our colleagues from across the Tasman, **Dr Jane Fisher** and **Dr Caroline Crowther**. Jane's research provides us with greater understanding of the power dynamics surrounding pregnancy and childbirth and her use of quantitative methods to illustrate this is particularly useful. Caroline has been guest speaker at the Perinatal Society conference which was timed to allow us to share speakers with our colleagues in the perinatal health field. Caroline has major input into the Cochrane database which has proved to be a remarkable resource for midwives.

We look forward to your insights and contribution to our midwifery knowledge.

Welcome **Professor Jill White** who, as the Chairperson of the department of Nursing and Midwifery at Victoria University, is working hard to support midwives as they move into higher education and research and start to add a New Zealand perspective to midwifery's knowledge base.

Finally, we welcome the **Honourable Jenny Shipley**, our present Minister of Health, and the **Honourable Helen Clark**, Leader of the Opposition. Helen, of course, 'midwifed' the Nurses Amendment Act into legislation.

We are grateful to you all for coming and sharing your time and wisdom with us and we hope that you will take away some inspiration from our organisation and from the profession of midwifery in New Zealand today.

This year, although our conferences are not being run concurrently, the National Home Birth Association conference follows on from ours and there has been a great deal of collaboration in the preparation of these conferences. The Home Birth Associations have always been strong supporters of midwifery and midwives and it is fitting that our midwifery partnership with women can be demonstrated in such practical ways. Welcome to all the consumer participants who walk the journey of midwifery partnership with us.

Welcome to all of the presenters who have come to share their work and knowledge. It is exciting indeed to read the programme and see the large numbers of New Zealand midwives and women who are giving presentations. We certainly have come a long way in the last six years.

The conference theme is 'Midwifery: The Balance of Intuition and Research'. This theme reflects our understanding of the holistic nature of midwifery practice. In the current climate of scaremongering by doctors it is essential that we can demonstrate the research base of our practice and prove our effectiveness and safety whilst at the same time maintaining our unique relationship with women and valuing the intuitive aspects of our practice which have developed with time and experience.

Midwifery as we all know is a subtle art and midwives have great skill in helping women to balance and make sense of the many strands which will influence their pregnancy and childbirth experiences. Our work is often invisible and difficult to explain. As midwives who share the birth experiences of women, on a daily basis we understand the depth and subtlety of the phrase 'with woman'. We know that giving a woman time to talk during a pregnancy assessment is much more than just listening, it is getting to know this woman and finding out her fears and wishes for this birth and this baby. It is building trust. We know that rubbing a woman's back in labour is much more than helping her with the pain. It is connecting with her, sharing her experience, giving her strength and giving her confidence. It is also comparing her experience with all the other women we have been with, analysing all the signs we see, the monitoring we do and our knowledge of her, to decide whether this woman's experience remains normal for her. We know that having confidence in the woman's ability to make decisions for herself and her baby is more than just platitude. It builds her confidence and takes her further along the road to self responsibility.



Midwifery is the weaving together of all we know from science and from experience and from women and from other midwives and using this knowledge to help meet the needs of each woman we work with. It is our ability to balance the art and science of midwifery which makes our practice unique and allows us to offer women a truly holistic service.

Midwifery in New Zealand continues to face challenges mainly from medicine despite, or perhaps because of, our increasing support from women, as evidenced by the ever increasing numbers of women choosing midwifery-only care. Some 20 per cent of women are now estimated to choose a midwife to provide all of their care and 80 per cent of women now know their own midwife before they go into labour. This is a significant increase in only six years and it is easy to see why doctors feel threatened by this consumer shift away from medicine.

The media continue to portray the maternity service as a battleground between doctors and midwives despite our best attempts to get them to understand and represent the real issues. Most of the media continue to buy into the doctors' unsubstantiated and misleading claims that their concerns over the new Section 51 advice notice are to do with safety. As Joan Donley pointed out in a recent letter to the *New Zealand Herald*, doctors in 1993 claimed that shared care between doctors and midwives led to poor outcomes. This of course was during the Maternity Benefits Tribunal when doctors worked hard to remove midwifery autonomy. They did not succeed. Now, in 1996 when faced with a drop in income through having to share fees with midwives if they 'share care', they tell the public that lack of funding for shared care is a major safety issue. Now, according to doctors, the safest care for women is that shared between doctors and midwives and this option needs more funding. Interestingly our own data does not support these claims. The statistics we now see through the Standards Review Committees demonstrates that women have significantly better outcomes when cared for solely by a midwife than when cared for by both a midwife and a doctor. Of course, in 1993 doctors attributed these poor outcomes to the midwife. What we can now show is that the same midwife working with the same group of women will have better outcomes for total midwifery care as opposed to shared care. The added dynamic is the doctor and the underlying issues are those of power, control and gender.

The old (pre 1 July) maternity benefit fee schedule enabled the doctor and midwife to practise separately from each other and provided no real incentive for communication. The traditional doctor-midwife-patient roles were maintained and the inherent issues of power, gender inequities and control remained mostly unrecognised and unaddressed. The current Section 51 notice is an imperfect but at least beginning attempt to create a climate in which midwives and doctors must start to talk to each other, recognise and respect the part each plays in

each individual woman's maternity care and honestly discuss the payment this involvement deserves. Of course it was never going to be easy.

As a member of the negotiating committee for the past three years I recognise how difficult the process has been as we attempted to balance our midwifery perspective with those of the Regional Health Authorities (RHAs) and the doctors whilst still keeping the needs of women to the forefront. We have gone with our consistent negotiating committee which brings experience from politics, from education, from independent midwifery, from hospital midwifery and from consumers and we have given our best at every meeting. In between meetings we canvassed the views of midwives from throughout the country and we spent a great amount of time writing submissions and providing the RHAs with scientific evidence to support our views. We have always been clear about our fundamental principles. These were that midwives and GPs have statutory equivalence in the provision of primary maternity services and that as such both groups must be treated the same in the service specifications and in the payment mechanisms. The other was that women have the right to control the maternity service they receive and that the new structure must be underpinned by the principles of informed choice and consent.



The New Zealand Medical Association consistently brought about 16 doctors to the table, representing all the specialties as well as general practice. The members of their team changed constantly. The RHAs usually brought five representatives but the only consistent people were Sam Denny and Chris Geddes from North Health. I believe the RHAs have a real will to try to create a maternity system which places women at the centre rather than the provider, whilst at the same time meeting the government's need for fiscal restraint. What they did not appreciate in the beginning was the difficulty they would have in balancing two different world views. Midwives and doctors do see the world differently. What the doctors can't accept is that midwives are capable of providing care to women without medical input. Most of our work is invisible to them and therefore not valued. They

also pay lip service to the principle of choice and control for women. Their world view is patriarchal and positivist whilst ours sees multiple realities and takes a feminist perspective. Much of the time it felt as though we spoke a different language and our frustration was profound. Even when we provided scientific evidence to support our claims of the safety of midwives or the efficacy of continuity of caregiver, the doctors disregarded these. Interestingly, for a so-called 'scientific profession', they were never able to supply evidence for their claims. But with the arrogance born of years of unchallenged control over maternity services, this doesn't seem to worry them. Instead anecdotal and unsubstantiated stories were given great weight.

Fortunately for us the RHAs quickly gained some understanding of the real issues and were strong in their support for our bottomline principles and we have maintained equivalence with GPs in terms of practice and remuneration in the new proposal. We also achieved a great deal in the service specifications where, for the first time, the minimal expectations of maternity service providers are detailed. Midwives will recognise these specifications as the bare minimum of what they do daily, but to have even this spelled out as an expectation for GPs also was an achievement. The other positive achievements are the underlying principles of choice for women and informed consent. The expectation that the woman has an equal part to play in all decision-making and that ultimately the choice is hers, is a concept which will be new to many medical practitioners.

Where we had less success was when we finally came to talk money. The current Section 51 payment schedule is minimal, but we believe still provides adequate remuneration for a practitioner who provides the total service. Our main concern is that post natal home visiting is grossly underfunded. Midwives are seemingly expected to fund this service out of their own pockets as there is no reimbursement for actual travel costs to midwives. This expectation is unacceptable and we continue negotiations with the RHAs over this and other issues.

The most disturbing aspect of the whole process is the way the RHAs are allowing the doctors to manipulate women and the public for their own purposes as they seek more money and reject a framework to which their own negotiating committee had previously agreed. The actions of the doctors in publicising misleading information, frightening women and charging women for what is rightfully a free service are both immoral and unethical. Allowing the doctors to attempt to rewrite Section 51 in an effort to gain their support is depressing and serves only to show us that nothing much has changed in the balance of power. The way in which the doctors are setting midwives up in the media so that if their new proposals are not accepted it will only be because we are being unreasonable is even more depressing and difficult for us to counter.

There are some positive aspects to the Section 51 saga however. The public and some of the



media are becoming more sceptical of the doctors' stance. As some doctors withhold their services more women are turning to midwives to take on the lead maternity carer role. And, most importantly, midwives are standing solidly together. Despite the personal abuse to which many of you have been subjected by your medical colleagues, you have understood the real issues, trusted the College and supported our stance. This is really heartening. The maternity service cannot operate without midwives. We are the lynchpin on which it all stands or falls.

Section 51 provides all midwives, hospital and self-employed, with a real opportunity to practise independently within the full scope of practice as the lead maternity carer.

It is heartening to see how far the women's health managers have come in understanding the exciting possibilities which exist for their midwifery staff and the value they must place on these midwives. Similarly, hospital, employed midwives are keen to take on the challenge of Lead Maternity Carer. No one it seems wants to return to the days of fragmented midwifery with no opportunity to get to know the woman and work without continuity. The threats of doctors that they will subcontract only with Crown Health Enterprises (CHEs) for this fragmented care are empty in the face of the solidarity and awareness of CHE midwives. For the first time one early vision of the College looks set to be achieved. This was that all midwives, employed and self-employed, largely work independently and provide the total midwifery service on their own responsibility. It seems the adversity we face has served mainly to strengthen us and to clarify our vision. This is an achievement of which we must be proud.

As I said to you two years ago, I truly believe that if we can have the time, we will achieve our goals and the culture of childbirth will change to reflect a new society where women are in control of their own childbirth experiences and where birth is part of the usual life of the family and the community. We can make sure that we do have the time if we work together, ensuring that outside influences do not fragment us and set us against each other. We have seen what can be achieved through the united action of women and midwives. Let us maintain that unity and partnership and fight on together to achieve our goals.

This conference provides the perfect opportunity for talking and sharing and getting to know each other. Let us explore the art and science of midwifery together and use both to strengthen our practice and our understanding of midwifery. Let us use this time together to cement our bonds with each other and recognise all we hold in common. Let us use our power as women and as midwives to achieve our vision of the future. Enjoy the conference.

Tena Kotou, Tena Kotou, Tena Kotou Katoa. ■



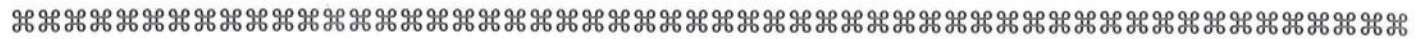
1996 Midwives Conference Organising Committee.

Conference dinner.



Karen Guilliland and Sally Pairman





# Address to the New Zealand College of Midwives National Conference

Thursday 29th August 1996

**Rt Hon. Helen Clark**  
**Leader of the Opposition**

**T**hank you for the invitation to address this fourth national conference of the College of Midwives.

The very large attendance speaks volumes about the dedication of midwives to maintaining professional contacts, networking and working as a collective.

These are qualities which have led to the profession in New Zealand making huge strides and, I believe, in establishing leadership for midwifery internationally.

Greetings to all who have come from all over New Zealand to this gathering and to those who have come from overseas. May you have an inspiring and challenging conference.

Midwifery has faced huge changes in New Zealand as in other Western countries. Had the dominant forces in the medical profession had their way in this country, midwives would have been permanently subjugated. Their places would have been as doctors' handmaidens, forever working under medical supervision – and never, never having the self-confidence and high self-esteem which comes from being independent professionals.

Fortunately that was not to be. Irrepressible spirits kept the cause of independence and autonomy alive.

Joan Donley and her sisters dared to think the unthinkable and the unthinkable became the possible, then the desirable and then the inevitable.

When the legislation for autonomy went through Parliament it was passed unanimously. It was a change whose time had come.

It was a change desired not only by midwives, but also by women. It opened up the possibility of continuity of care by midwives – through pregnancy, labour, birth and the postnatal period.

Those who had experienced that through the home birth movement and the services of domiciliary midwives knew what it meant. Pregnancy and childbirth could be experienced for what it is meant to be – a normal, healthy experience for healthy women.

I take enormous pleasure now in seeing these options opened up to so many more women.

And increasingly women have been prepared to opt for midwifery care only. The statistics compiled by Marjet Pot and Linda McKay point to that huge growth and I believe the number will continue to rise as the word spreads about the wonderful service which is available.

What has happened in midwifery in New Zealand is attracting world-wide admiration and respect.

Representatives of this College at international meetings are much sought after to find out how progress happened here and what others might learn from it.

And what a thrill it was to read in your national newsletter the wonderful article by Professor Lesley Page of London after her visit to New Zealand. She spoke of the strong idealism of New Zealand midwives, of your integrity of principles and purpose and of the pride within the profession here. From having worked alongside you throughout my 15 years in Parliament, I know this to be true. The support and care and respect I have received from midwives is something I will always treasure from my time in public life. And these are the very characteristics which the women of New Zealand see in you and value very much.

Professor Page spoke of the challenges facing midwifery: the challenges of rehumanising maternity care, of restoring the possibility of continuous and sensitive relationships between mothers and midwives from highly fragmented systems; of reducing high intervention rates; and of restoring pride in the profession of midwifery.

New Zealand rates highly in her estimation because the midwives have been freed to tackle these issues. Midwifery's self-esteem is high. There is pride in the profession. And continuity of care is rehumanising maternity care.

Of course we still face challenges. They lie in the other challenges Professor Page has mentioned and in the issues the profession has been grappling with in the health system here in recent years.

Many midwives have ensured that I have continued to be briefed about developments in the profession and between it and other health professions and the state's purchasers and providers of health care. Like you have, I





have often wondered whether we have taken three steps forward only to go two steps back, as debates have raged over access agreements to hospitals, payment arrangements and protocols for the management of pregnancy and birth.

Yet overall I remain very optimistic that midwifery will triumph because you are focused, well led and the women are on your side.

For the most part midwives appear to have accepted the move away from fee for service which the medical profession has found so difficult to accept. I have no difficulty in principle with a global fee for the management of pregnancy, childbirth and post-natal care – if the fee set is adequate. Fee for service at its best recognised the costs involved in providing each aspect of service.

A global fee is a problem if it is a mechanism for cost cutting by the state with adverse consequences for service.

It is critical, for example, that our rural midwives are adequately compensated for their costs in covering large areas, spending a lot of time travelling, having fewer, if any, colleagues to spread their workload with. I have been conscious for many years of the pressures on rural general medical practice and hope that for all rural primary health care providers we can offer a better deal.

The concept of the lead carer is also one with which in principle there can be little difficulty. Nor would there be any difficulty with it for the medical profession if their members were always designated as the lead carers! It seems that the prospect of the midwife holding the budget and maybe contracting in medical services is what presents the problem. We will just have to work through these developmental problems!

When I promoted the autonomy of midwifery, I envisaged not only that it would

facilitate independent practice in the community, but also that it would open up new opportunities for continuity of care by midwives employed in the public health system.

Initially the system was very slow to move and, I believe, ended up losing midwives to independent practice who, had there been more flexible systems operating from the hospitals, may have been willing to stay.

It is a pleasure now to learn of the changes taking place in our hospitals to make it possible for the hospital-based midwives too to take on a case load and offer continuity of care.

I do believe that the state also needs to work alongside midwives in independent practice in our small town and rural areas. Recently I was privileged to visit the birthing unit at Warkworth where the area health board used to employ midwives. Now the facility is the base of an independent practice – and a very welcoming and pleasant one it is.

What concerns me is the threat which hangs over services like this one of the Crown Health Enterprise (CHE) wanting to give up its responsibility for making the facility available and to exit the service entirely.

In the case of Warkworth, and I am sure of many other places, the facility has been contributed to over many years by the community. It seems wrong to me for the CHE to sell up and leave the midwives to fend for themselves. That would involve substantial financial outlay on their part – to the extent that we may drive midwifery out of rural areas altogether. There is a role here for partnership and I will be expecting the new public service health organisations which replace the CHEs under Labour to perform that role.

There are concerns emerging about the extent of cut-backs in our hospital-based maternity services. Reductions in the numbers of postnatal beds at Middlemore have led to a crisis in provision there. Frequently women are being detained in the delivery suite because there are no postnatal beds. The longest delay recorded was 13½ hours. Pressure, however subtle, has been placed on mothers to go home earlier than they should. In recent weeks a mother of twins, who were born at 36 weeks, was sent home after 36 hours. That is too early. I understand that another with twins born at 36 weeks went straight home from the delivery suite. In some cases, postnatal mothers are accommodated in surgical wards. There is huge pressure on the midwives on postnatal duties in the community.

All this tells me that cuts have gone too far and that the safety and health of mothers and babies is being compromised. The injection of funding for the public health system which Labour proposes will enable our hospitals to address these serious problems.

One of the major underlying problems in the health system today is the competitive model on which it is based.

I know as you know that our public health services work best when they are based on an

ethos of co-operation and caring and professionalism. The changes Labour proposes will enable our health system to work like that again. We will have health boards accountable to their communities again through elections – and accountable for providing services which meet the needs of people and not the needs of business for profit.

There are two other issues specific to midwifery which I wish to mention.

One is direct entry midwifery in education. What a thrill it is to see those midwifery education diplomas we made possible in 1990 transformed into the nation-wide model for midwifery education which it will become by next year.

I meet midwifery students all over New Zealand. They are inspiring in their enthusiasm and their commitment to women and to the profession. I acknowledge also the growing numbers of Maori midwives and welcome their contribution to making birth a positive experience for Maori women.

Finally, I turn to the future governance of midwifery. The review of the Nurses Act, now stalled I believe, should have offered opportunities for reconsidering the place of midwives under that Act.

I have always been open to the writing of a completely new act for midwifery if that is what midwives believe is best. I have great respect for nursing and will do all I can to promote the profession and status of nursing.

But midwifery is not nursing.

If that means recognition in a separate statute, then so be it.

Let me conclude my comments on this note.

Healthy pregnancy and childbirth is possible, achievable and desirable. But where women are poor, a healthy outcome cannot result.

In New Zealand today there is significant poverty. It is affecting women, men and children. We need a war on poverty. I am committed to eliminating it from our country. Our benefit levels, family support levels and minimum wage levels must rise – and they will under Labour.

Income-related rents for state housing must return. We must take the severe financial pressures off low income families. As midwives you will know the difference it makes for women to be well housed, warmly clothed and properly fed. These are the basics of good health and the Labour government I lead is going to provide them.

Thank you for the privilege of addressing you today. I wish you all the best for a wonderful conference.





# Beyond the Comfort Zone of Rage: Shared Experiences for a New World

Paper presented at the NZCOM  
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28-31 August 1996

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Midwives  
Canberra, Australia

Last year in Canberra we had an opportunity to write a new midwifery curriculum, an opportunity we were surprised to get and one we had thought we would never have again. We had expected midwifery to transfer to the tertiary sector but that didn't happen as anticipated and we needed more midwives. In writing the new curriculum, we tried to mirror the changes already happening in midwifery and to produce further effective and radical change. A vision for the future, if you like.

Bronwyn Davies, an academic who has done a great deal of research into the construction of gender, describes a post-structuralist theory of change which is useful when discussing the magnitude of change suggested by the curriculum. Davies says that effective change happens at three levels:

- the first is at the level of structure which relates to organisational factors and variously includes physical structures, laws and policies, institutional arrangements and many established practices.
- the second level at which change occurs is the level of discourse. An essential element in discourse is language but discourse refers not just to words or communication but to the power of language to construct reality. Our thinking and our practice are constructed through the particular discourses in which we find ourselves.
- the third level is the level of psyche or desire. This refers to individual desire which Davies and the feminist post structuralists say is also constructed. So, if we are about making change of any kind we need to intervene in the structures which hold the status quo in place, to create a new discourse or find ourselves a new position within the current discourse and to work at making changes at the level of desire in the individuals who are part of this discourse (Davies 1993; Browne 1994).

The Canberra Hospital (the then Woden Valley Hospital) 1995 midwifery curriculum embraces the need for new structures which support the process of birth in its social context as a normal part of life, a new discourse which names the normality of birthing, values women's contribution to society through the process of birth and recognises midwives' usefulness in this process and a desire to celebrate the joy of birth and the power of women in the bringing forth of children.

The 1995 midwifery curriculum conceptualises the woman as the central focus with midwifery encompassing that focus and has four interactive modules representing the theoretical concepts on which the curriculum is based:

- Midwifery,
- Women, Family and Society,
- The Process of Birth and
- Alterations in the Process of Birth.

The curriculum is based on a social model of health. It explores the way childbearing women and their families are influenced by the healthcare system and society and how midwives can be constrained in their work and education by these same influences. The nature of women, family and society, the process of birth and the nature of midwifery are examined and a primary healthcare approach encouraged.

Primary healthcare is the first level of contact of individuals, families and the community within a nation's healthcare system. Primary healthcare recognises that women and their families are self reliant and self determining and have a right and a responsibility to participate in their healthcare, in partnership with health personnel (World Health Organisation 1978; NCEPH 1990). A primary healthcare approach allows full utilisation of midwifery knowledge and skills and such an approach encourages midwives to provide holistic, women-centred care and demands a broader social view of health and illness as a basis for maternal and child healthcare (Brodie 1992; Walker 1993). The concept of midwifery as partnership between women and midwives described by Guilliland and Pairman (1993) is used extensively throughout the curriculum. We used the term 'Primary midwifery' to describe this image of midwifery as it is suggested in the curriculum. It follows that a concept of 'secondary midwifery' assists women to remain in control when they have some alterations in the process of birth or they are being cared for in an institutional setting.

We had discussed at length the disadvantages of attempting to implement a midwifery model in a tertiary setting which has a strong obstetric influence. We know that when midwifery transfers to the university, students benefit in some ways by being further removed from institutional work places. We also know that tertiary educated students will, in the main, work in such institutions on graduation and will then have to deal with the same joys, difficulties and abuse as their hospital educated sisters.



We attempted to address these challenges by implementing a process approach to curriculum. This approach fosters the maintenance and development of transferable or life-long skills such as critical reflection, effective communication, information processing skills and problem solving as well as social and life skills. A process approach spotlights the journey rather than the destination (Stein-Parbury 1994).

Jane Stein-Parbury (1994) says that her research into using this personalised approach to learning shows it produces greater tolerance for diversity and a greater understanding of the nature of the relationship between health professionals and the people with whom they deal. Bevis and Watson (1989) speak of the primacy of the relationship between students and teachers, suggesting that the relationship and the interactions between participants in learning and teaching are the curriculum. It is easy to continue this thought in midwifery education to women and midwives (or student midwives in the case of the curriculum) to say that the relationship and the interactions between women and midwives is midwifery. The similarity of these relationships is promoted by and through the curriculum.

While we were very aware of the possible pitfalls for the students (and others, including the course co-ordinator), we decided to 'go for broke' and write down and then facilitate midwifery which we believe is often women's choice and always their right. This is a discussion of the outcomes of that decision.

Now let me tell you a little about the maternity system in which the curriculum was implemented. Currently in Canberra we can afford for birthing women to have a one-in-five chance of having their baby by Caesarean section, but we can't do home visits for well women during pregnancy because that's a 'luxury'. We decide to borrow \$600,000 to buy an ultrasound machine for our antenatal clinic, but we can't afford to fund a community midwives programme. Women cannot have a home birth in the public health system in Canberra because it is deemed unsafe, but we can undertake research using serial ultrasounds for women who are pregnant with small babies. In Canberra, for most women, if they want a midwife to care for them throughout the whole process of birth they have to pay large sums of money and are rarely reimbursed. We have a new and expensive infrastructure to support medical education but the process of transferring midwifery to the tertiary sector is continuously stalled by lack of commitment and funding. Some days it feels like the transfer will not happen in my life time. In Canberra, visiting rights for midwives were rejected by a committee of four male doctors because the proposal 'did not attract support at this time'.

This is the environment we have in Canberra for women to do birth and for midwives' to do midwifery'. Into this world was born the class of '96.

## Kate's Story

From the moment I opened its covers I knew I was onto a good thing. The curriculum proclaimed 'feminism' 'partnership with women' 'birth as a natural physiological process' and 'primary healthcare' in big, bad, bold letters. My heart and mind lurched at the possibilities of the journey ahead.

Yet deep down there lingered a seed of doubt. Was it possible that all this could be achieved within a hospital? Historically, hospitals have always been patriarchal institutions famous for their oppression and abuse of women (Tew 1995), where the dominant paradigm of maternity care has been one of medicine and technology and where midwives,

... the oppressed ... 'submerged in reality' cannot perceive clearly the 'order' which serves the interests of the oppressors whose image they have internalised.

(Paolo Freire, cited Styles and McGregor 1991, p. 6)

This image has emerged time and time again in the form of horizontal violence between midwives (Hastie 1995) and the suppression of individuality and creativity. An image that historically has failed to meet birthing women's needs and cries for choice, control and continuity of care.

Casting this seed of doubt aside, the long journey of self-discovery, with 10 other women and an educator, began. At the very beginning we were told by a 'chief pretender' (O'Brien 1996) in her sensible way to prepare ourselves for the great midwifery changes that lay ahead. We wanted desperately to believe but our intuition proved correct for she spoke with forked tongue. Literature (Donnison 1974; Ehrenreich and English 1974; Barclay, Andre and Glover 1989), intuition (Davis 1993), research (Wagner 1994; Tew 1995; Arms 1994) and recent experiences have revealed that the women who dare to speak out are most often silenced (Birth Centre Review 1995). That the changes sought by many women and some brave midwives (Community Midwives Pilot Project 1996; and Strategic Framework for Maternity Services in the ACT 1995-1998) are suppressed under cover of economic rationalism when in fact it is institutionalised patriarchy.

We discovered that our educator fought valiantly for women's rights and social justice for all and this gave us strength. Her philosophy of partnership with women (Guilliland and Pairman 1994; Browne 1995) was extended to us on an individual and collective basis and we took this philosophy back to birthing women. When we faltered it was most often because we were not 'with woman' (Guilliland and Pairman 1994; Browne 1995). As students and women within a hierarchal system, no matter what anyone says, there is a sense of powerlessness as individual skills and expertise brought from outside to within are not recognised. Cogs in a machine that churns and spits out workers to serve the institution and

not the people it is there to serve.

The physical and mental exhaustion that has hounded us through full-time work and study has made research and political activism a difficult task. It is difficult to remain 'woman-focused' when exhausted, when you witness unnecessary medical intervention time and time again and when your rights and the rights of others are ignored. For how can you empower a birthing woman when you are disempowered? To pretend it doesn't happen is like pretending fear is not real for some birthing women. You have to validate the experience before it can be changed.

All fear has a basis and to belittle it is as damaging as not to admit its presence.

(Ingwersen 1996)

Throughout our midwifery journey we were introduced to wise women within and outside the system who made us question and hunger for knowledge. We were encouraged to pursue our own paths but were united by our 'woman-centredness'. We questioned and debated whether remaining within or stepping outside the system was the right or wrong way to go (Lecky-Thompson 1995; Bloom 1995, p. 57).

Reflective journalling (Johns 1995) has proved an invaluable tool in our growth as women and midwives. Journalling provides an insight into the machinations of our minds but there are inherent dangers in sharing the process with an educator. Mutual trust must be negotiated before you can begin and it is only fair that if you are expected to share, you should expect sharing in return. Journals are not just impersonal observations, they chart the territory we have crossed, the pain and pleasure of working through concepts and experiences and they contain drawings and quotes. For me they became the venue to critique fascinating papers and uncovered a love of writing, of playing with words and ideas. They grow in numbers on my shelves.

From the very beginning we knew our midwifery and feminist 'herstory' was difficult to access for history has been written in indelible ink by men and scribbled in the margins by women. We knew that all our private and public institutions (medical, religious, educational, legal, financial and the family) have always oppressed and abused women (Thompson and Thompson 1991; Davis-Floyd 1990). We knew all this but as we peeled back the layers of gender construction that have led to the oppression of women we uncovered more pain and discovered rage.

And it should be noted that there was a defect in the formation of the first woman, since she was formed from a bent rib, that is, a rib of the breast, which is bent as it were in a contrary direction to a man. And since through this defect she is an imperfect animal, she always deceives.

(Malleus Maleficarum 1486, cited Davis-Floyd 1990, p. 178)



At times the rage and the pain at the inequalities posed by gender immobilised us. It would have been easy to stay within this comfort zone of rage but we recognised that the greatest challenge for us as midwives and women was to move beyond this zone for it inevitably leads to a dead end if rage is our sole motivating factor.

Our collective endeavours to remain 'women-centred' at all times has united us through thick and thin. It has prompted political action and was the inspiration for our first attempt in taking midwifery back where it belonged, in the community. Such has been the subjugation of midwives in the ACT, that one of us was asked 'who allowed you to do it?'

Under the auspices of the ACT Branch of the Australian College of Midwives, beneath a beautiful purple and gold banner bearing the words of our New Zealand sisters and with the support and goodwill of many we marched forward. We designed, printed and widely distributed a pamphlet listing all the midwifery services available for women in the ACT, media coverage of midwifery was promoted, defiant road banners proclaiming 'Start Life with a Midwife' were hung throughout Canberra and we wore the T-shirts we designed and printed proudly within and outside the hospital. We even held the ubiquitous cake-stall and raffle to pay for our efforts. Our endeavours culminated in brilliantly successful stalls promoting midwifery at local markets. These were visited by hundreds of women and their families. Each time the 'boyish pretenders' (O'Brien 1996) lay in wait and each time they pounced.

As Tricia Murphy-Black (1995) says,

What is the point of marching behind banners selling T-shirts and writing letters if the decisions are to be made by the comfortable men ignoring the opinions of the uncomfortable women?

We were dismayed but not beaten by the medical model of maternity care because we were encouraged to listen to the different voices of women, respectfully individually and collectively (Hunt 1995). We learned much from them and they from us. These were the stories that did not appear in medical histories, progress notes and much of research. These were the stories of domestic violence (Lohse 1996), sexual abuse (Lehane 1996), discrimination (Jelinek 1996) and different ways of working (Haverfield 1996; Parker 1996; Smith and Ellis 1996). Perhaps the right questions in a different voice to that of medical men had never been asked. Perhaps they had but the answers were deliberately omitted because they were in the realm of 'soft' (Oakley 1983), outside the medical 'norm', or liable to result in judgemental or punitive treatment by others.

Working with the curriculum we uncovered many and varied areas for midwifery research. We have to move beyond the gender stereotyping of researchers by midwives (Hicks 1992, 1994,

1995), the bias of research committees and hospital management in favour of medical models even with all their faults (Barclay 1995) and the negative attitudes of doctors and others to midwifery research (Hunt 1987; Sleep 1992). These beliefs and attitudes have held us back in the past. If we can change these beliefs and attitudes then the feminist models of research and their results (Hall and Stevens 1991) and those incorporating anthropological and sociological methods will be valued and not shelved.



The curriculum promised primary healthcare, but its full meaning was not to be. This excellent model promoted by the World Health Organisation promotes accessibility, individual needs instead of standard protocols, and shared control and empowerment rather than medical and hospital control (Walker 1993; Young 1994, 1995). Why are midwives so afraid of stepping back into their community, preferring the comfort of rosters, the rumblings of their discontent, the well-worn corridors of power and the closed doors that keep women out? Are they so disempowered that they cannot imagine taking hold of power with other women without the support of the medical model or do they rightly fear financial difficulty, exploitation and rejection by those who remain within? The picture of government support for women's health has never been a pretty one. Its support is usually short-term, election motivated and liable to be cut when media attention fades to chase after the next 'flavour of the month'.

As student and educator we were aware that the curriculum might set us up for failure. Sometimes we saw it coming and were prepared, but sometimes it caught us unaware and left us battered. Then our recovery was slower but because we believed in the power of women we were reminded that through examining the personal experience of many and raising awareness

of the collective nature of privately experienced pain (Sawer and Simms 1984, cited Hopkins and McGregor 1991, p. 8), the personal becomes political with its own driving force to seek social change.

With our 12 months drawing to an end and the recognition that 'our work is undertaken in the context of massive social change and increasingly complex societies' (Barclay 1995, p. 3522; Page 1995) our journey has just begun. It is time we looked beyond midwifery, to the successful strategies adopted by new social movements such as the peace, environment and domestic violence movements. These movements have used consciousness raising strategies to mobilise grassroots workers. To get governments to act they have used lobbying electoralism and the bureaucracy in different configurations to those used by midwives. For example, the domestic violence movement has successfully used the Women's Electoral Lobby and various offices of women's affairs at state and federal levels drawing on the power of femocrats to empower women. A strategy which appears to have been overlooked by midwives.

### Jenny's Story

The class of '96 has been special. It is as if the women in the group have the spirit of midwifery. They have the freedom and strength to practise midwifery even within a system which actively undermines their ability to do that. The group is cohesive far beyond the solidarity which can normally be explained by studying and working together. They have a group think and speak which is striking. They are strong and brave and women-centred and absolutely sure of their own rightness. They are realistic, honest and practical. They have a courage which is contagious and remarkable. They have made a difference and I believe they will continue to do so.

Together with birthing women and other midwives who have been active in demanding and instituting change, they have fought the system which is outrageously blatant in its conservative view of pregnancy and birth as potentially if not actually dangerous. They have fought the medical model on a daily basis in assisting women to grow their babies, labour and give birth and care for their children in ways the women want to. They have carried their beliefs into the public arena, where truth is seldom told in Canberra, learning painfully of media bias caused by powerful vested interests. They have laboured long and hard to promote and provide a birthing system which serves the interests of women and their babies and their families in Canberra, not the interests of the care givers, be they medical, nursing or midwifery. They have translated the words of the curriculum into deeds and in so doing have transferred their rage into useful action. They have given me strength to keep fighting.

What of the future? Before I met these women I wrote in the curriculum:



Childbearing women and their families need midwives who are strong, knowledgeable, clinically competent, caring, politically astute, politically active and brave in the face of adversity. A confidence in women's ability to undertake the process of birth, a strong belief in midwifery and an attitude of 'we are in this together' are needed by midwives in order to meet the challenges of the future.

## The Next Chapter

As we come to the end of this story, another unfolds. Listen carefully, pretenders and medical men, for we were strong women before we entered your institutions and we are stronger and wiser now. We have taken back the secrets you stole from us and we will not rest until there is justice for all women. Be wary, for we know that the secret of walking on water is knowing where the stones are.

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# On the Edge: Midwifery and the Art of Knowing

Paper presented at the  
NZCOM Conference  
28-31 August 1996  
Lincoln University

**Bronwen Pelvin**

**Midwife**

The theme of the 1996 conference is 'The Balance of Intuition and Research' and when I first heard it, it set me thinking about another theme which becomes a part of the life of a midwife and that is the concept of 'not knowing'. What I want to do in my paper is explore that idea using some examples from my own midwifery practice and my career. I want to look at the need for midwives to develop abilities which can assist them to adapt to working in a profession that deals with the life process of a woman going through a profound experience of the birth of a baby; doing it over and over and over again with each individual woman that they care for, with all her individual circumstances – not only her social environment but more importantly her intrapsychic process and her changing relationships with those around her.

Midwifery is a living, breathing profession that grows and develops in relationship to each woman we connect with; also within each midwife as she increases her understanding of her roles and functions not just in relationship to each woman, but also in relationship to women as a group in society and to society as a whole.

My main purpose in presenting this paper is to get midwives thinking about their own internal functioning and become more conscious of the things that motivate and inhibit us in our ability to function within our chosen profession. I also want midwives to become more conscious of the importance of the work they do in relationship to women and the responsibility they have to 'model' a way of dealing with life that will be of assistance to the women they care for.

As I begin to address this topic, I am really aware of my own life path. I attended my first home birth up the Wanganui River in 1974; followed that with midwifery training; set up in practice to attend home births in Nelson; left that 15 years later to manage a maternity unit in Timaru, and now am on the brink of who knows what! I am aware that at each stage of decision-making in my own life, it is only with hindsight that I can see a purpose in all the above and it is the ability to see that purpose backwards that gives me the ability to move forward into uncharted waters, both professionally and personally with the faith and trust that I am, in fact, going somewhere. I don't know where. I don't know.

Let's start with the life process that we all deal with whether we work providing continuity-of-midwifery care or care while on rostered shifts or in a supervisory role over a maternity service.

Pregnancy and childbirth – an enormous journey for a woman and also for the midwife who connects with her in that process. If she provides the woman with continuity-of-care, the effect can be, and often is, profound; if she meets the woman while she is working rostered shifts, the midwife's knowledge of the woman's own process is less deep but it can still have an effect on the midwife's practice and her life. For this to happen, however, the midwife must have developed her own internal reflection on the nature and content of her midwifery practice.

In this process there are certainties and uncertainties, and they are sometimes combined. A woman becomes pregnant, she will have a baby. Or will she? She is fit and healthy; she will remain so because pregnancy is a normal state for women. Or will she? She will have a healthy baby because she looks after herself so well; or will she? All will go well with her birth because she has given birth twice before; or will it? This woman will be able to breastfeed because she is so relaxed about her body; or will she? On and on and on. All the things that we feel sure of and think we know until the reality of a particular woman and her particular physical, physiological, mental, emotional, psychological, spiritual and social circumstances interact with the process she is going through.

I'll use some examples from my own practice as a midwife to demonstrate.

The woman who ruptured her membranes at 36+ weeks gestation and did not want to go to hospital to be induced. I visited her on a daily basis for five days until she went into labour; she took her temperature; I checked the condition of her baby and the status of her contractions (or lack of) every day. I checked with her that she wanted to continue with this decision. She already had two children before; there was no reason to anticipate any complications occurring so we dealt with it, making it up as we went along.

A woman with a history of two normal pregnancies and births presented at 35 weeks gestation with hypertension and a placental abruption. A caesarian section was performed resulting in a stillborn baby. Who could have anticipated or predicted this? The woman who went four weeks past her due date but still wanted to stick to her homebirth in the water pool – nothing to give me, as a midwife, any inkling that I would have to deal with this. The four babies who all were born within 16 hours, half an hour apart at each end of those 16 hours and all with due dates nowhere near each other! The woman expecting her first baby and in perfect primigravid health



who turned up at 34 weeks' gestation without having felt her baby move in the last two days. The phone call from the general practitioner in the early hours of the morning to tell me that he has the woman who gave birth completely normally 48 hours ago is at his place with her baby who is dead. Who could have prior knowledge of this?

This is not to mention the other aspect of unpredictability that midwives deal with on a daily basis, that is the timing of these events. Any time of any hour of any day of any week of any month of any year! And we have to be ready to drop what we are doing and respond. This also happens to rostered shift midwives; the only difference is that they get to do it for an eight-hour period on any given day and they know in advance which those days are going to be.

So talk to any midwife. We all have a fund of stories relating to events and times we have experienced. They demonstrate the unpredictability of the process that we are connected with and the 'unknowability' of what we can be doing on a daily basis. This is not even to mention the unpredictability of the political aspect of our work - Section 51, Crown Health Enterprise restructuring, the election, etc. etc!

While working at Timaru, I've been fortunate to come in contact with both midwives and nurses going through the degree programme at Otago Polytechnic.

One paper that I've observed them doing is 'Journalling' and I've been impressed with this as a tool for developing insight into one's own functioning. I've never kept a journal during my midwifery career, and probably nor have a lot of midwives, but I know that the hours I've spent driving zillions of kilometres to women's homes over the years have afforded me an opportunity to reflect on the things that have happened and my part in them as well as try and work out what the woman's process is and reflect on her relationship with her baby and how I can best help them get together. I know that many of you do the same thing - and if you aren't doing it, you should be!

The ability to reflect on events and our own functioning helps develop our ability to not only deal with those events as they happen, but it also helps us to deal with the unpredictability of the many and varied things that occur in relation to pregnancy, childbirth and the postnatal period.

Midwives in their educational programme learn the basics of midwifery practice and consolidate that with their experience of working with women, their babies and their families. What also needs to happen is that midwives need to learn to be in a state of readiness to respond to any situation at any time because we are working within a process that any event can occur at any time and as we are the ones that respond to those events in our professional capacity, we have to be ready to deal with them.

Obviously a midwife who chooses to work as a continuity-of-care midwife and to enter into a partnership with the woman who is going on

this unpredictable journey is exposing herself to working with the unpredictability of the when, what, how of childbirth and its related topics. But midwives who work rostered shifts also have to be prepared and vigilant to deal with the unpredictability of their lives within a maternity facility, especially if they are still in the situation of having to care for women who are in labour and giving birth or who are in the antenatal or postnatal wards in this country. We are all in the business of having to deal with not knowing what is going to happen at any given moment.

How does intuition relate to this aspect of our work? I've never considered my intuition to be very highly developed, so I've always functioned pretty much in a state of 'not knowing'. I imagine that those midwives who do have highly developed intuition, have it in relation to individual women and the events that will occur to them and maybe even the when of those events. My basic contention though, is that some things will always remain 'unknowable' until they actually occur. I believe that the woman's intrapsychic process is 'unknowable' except on reflection and in hindsight, just as our own intrapsychic process is to us. While I accept that midwives often have 'feelings' about one or other

of their clients, it is not until the actual specific events occur that the basis for the 'feeling' becomes clear. To operate in a state where you believe you 'know' what is going to happen seems to me to be somewhat dangerous in relation to an unpredictable, life-and-death process. Far better to be in a state where you are ready for anything!!

I see the attribute of being in a state of 'not knowing' and ready for any eventuality as one of the most important developmental tasks of midwifery; one that we need to be more conscious of aiming to develop and more able to discuss with each other when we meet together. Having to be 'ready' to deal with any event, some of them traumatic and life-threatening, some profound and wonderful, all highly significant to the women and families who are experiencing them creates enormous stress on the midwife as she strives to practise her profession to the highest standard as well as meeting the needs of those she cares for. We have to develop the ability to take care of ourselves and the acknowledgement of what we are actually doing on a daily basis is a first step in being able to care for and nurture ourselves so that we can keep doing our important work in the world.

  
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# Breech Birth Woman-Wise

**Maggie Banks**

**Midwife**

My interest in breech birth was sparked as a student midwife when I was working in the delivery suite at Waikato Women's Hospital. A woman was about to birth with her baby coming bottom first and all the obstetric staff were busy doing Caesarean sections. The midwife in charge said, 'no problem, you come with me', which I obediently did. The woman was 'delivered of her breech' by a series of twists, turns, manipulations uplifting, pulls and general manoeuvring. The baby was then lain on the woman's abdomen, she having been supine throughout, where both baby and woman looked stunned and shocked. The charge midwife said to me, 'who needs an obstetrician – that was great experience for you'. My initial reaction was if that's what breech birth is all about, who wants a midwife either? The woman may have escaped the epidural, lithotomy, episiotomy and forcep but her baby's birth was none-the-less manipulated and managed with the woman having no control over her own body or experience.

My further experiences of breech birth as a midwife in Waikato Women's Hospital were of the routine variety where women either had elective Caesarean sections or induction of labour at 38 weeks. The odd situation arose where a woman would present with an undiagnosed breech about to birth and there would be a great flurry of Ohio resuscitaires, a clanking of delivery trolleys being set up, flushed and panting anaesthetists and paediatricians arriving and house surgeons with gleams in their eyes as they anticipated 'delivering the breech in Theatre 5'. Amongst the pandemonium would be a woman struggling to get up on a bed that was too high for her only to have half of it disappear, her legs held astride as she was put in lithotomy and her perineum spotlighted. Taken out of her labour rhythm she was instructed to push or not to push according to the whim of her deliverer, to which she responded with wide-eyed obedience. After the frenzy was over and the baby was cocooned and her wounds were being stitched up there was always the inevitable talk about how lucky she was to be in the safest place and how badly these things can sometimes turn out.

The experience which rocketed me into a new dimension happened at home two-and-a-half years ago. Sally, who was having her first baby, was pushing. She lounged in a birth pool between contractions and stood each time she had the urge to push. When I saw the baby's purple bottom instead of a head I was stunned. She lived approximately an hour away from hospital so transfer was out of the question. I got her out of the pool to check that she was not pushing with any cervix left. She put her foot up on a stool so I could do a vaginal examination. That action saw the baby being born to the hips with the next contraction and it was obvious nothing was going to stop this little girl from being born – and very soon. At the end of that push Ella was born to her waist with her legs still folded against her chest. Her legs came down with the start of the next push and her arms popped down at the end of it. After the end of the next two pushes Ella was hanging by her head and was born with the next contraction.

However, stunned as I was at the time with an unexpected breech presentation, a similar thought came to me as it had many years ago with vertex presentation. I wondered how many of the problems associated with breech birth are *created* rather than inherent to breech birth. The answer has led me to support women in planned home births with breeches. This was just as well because the next time Sally was pregnant she again had a baby who sat in a breech position – probably from conception!

As student midwives we are taught the four "p"s of labour – the psyche, the passage, the power and the passenger. Perhaps a fifth and sixth should be added – the politics and the partnership.

## The Psyche

Seeking out options with obstetricians at Waikato Women's Hospital can be a shocking experience for pregnant women (Donna 1995, Heidi 1996). The consultation has proved to be very effective motivation for women to find alternatives. Donna, having made a decision through her pregnancy to avoid the induction of labour for postdates she had with her last two births, could see all her control rapidly disappearing. Her wonderful midwife had spent much time with her and this was the first pregnancy in which she knew what was going on and where she had been given the support and information to question routine care. She knew she could give birth to her baby, but she could see she would not be supported in Waikato Women's Hospital in the way she wanted so she birthed at home.

Sally's second baby was palpated as breech from 31 weeks. I gave her information on the options for encouraging a breech to turn. She chose to use homeopathy at 35 weeks. It had no effect and her attitude was my baby is breech – so what? Sally was well aware of the recommendations an obstetrician would make to her and certainly birthing at home would not be one of them. She declined to see an obstetrician. She did not see her baby's presentation as a problem and for me to pursue it would have created



one. So Sally and I decided that she was back to having a baby rather than having a breech.

Nwosou *et al.* (1993) found that 'breech presentations diagnosed for the first time in labour were more likely to deliver vaginally than those assessed and allowed to go into labour'. He reports morbidity is inversely related to the dilation at the time of diagnosis in labour (*ibid.*). While many midwives have said to me that it is best not to know the baby is breech until the birth, I do not like surprises in labour and prefer to know.

Fear can be a major immobiliser for both labouring woman and attendant. Gimovsky *et al.* (1983) report a neonatal death in the study of nonfrank breech presentation. The woman, a 20-year-old whose antenatal care started at 34 weeks and who laboured at 36 weeks, was reported to have become hysterical as the baby's midriff was being born. She was anaesthetised and her baby was delivered by extracted breech. He was asphyxiated and failed to respond to resuscitation and died. Cooper (1992) and Gaskin (1986) stress the point of trust, relaxation and a lack of fear as being major factors in allowing the baby to come readily in second stage and in preventing entrapment of the head.

Odent (1994) identified the nocebo effect as being the opposite to the placebo effect. Nocebo from the Latin means I shall do harm. He notes language can have a powerful impact on birth by increasing or decreasing anxiety. After attending 300 breech births he states 'the word breech when used in labour has a strong nocebo effect' (*ibid.*).

## The Passage

Steady dilatation of the cervix in labour with the descent of the baby's presenting part is the best indicator of pelvic adequacy regardless of whether a baby is coming head first or bottom first. Manual pelvic assessment prior to labour is therefore of little value. X-ray pelvimetry is of no value as an indicator of pelvic adequacy. Biswas (1993) reports 'fewer Caesarean sections were done, without adversely affecting the neonatal outcome, when X-ray pelvimetry was not used to select the mode of delivery of uncomplicated singleton breech presentation at term'. Enkin (1995) states 'there is no reason to expect that X-ray pelvimetry should be more accurately predictive of cephalopelvic disproportion for breech than it is for cephalic presentations'.

Active birth with women standing, squatting and kneeling maximises pelvic diameters. To be free to assume whatever position desired in labour sees women rocking, rotating their hips, squatting, sitting astride, getting up and down for contractions and marching on the spot. Donna, when getting an urge to push, felt all the strength going in her legs. She had been kneeling and I suggested to her that she sit on her husband's knees so he could hold her weight. She clambered on top of him sitting astride, holding his shoulders to grip onto and rode up with each push - a very effective way to ensure flexion of the head.

To confine labouring women to a position of the attendant's choice is to potentially limit the capacity of a woman's pelvis to open. Botha (1968) describes Bantu women squatting on their haunches and Polynesian women giving birth using gravity by lying over a crossbeam with the pregnant abdomen downwards thereby negating the need for manipulative interference. While the Bracht manoeuvre (Jotkowitz 1971) acknowledges the mechanism of the physiological breech, the attendant, when the woman is in a dorsal position, needs to lift and hold the baby's body against the woman's symphysis. This is the method used by Gaskin (1986). This is unnecessary when the force of gravity is engaged. The use of the Lovset manoeuvre to release arms which are extended, flexed or around the nape of the neck as demonstrated by Gaskin (*ibid.*) are seldom needed when women are in upright positions. In the supine position this intervention may well be routinely necessary. Cooper (1992) attended 89 breech births with weights up to 4650gms and only one baby needing assistance to have an arm brought down. Those women birthed standing or squatting. The Mauriceau-Smellie-Veit grip is used to flex the head by applying pressure to the malar bones while drawing down on the baby's jaw with a finger in the mouth (Myles 1968). This manoeuvre is less likely to be necessary where a woman is in an active birth position and able to move her pelvis as needed. The effect of the baby's body hanging and her tilting her pelvis backwards automatically brings the baby's head into a flexed position. Odent (1984) states 'never risk a breech delivery with the mother in a dorsal or semi-seated position'.



## The Power

When a woman goes into labour, especially with her first baby, her pattern of labour and the length of time it will take her to give birth is largely unknown. Arbitrary time limits are not part of midwifery practice, as midwifery recognises the individuality of each woman on a one-to-one basis.

Odent (1984) reports that it is important not to stimulate labour with a breech birth. If the birth progresses well there should be no need for interventions such as artificial rupture of membranes or oxytocics. If the labour is not progressive then this is an indication for Caesarean section. He sees an unduly painful labour as an indication for Caesarean section. Odent reports a Caesarean section rate of five per cent for breech birth (*ibid.*). Waikato Women's Hospital (1996) reports a 'greater than 50 per cent' Caesarean section rate.

Chadha (1992) concludes following a study involving 643 women who had 'singleton breech presentation and spontaneous onset of labour at term ... epidural analgesia was associated with long duration of labour, increased need for augmentation of labour with oxytocin infusion and a significantly higher Caesarean section rate in the second stage of labour'.

A longer and slower labour, without epidural anaesthesia, is not necessarily problematic or the result of a breech presenting. It may be that woman's pattern. As midwives we need to acknowledge these differences and that the longer labour may not be necessarily be due to breech presentation.

## The Passenger

Babies are often viewed as passive in the role of birthing. They are far from passive, cycling and drawing their legs up and down, flexing shoulders and twisting their bodies as they make their way down and out. Babies often wriggle their arms free needing no assistance to do so. I have found it necessary to hold the weight of the baby's bottom when women assume such open positions. Once the baby is born to the nape of the neck, the weight of the baby can bring the head too quickly, resulting in a tentorial tear (Myles 1968).

I have not found it necessary to bring down a loop of cord once the baby is born to the umbilicus. The umbilical cord rate is often very low as the head comes through the pelvis despite the baby being very pink throughout and usually requiring no resuscitation. It is interesting to consider how much of the wind being knocked out of their sails is due to head compression which of course comes last with breech presentation. With the vertex presenting the baby generally has a rest period with the head out before being born. By the time the rest of the body comes the baby has had time to recover. This is not the case in a breech presentation and may well be a factor in the increased need for resuscitation with breech birth. If any suctioning, whiffs of oxygen or active resuscitation is needed this does not require separation from the mother as occurs in the hospital setting. The mother plays a vital role in 'calling her baby in' telling him how pleased she is to see him and how beautiful he is and by instinctively not taking her eyes off the baby. In the meanwhile the baby has the continued support with the cord still intact, beating and providing oxygenation. If it has stopped beating it may restart later (Johnston 1995). The baby can be kept warm next to his mother with the aid of hot water bottles or wheat packs.

## The Politics

Mandatory policies (Health Waikato Ltd 1995) ensure that breech birth is conducted according to the medical model. Nine years on from the Cartwright Report there is an almost universal lack of understanding by health professionals of



a woman's right to withhold her consent to recommended medical procedures. The reality is when one transfers with a breech presentation, the women's choices will be very limited. Heidi, a 17-year-old, had planned an active birth. When her baby was discovered to be breech at 38 weeks and she saw the team she was told 'we don't do squatting births here - that's for midwives (Heidi 1996). She felt she had no option but to birth at home - which she did.

Childbirth practices can be based on practitioner prejudice despite extensive research to the contrary. This was demonstrated when a bright young registrar presented a session on breech at Waikato Women's Hospital last year. One consultant obstetrician commented that ECV was outdated now with Caesarean section and that X-ray pelvimetry was an essential prerequisite for a trial of labour in breech presentation. When the registrar drew attention to the long ago reported value of external cephalic version (ECV) at term and the lack of value of X-ray pelvimetry he was met with a watch it boy! from one consultant and a wry smile and a shrug of the shoulders from the other.

With the transfer of 3-4 home births with breech babies there is one obstetrician who has seen squatting or standing breech births. This is, however, at a \$400-10,000 cost to the woman. Ensuring birth support does not come cheap.

Midwives who provide care for women who do not consent to transfer to specialist care or who chose to birth at home are very open to hostility and Nursing Council action from those practising in the medical model. Women need to be aware that the midwife supporting them may well need support herself in the future because of that hostility.

## The Partnership

Midwives have been presented with a clear framework of partnership with women (Guilliland and Pairman 1994). Birth planning is a continual process. If a baby presents in a breech position the woman's health care needs are additional to her existing needs, not in place of them. Many women see their control of birth experiences disappear with only the medicalised option presented to them, i.e. elective Caesarean section or induction of labour at 38 weeks gestation. Referral criteria cover the broad areas of a woman's physical experience without acknowledging her baby's birth as also being a social, emotional, spiritual and sensual experience. To deny these aspects is to reduce a woman to pregnant uterus and her baby to a foetus needing to negotiate a hazardous route to the outside world.

It is difficult, if not impossible, to ensure a calm and loving environment for a woman to birth when she does not want to be in a hospital. Waikato Women's Hospital is like a dungeon with neither windows in the rooms nor locks on the doors. There are doors on either side with utilitarian furniture and medical apparatus

abounding. The dank atmosphere of calamity and fear is often palpable. Midwives, nurses and doctors dress in camouflage and abattoir clothing. A paediatrician and an anaesthetist are in the room for breech birth. This is not an environment which sets the scene for gentle birth. Gaskin (1992) reports assisting at 55 breech births of which 37 were at home. Three were born by Caesarean section which equates to a 5.4 per cent rate. She states: '... breech babies can be safely born without surgery. And with the help of an experienced practitioner, they can be safely born at home' (ibid.).

It is my belief that if a woman has all the information and decides she wants to birth at home with her breech baby, or in hospital without being subjected to the medical model of birth, she should be supported to do so. She is most unlikely to get that support from anyone other than a midwife. To enable this to happen midwives need to re-educate themselves, reclaim midwifery knowledge, have the courage to practice what they know and walk in an equal partnership with women.

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## Author

Maggie has been working with women and childbirth since 1977, first as a registered nurse in Tauranga Maternity Annex and later in the newborn unit at Waikato Women's Hospital where she did a course in newborn care. Following midwifery registration in 1987 she worked in the delivery suite in Waikato Women's Hospital for two years before becoming a domiciliary midwife in the Waikato in 1989. She has provided midwifery-only care since the 1990 Nurses Amendment Act and attends only home births. Two-and-a-half years ago she started supporting women to birth at home with breech babies. Maggie lives in a rural area with her husband, three children and one grandson. A second grandchild will join them by the end of 1996.

## Letters to the Editor Continued

## Receipt of Book

Dear Editor,

Thank you for the book *Immunisation - Theory versus Reality* by Neil Miller (1996), which has been reviewed in this issue of the journal. It is another valuable contribution to the debate on immunisation and has been placed in the library where students and practitioners alike can access it.

Department of Nursing and Midwifery  
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# Midwifery: The Balance of Intuition and Research

Presented at the  
New Zealand College of Midwives  
1996 Conference, Christchurch

**Professor Jill White**

**Department of Nursing and Midwifery  
Victoria University of Wellington  
Wellington, New Zealand**

Thank you for the opportunity to speak with you this morning. It is a real pleasure to be here with midwives and mothers and to talk about midwifery and birth. However, I have to admit to some discomfort in addressing such a gathering. Before coming to New Zealand in 1994, I named my area of practice midwifery. It is only in coming to live and work among you women that I have come to appreciate my practice as obstetric nursing and my philosophy of practice as midwifery. So I accept your invitation to speak to you very much with the understanding that my contribution is a sharing of academic understanding, passion for a midwifery philosophy and with personal experience as mother and teacher.

A discussion on the balance of intuition and research is particularly relevant in New Zealand at this time of rhetoric on accountability and evidenced-based practice, which appears to be the latest ministerial buzz word. I would like in this discussion to take the notion of INTUITION first and then move to RESEARCH.

Intuition is a frequently used and frequently misunderstood word – we use it colloquially to mean 'undifferentiated gut feeling' and at other times very specifically to mean expert clinical judgement. One of the major confusions in looking at this concept is that we don't often stop to explore and ensure that our use of the word is received with shared meaning.

Miller (1995, p. 307), in a review of the literature on intuition within the discipline of nursing, devised the following definition from the literature:

Intuition was conceptualised as a way of knowing that was not dependent on conscious, deliberative use of rational thinking and that it included an affective component that indicated the correctness of the knowledge.

We have all heard people say they 'just knew' something, that they had a 'gut feeling', but what is it that distinguishes the type of intuition ascribed to the expert practitioner and that which is referred to as naïve, mystical magical thinking or simple prejudice? As Paley (1996, p. 667) points out, 'intuition is not something commonly regarded as the prerogative of experts' and yet in the clinical literature it is often seen as the hallmark of expert practice. Perhaps if we look at the practice focused literature on intuition we may find a clue to the discrimination between these meanings.

The term INTUITION appears to have entered the clinical literature in the 1980s with the work on skill development in practice by Dreyfus and Dreyfus (1985) and Schon (1983) and within nursing with Benner (1984), Benner and Tanner (1987) and Benner and Wrubel (1989).

The expert performer was defined by Benner (1984, p. 32) as one who:

... no longer relies on an analytic principle to connect her or his understanding of the situation to an appropriate action. The expert – with an enormous background of experience, now has an INTUITIVE grasp of each situation.

Benner's (1984) work was a refinement and application of the work on skill development by Dreyfus and Dreyfus (1985). They had devised a skill development schema by studying airline pilots and chess players from which they came up with five levels of skill acquisition: Novice, Advanced Beginner, Competent, Proficient and Expert.

The movement through the levels of skill acquisition is characterised by:

- A movement from reliance on abstract principles to the use of past concrete experiences.
- A change in the learner's perception of the demand of the situation in which the situation is seen as less and less a compilation of equally relevant bits and more and more as a complete whole in which certain parts are more relevant and
- A passage from detached observer to involved performer.

(Benner 1984, p. 13)

When the expert demonstrated her command of practice she was seen to use intuitive judgement. The key aspects Dreyfus and Dreyfus saw as representing this intuitive judgement were:

**pattern recognition** – similarities and links with previous experiences.  
**similarity recognition** – 'fuzzy' resemblances, similarities despite differences.  
**common sense understanding** – knowing the practice setting and its patterns.



skilled know-how – mastery of the 'job'  
sense of salience – recognition of some events as more important than others.  
deliberative rationality – exploring what might stand out as significant if one's perspective were changed.

(White 1990, pp. 72–73)

In later refinements on the concept of expert practice Tanner *et al.* (1993) took Benner's notion of involved performer and explored it further through what they termed 'knowing the patient'. They saw this as a precursor to the exercise of intuitive judgements. Two specific elements to 'knowing the patient' were found: 'in-depth knowledge of the patient's responses' and 'knowing the patient as a person'. In-depth knowledge of the patients' patterns of responses included responses to therapeutic measures, routines and habits, coping resources, physical capacities and endurance and body typology and characteristics.

This was illustrated by the following clinical exemplar:

You look at this kid, because you know this kid and you know what he looked like two hours ago. Its a dramatic difference to you but is hard to describe that to someone in words.

(Tanner *et al.* 1993, pp. 275–276)

Knowing the patient as a person, on the other hand, was seen as the need to be able to know the person outside their present situation, particularly where the patient was a baby or an unconscious adult.

I had never ever spoken to this man, but I grew to know him because of the family, because I became real close to his wife and son and knew what he was like before.

(Tanner *et al.* 1993, p. 276)

This knowing the patient Gadow (1989) believes enables health professionals to care for people through what she calls 'engaged advocacy'. In extending Gadow's argument, Tanner *et al.* (1993, p. 279) say: 'Knowing the patient creates the possibility for advocacy in its most basic sense limiting the vulnerability of the persons and preserving their dignity and integrity.'

Cash (1995) in her critique of Benner introduces another important element in the exercise of intuition in practice and that is the issue of 'epistemological power'. In speaking of the situation in the neonatal intensive care unit Cash (1995, p. 533) says: 'the negotiation that takes place for that intuition to be recognised – the physicians have control over the clinical situation, the nurses' power is negotiated with them. Intuition, because it lacks immediate confirming evidence relies therefore for its status on the perceived epistemological power of the person having the intuition.'

In a research study by Shaw (1992) of the role of intuition in hospital based midwifery practice she echoed many of these findings when she looked at what facilitated the use of intuition in practice. She (Shaw 1992, p. 68) found the following to be influential:

- Experience
- Reflective Practice
- Midwife/Client Relationship
- Self-confidence in communication with colleagues and
- Time or timing.

I suppose over the years you develop it, that feeling that you know it's right and that's the way you want it to go and you can't fit words to reasons at the time. I suppose it's just feelings. It comes. It's not something you consciously set out to do. I'm sure it just comes with and because of, experience.

(Midwife in Shaw 1992)

When there is an intense relationship between the woman and her midwife, it's easier to be intuitive.

(Midwife in Shaw 1992)

She was just in normal labour. She got to fully. I thought she was fully and got her pushing. Everything was all right. There was no fetal distress and for some reason I thought ...

(Midwife in Shaw 1992)

The interpersonal relationship and time, to take time, the timing – were an essential part of the 'knowing the person', the need for the self-confidence to speak out on the basis of a feeling corroborates Cash's (1995) notion of 'epistemological power' as does the notion of knowing the colleagues with whom you work. Tanner *et al.* (1993) found that an important issue was that of what they called 'anecdotal medicine' – the shared understanding and experiences that come from working together and developing mutual trust and respect. The experience which Benner (1984) and Schon (1983) speak of is experience that incorporates reflective practice as they both speak of experience not simply being time spent, but new understandings that come with a disturbing of the taken-for-granted and expected happenings through reflection-in-action or reflection-on action. In Benner's words experience results when 'preconceived notions and expectations are challenged refined or disconfirmed in the actual situation' (Benner 1984, p. 3).

In New Zealand, midwifery has set the scene for the accomplishment of many of these precursors to the development and use of skilled practitioner intuition. You have reframed the setting to deal largely with the notion of epistemological power by changing the place of birth and enabling the dominant epistemological power to be shared between the woman and her

midwife, the relationship' and its inherent time for the woman through continuity of care and carer enables the very thorough 'knowing the person' that Tanner *et al.* (1993) speak of as critical to intuitive judgement. Embedded in the College of Midwives' Standards Review Process is formal and informal reflection-on-practice.

If one accepts, then, that there is an important component of expert practice that has, for good or ill, been named intuition, I return to the question of how do we differentiate this from the more colloquial use of the term? Well, here I think the work of Belenky *et al.* (1986) in 'Women's Ways of Knowing' may be helpful. This research was influenced by the work of Kohlberg (1981) and Perry (1970) on psychological development and by Gilligan's (1982) critique of these works as gender distorted. Perry's (1970) work in particular interested Belenky *et al.* (1986).

Perry (1970) had arrived at four 'positions' of moral and intellectual development. He traced the progression from BASIC DUALISM where students viewed the world in polarities, through awareness of diversity to MULTIPLICITY, coming to understand that 'authorities may not have the right answers' (Belenky *et al.* 1986, p. 10). When challenged to support their assertions students were moved to positions of RELATIVISM SUBORDINATE, then to full RELATIVISM where there was an appreciation that 'meaning of an event depends on the context in which an event occurs and on the framework that the knower uses to understand that event' (Belenky *et al.* 1986, p. 10).

Belenky *et al.* (1986) found, as a result of their extensive research with women, that their 'positions' were better represented as five ways of knowing and that women need a position before dualism, that of 'Silence' where they perceived themselves as having no voice at all.

The five ways of knowing were:

- Silence
- Received knowledge: listening to the voices of others
- Subjective knowledge: the inner voice
- Procedural knowledge: the voice of reason, separate or connected; and
- Constructed knowledge: integrating the voices.

The reason I introduce this work today is that I think they provide us with a strong point of differentiation between the ways in which 'intuition' is used. The chapter on 'Subjective Knowledge' begins with a quote from a young mother, Inez:

There's a part of me that I didn't know I had until recently – instinct, INTUITION, whatever It helps me and protects me. It's perceptive and astute. I just listen to the inside of me and I know what to do.

(Belenky *et al.* 1986, p. 52)



This stage of 'subjective knowledge' is not dissimilar to Perry's (1970) MULTIPLICITY, where things cease to be clear cut and personal freedom and personal opinion are asserted. Inez goes on to say:

I can only know with my gut. I've got it tuned to a point where I think and feel at the same time and I know what is right. My gut is my best friend – the one thing in the world that won't let me down or lie to me or back away from me.

(Belenky *et al.* 1986, p. 53)

I don't want to denigrate this powerful personal knowing. It is a deep point of inner strength on a journey of knowing, but it is a private knowing and as such has the limitations of 'small sample size and limited generalizability' and suffers the inevitable influences of potency of an experience and recency of experience. First hand experience and the inter-generational stories of those in close private spaces are critical to the development of this knowing. It is the 'feel right' component of knowing, for example, one's children. It seems not dissimilar to the knowing described by Tanner *et al.* (1993) in their work on 'knowing the patient' – with its in-depth knowledge of the patterns of responses and the knowing of the patient as a person.

It is the agency of 'maternal authority' and is therefore not to be ignored. However, it is to be understood as contextually confined.

As an aside, an interesting difference in the wording of subjective knowledge and multiplicity is of the masculine assertion, 'I have a right to my opinion' contrasted to the less confronting position 'It's just my opinion' (Belenky *et al.* 1986, p. 66). This qualification 'just' characterises women's description of their intuitions as does the description of the 'feeling' component.

In moving to procedural knowledge there is a profound shift – a shift to appreciating the fallibility of gut feelings and an appreciation of the importance of shared knowledge and understanding which can be gained without direct experience of an event. Seeing outside one's own frame of reference characterises this stage.

Let me take this opportunity to turn from INTUITION to RESEARCH – to seeking to understand that which we have not or could not directly experience; that is, Belenky *et al.*'s Procedural Knowledge. What place does research play in the development and exercise of skilled practice?

Clearly there have been profound advances in medical sciences and the understanding of function and dysfunction of the human body from research using randomised controlled trials (RCTs), the 'gold standard' of research as it is known to the scientific community. Latterly this has been enhanced by the meta-analyses being collated by the Cochrane Collaboration. In the area of pregnancy and childbirth clinicians and interested women have the huge advantage of having a proscribed area for study and therefore

relevant research is seen to be easily targeted. Chalmers *et al.* (1989) in particular have contributed enormously to this knowledge base with their 'Effective Care in Pregnancy and Childbirth' volumes containing all the RCTs in meta analysis. Even more easily digestible form is provided with the slimmer 'Guide to Effective Care in Pregnancy and Childbirth', 2nd ed. (Enkin *et al.* 1995) with its user-friendly 'forms of care', those which reduce negative outcomes, those which appear promising, those which have unknown effects and most importantly those which should be abandoned. We have also the 'Research and the Midwife' conferences, Midwifery journals, MIDIRS – the Midwives' Information and Resource Service and the plethora of research reports in texts such as those edited by Robinson and Thomson (1989, 1991, 1994) and the series by Alexander *et al.* (1990a, 1990b, 1990c, 1993). This body of knowledge is then supplemented by the research from other relevant disciplines such as sociology, with influential works like Oakley (1979, 1980, 1984, 1992) and Katz-Rothman (1982, 1986, 1990).

The issue for midwifery is not necessarily the lack of traditional forms of research but the two issues of (a) having practitioners incorporate the research findings into practice, particularly the ones such as those identified as those 'which should be abandoned', and (b) the circumscribed nature of the research that is deemed relevant, particularly by funding bodies. Here I am reminded of Katz-Rothman (1990, p. 178), in her chapter on 'Midwifery as Feminist Praxis', saying:

I have come to see that it is not that birth is 'managed' the way it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed. And the way childbirth has been managed has been based on the underlying assumptions, beliefs and ideologies that inform medicine as a profession.

Guilliland and Pairman (1995) in their monograph 'The Midwifery Partnership: A Model for Practice' provide us with a reframing which allows us another way to know about midwifery, a reframing away from the medical discourse.

Carper (1978) provides a much less specific framework which, although designed for nursing, is applicable to any practice discipline. She postulated four patterns of knowing: Empirics, Ethics, Personal and Aesthetic knowing. In 1995 I postulated a fifth pattern, Socio-political knowing (White 1995). Some of you will remember me suggesting these five patterns at the education workshop as a possible framework for organising our understanding of midwifery knowledge. Let us briefly look at what they offer to our understanding here.

**Empirics** – 'Systematically organised into general laws and theories for the purpose of describing, explaining and predicting phenomena

of concern' (Carper 1978). This is of course fostered by the type of research we have just been talking about.

**Personal knowing** – This pattern is about knowing oneself in order to form connected relationships with another. It is characterised by the congruence of one's knowledge and actions 'Do I know what I do and do what I know?' (White 1995, p. 81). This type of knowing is helped by providing opportunities to walk in the shoes of the other and can be accessed through storytelling, by novels or books of accounts of experience such as McDonald's (1992) 'Speaking of Birth' or Davis *et al.*'s (1992) 'Women in Labour'. In both books women recount their experiences of childbirth; poetry such as that presented by Chester (1989) in 'Cradle and All: women writers on pregnancy and birth', Spears (1986) poetry and drawings of babies in intensive care, or even in the most unlikely places listening to a pub poet such as Sam Hunt recall his 'Birth of a Son'. And one must include in any such account the work of Adrienne Rich (1976) 'Of Woman Born'. These provide us with profound glimpses into the experiences of others and increase our personal repertoire of knowing and, therefore, our readiness to interact appropriately with others. This knowing can be elaborated by narrative analysis, phenomenology and other interpretive methodologies.

**Ethical knowing** – What should and/or ought to be done? There has been a blossoming of the literature in this area since Carper (1978) wrote about this pattern. At that stage the primary interest was in traditional bioethics and principally with the notion of justice. Later developments have focused on the ethic of care. This has been predominantly in response to the work of Gilligan (1982) and extended by Noddings (1984), Ruddick (1989) and then critiqued by feminist ethicists such as Jaggard (1991), Hoagland (1991) and Held (1993). Midwifery has an opportunity to contribute here. It is most timely that midwives explore the moral stance explicit or implicit in their practice. Do they stand within an ethic of care or a feminist ethic? And if so what does this mean for their practice? These issues too can be explicated using interpretive research methodologies.

**Socio-political knowing** – This pattern of knowing includes two levels of understanding:

- the socio-political context of the profession and its relationship to other professional groups, much of which is currently being played out with the Section 51 debates; and
- the socio-political context of the persons involved.

This fundamentally addresses culture and relationships to language, identity, family and land connection. It includes exploration of whose voices are privileged and whose silenced. It seeks to expose and explore alternate conceptions of reality.





Here the work of Donley (1986, 1992) and Guilliland and Pairman (1995) helps to position New Zealand midwifery and Kitzinger (1988) and more recently Murphy-Black (1995) position midwifery internationally. Ramsden's (1990, 1994) work on Kawa Whakaruruhau offers midwifery the opportunity to explore its practice in relation to cultural safety. This dimension of our knowing is just beginning to be developed and holds much challenge. I believe New Zealand is leading the world in this area as was evidenced at the recent ICM. We can enhance our socio-political knowing through methodologies which are grounded in critical theory such as action research, by critical ethnography, by feminist studies or by discourse analyses.

Research journeys in midwifery, despite the enormous knowledge available at present, are only just beginning as we begin to explore reframed territories.

When we open our eyes to what we can know it becomes enormously challenging and I am reminded of the opening lines in Chester's (1989) book:

When we are stunned by something completely beautiful, the mind dilates in order to more fully perceive. The natural reaction to this is contraction, for to be opened up is to feel pain. The pupils of the eye have this knowledge, they dilate when beholding the beloved. But to love is to be vulnerable to loss. And so it is with childbirth.

(Chester 1989, p. 1)

I think this is so for practitioners – to be open to the miracle of pregnancy and childbirth is to feel vulnerable and to become less vulnerable we are tempted to withdraw, to control, to retreat to traditional procedural patterns of knowing, to disconnect, rather than to explore Carper's fourth pattern – Aesthetic knowing – artful practice or what Belenky *et al.* (1986, p. 134) call Constructed knowledge: integrating the voices ... obliterating the spaces between private and public knowing: '... weaving together the strands of rational and emotive thought and of integrating objective and subjective knowing'. The artfulness of practice can be represented in photography and other literary and art forms, but these remain only representations. The real learning of aesthetic practice is through the intelligent watching of the practice of ourselves and others and reflecting in and on that practice.

Being able to enter our practice open to all possibilities is a difficult challenge. Cox (1992, p. 1) describes the practice world thus:

Every day clinical practitioners face situations with ambiguity of clinical evidence and uncertainty about what is wrong, what's likely to happen and what will be the effects of different treatments. Despite these approximations to accuracy, the clinician must decide what to do for

the best. What is 'best' is influenced by hopes and values of those effected, principally the patient – this requires judgement and wisdom.

(Cox 1992, p. 1)

Cox's statement can be easily paraphrased for midwifery. Within a woman-centred partnership model we speak not necessarily of 'what is wrong?' but certainly 'what is going on and what meaning does this have?' Most definitely any notion of 'what is best' is strongly influenced by the hopes and values of the mother and family. Judgement with wisdom is, however, often necessary the ambiguity of the situation.

To truly bring INTUITION from our private life experiences (subjective knowing) and RESEARCH undertaken for enhancing knowledge in the public domain (procedural knowing) together in their fullness through practice based experience is to gain the other type of INTUITION (expert clinical practice). This is the very best we can do for those for whom we care.

But as a personal, let us not continue to do ourselves and those with whom we work a disservice by continuing to use a term INTUITION without shared meaning. Let us name it what it is, the best of constructed knowledge in action - PRACTICE WISDOM.

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## BOOK REVIEW

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**Book Title:** *Immunisation – Theory versus Reality*

**Author:** Neil Z. Miller

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**Recommended Retail Price:** \$25

**Reviewer:** Orma Bradford, Midwife, Otago Polytechnic.

Neil Miller explains that he is not a health practitioner and does not recommend for or against vaccines, but is aiming to present information so that parents can make an informed choice. The information he does present is exclusively against vaccination. He suggests that vaccinations are crude experiments conducted on innocent people; that information which does not support the vaccine theory is being suppressed; that the reduced incidence of some diseases is not as a result of vaccination programmes, but due to other factors; and that sickness is the body's way of making needed adjustments and should not be feared.

Some of the language Miller uses is quite emotive. One chapter is headed 'Human Sacrifices'; it discusses parents' stories about the death or disability of their infants as a result of vaccination. None of these families were told the risks of vaccinations; at most, parents were told that 'the risks outweigh the benefits'. Many of these stories focused on a willingness of health professionals to diagnose SIDS as a cause of death and an unwillingness to connect the symptoms with vaccination. Miller points out that the Vaccine Injury Compensation System has already paid out more than \$522 million to settle claims of vaccine-induced damage or death.

In the chapter headed 'Ploys' Miller discusses strategies that health professionals use in an effort to gain parental permission for vaccination. These include bribes, threats, rationalisation, denial and fraud.

In a wider context of vaccination there is a chapter headed 'Genocide' that discusses chemical and biological warfare and the effect of vaccinations given to U.S.A. military personnel involved in the Gulf War.

This book is written with an American focus and language which gives 'shots', not injections, and refers to U.S.A. legislation in relation to immunisation and control of drugs which may limit its use in New Zealand/Aotearoa.

If you have never questioned the validity of national vaccination programmes, this may well be a useful book; it certainly presents an opposing view in the vaccination debate and reminds us of informed choice and consent issues in relation to vaccinations.



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# Knowledge, Power and Control as Women Learn to Breastfeed

Orma Bradfield

Midwife, Lecturer,  
Lactation Consultant

Breastfeeding has been the subject of increasing research in recent years. However, little of this research actually discusses women's experiences of breastfeeding. The purpose of this study was to hear women's accounts of their breastfeeding experiences following childbirth and to examine influences on those experiences.

Kitzinger (1992) claimed that we are only just recovering from the havoc caused by mainly medically-qualified writers from the past who advocated regimes that were totally inappropriate for breastfeeding women. 'In a technological culture doctors define birth, while women experience it' (Kitzinger 1992, p. 63). Women need to rename parts of their world and shift the balance of power. Part of that renaming is talking about their breastfeeding experiences. Women have always had their own knowledge about breastfeeding, but this has not been accepted as the 'official' knowledge. From the 1920s to 1940s in Britain, most midwives working in the community admitted they knew the officially advocated four-hourly feeding routine was counter productive to establishing breastfeeding (Leap and Hunter 1993). However, the four-hourly routine increasingly became the expected way for women to breastfeed. Following on from the denial of women's own knowledge and experience, much of this knowledge and experience of breastfeeding was lost, both by women who bottle-fed and by health professionals. Hospital practices further exacerbated this situation by setting protocols that limited a woman's ability to breastfeed (Hood, Faed, Silva and Buckfield 1978).

This paper discusses two of the six areas of focus that emerged in this study of women's experience of breastfeeding following childbirth: knowledge of breastfeeding and power and control in breastfeeding. Women sometimes remained silent, or struggled to have their voices heard, against the dominant discourses of the staff. In 1995, it seemed that while women are being encouraged to breastfeed, some hospital practices may limit women's ability to breastfeed successfully.

## Method

In this qualitative study, six primiparous women who identified as having had some difficulty with breastfeeding, which ranged from temporary sore nipples to the baby not attaching to the breast, agreed to participate. Four were contacted through hospital staff caring for them and two responded to an advertisement in a local community newspaper.

These women talked about their experiences of breastfeeding during initial semi-structured audiotaped interviews in their homes, undertaken when the baby was six-weeks-old or less.

A second interview in the women's homes, after the women had read the transcript of their first interview, discussed themes that emerged in the first interview and gave the women opportunity to comment on the accuracy of the transcripts.

A final group meeting was held when the women had read the report draft. This gave opportunity for them to discuss changes they wanted made to the report. At their request the researcher undertook to contact them in one year to outline changes that had been made as a result of the report.

Material from the transcripts was grouped into areas of shared focus which were analysed for dominant discourses. Quotes from the transcripts were used to identify and examine discourses on breastfeeding and to explain the working of power on behalf of specific interests. A feminist methodology was used and feminist poststructuralist theory was used as a framework to study discourses related to women's experiences of breastfeeding. Feminist poststructuralism is a way of knowledge production that uses theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change (Weedon 1987).

In this study, women's voices about their breastfeeding experiences were heard and opportunities for change were suggested.

## Results and Discussion

Discourses seek to govern individuals and are always part of a wider network of power relations. Discourses related to knowledge emerged frequently; to the effects of knowledge, who had the knowledge and sometimes exhibited conflict between the knowledge of the women and the

knowledge of the staff. Knowledge, in post-structuralism, is no longer neutral and objective, but is closely associated with power and those who have the power to regulate what counts as truth are able to maintain their access to material advantages and power (Paulin 1992).

### (a) Knowledge of Breastfeeding

#### *Knowledge of Mothers and Sisters and Friends*

The knowledge of mothers, sisters and friends was accepted and valued. They provided role models who could be watched and/or whose breastfeeding experiences could be reflected on. They had knowledge that they were willing to share, often based on their own experience and they added to this information with practical assistance so that the new mothers could take advantage of the advice they were given.

*Shirley* – Well the thing is my mum had 13 children and I think well, I should manage with one. And, she breastfed all of them.

*Kiri* – my sister, encouraged me ... she's still breastfeeding him [her son] and she encouraged me a lot ... she went through worse than me at the beginning ... both her nipples were cracked.

*Lee* – I've got so many relations and cousins who have babies I sort of watch them. A lot of my friends said look don't worry about cleaning up your house just catch up on as much rest as you can, they'd be running around doing the washing or something.

*Tania* – Whether or not it's the right way to do it [express] I don't know but it's not sore when I do it and it's not sore afterwards. But if I think it's not the right way I can always ask my sister because she expresses milk, she breastfeeds as well.

The most obvious division of labour in perinatal care is between people who are paid, such as midwives and doctors and people, who are not paid, such as 'patients' and their families. Oakley (1993) suggests that it is a predominant myth of the modern age, an aspect of the 'theology' of medicine, that the only people who can provide healthcare are those who have been formally trained and licensed to do so. For some



of the women in this study, the support and information offered by mothers and sisters and friends enhanced their breastfeeding and helped them to overcome difficulties.

#### *Knowledge of Midwives, Nurses, Lactation Consultants*

*Tania* – Just the fact she was showing me how to breastfeed properly and stuff like that I think that's why Kelly is so good at taking to the breast now because Jan [midwife] showed me the right way of doing it, when everyone else expected me to know how to do it.

*Sarah* – I requested to talk to a lactation consultant because I felt that I wasn't getting enough being a first-time mum but really, I needed some more advice and so she came down and I just kept requesting to see her for guidance really and reassurance.

*Lee* – There was one nurse who was on who was really nice when I said I can't do this and so she'd take baby away because it would be like three hours I'd been trying him on the breast ... she'd take him for a walk around the ward ... just to give me a bit of rest ... I can remember her now. I always used to look forward to the night time when she'd come on.

*Shirley* – The nurses are really good. They helped out quite a lot as to how to hold the child and how to position it and what to expect.

*Kiri* – She [the midwife] helped with the first feed she had she attached her onto me and was explaining the protein and stuff and the difference between powdered milk and breastmilk and just told me that breastfeeding is better for winter babies ... after she did it I managed it.

*Bridget* – There was one really nice one [staff member] on the last night that I was in hospital and she was showing me how to feed him lying down so I could get some sleep.

Knowledge here is used to support and encourage. Midwives, nurses and lactation consultants in these comments are referred to by the women in a similar way to which they refer to their sisters and mothers and friends. They offered information as well as practical support and demonstration so that the women learned how to do it for themselves. In many situations, one person in particular was recognised as having the skills and knowledge that the women needed: these people were particularly valued. In the above examples, staff are able to participate in a meaningful experience with the women.

(Montgomery 1993)

#### *Knowledge of the 'Experts'*

This was a different view of hospital staff:

*Bridget* – I felt pretty awful. I just kept trying everything they said to do and let him cry. Lots of people told me it was a behavioural problem. That he wasn't sleeping because he needed to be put in his bed and let cry for 10 minutes and I went along with that because I thought I'm a first-time mum, what do I know.

And of course they kept saying 'you've got plenty of milk, you've got to get him settled into a routine and you can't let him keep feeding the way he is' because I was just feeding for an hour-and-a-half at a time.

Bridget is faced with the discursive field that claims that hospital staff have the breastfeeding knowledge, and therefore the power, and that first time mothers are not expected to have knowledge.

When a dominant culture insists that power lies outside the individual, in hierarchical organisations, people eventually cease to believe in their own inner power (Walters 1991). And when the things that women say do not fit the medical model, their problems are often diagnosed as being in the mind. Bunkle (1992), suggests that what women say is not interpreted as information about their physical condition but as a symptom of their state of mind.

It is the efficiency of infant suckling and/or milk removal which governs the volume of milk produced (Akre 1991). Bridget knew that her baby was not sucking well and that she was therefore not producing enough for him, but due to the dominant discourse of 'experts', Bridget's knowledge, although it was about herself and her baby, was not considered appropriate.

There is victim blaming; it is Bridget's fault that this baby is crying; he should be in a routine; he has a behaviour problem; in such ways power is abused by the 'experts'. There is a dominant discourse that women will learn in hospital how to breastfeed. The less dominant discourse based on the women's experiences is that sometimes hospitals inhibit breastfeeding.

#### *Women's Own Knowledge*

As women developed their own knowledge about breastfeeding they seemed to regain their own power; they were less dependent on the health professional 'experts' as they became experts themselves.

*Bridget* – So I knew then that something was not right, I didn't have as much as all these other people had.

You would wait until the end of the shift of the person that you didn't like and then you'd ring the bell and get someone you did like.

*Sarah* – I was wasting my time waking her three-hourly because she wasn't waking properly. Whereas when we went back to the four-hourly she woke properly, had a decent feed and was a lot happier and so was I.

*Kiri* – Just making sure I got most of – not just the nipple but areola in the mouth ... yes, make her open her mouth wider.

*Tania* – I don't believe in breastfeeding a baby in bed, I prefer to get up and breastfeed.

*Sarah* – On her [lactation consultant] days off we were doing all right so I [was] just sort of waiting until she was back. I preferred to just stick with the one person instead of lots of different, conflicting opinions.

*Lee* – I don't think he was actually even feeding properly on this side because I always had to top him up with formula or something like that.

*Shirley* – Saying he wakes up I'm off and away, change his nappy, feed him and then don't call the nurse (laughter). Crikey, I hope this doesn't get back to them (laughter). It would just give me time without having a nurse there sort of looking over your shoulder watching how things were going, it would just give me time to adjust with the child by myself.

In these extracts the women are claiming their own knowledge of their breastfeeding experiences, gained from information and experience and watching others. Strategies were developed for acquiring more accurate knowledge. Some staff were selected and trusted, others were no longer expected to have the knowledge needed. The women's own knowledge changed the discursive field; they began to take control. But when the women developed their own knowledge and stopped thinking that they were first-time mothers and therefore had none, their own knowledge came in conflict with that of the staff.

#### *Women's Knowledge in Conflict with Staff Knowledge*

*Kiri* – One lady [staff member] came in ... and said that, because I was holding her and she told me to put her back into the bassinet thing in the hospital, that babies don't like being held. She was being a real snort ... they do like comfort when they are born. [later] She [the nurse] kept ordering me to wake her up but I said no.

Kiri claimed her own knowledge of herself and her baby in opposition to the staff, or 'official' knowledge. Had she not, she would have been tucking her baby down when she was crying and waking her up when she was sleeping.





Kitzinger (1979) found in a breastfeeding study undertaken in 1977, that mothers were often dissuaded from handling their babies because it was not considered 'good' for them. This attitude seems still to exist in some situations.

There is an element of threat in this comment from Kiri:

*Kiri* – [Staff members said] Oh no, it's going to be a big snow fall ... and they said if anything happens that I won't be able to get back to the hospital – but my midwife stayed at home.

The independent midwife offered to stay at Kiri's home with her for the first night in case Kiri needed breastfeeding support and snow prevented travel. This made the 'knowledge' of the hospital staff less powerful; it gave Kiri options to choose from.

Lee was clearly more concerned about developing a transitional method of feeding that was manageable for her than worrying about possible nipple confusion in the baby:

*Lee* – In the hospital it [baby] was cup fed, it was really messy and I was getting really irritated by it so when the nurses weren't looking I'd bottle feed him, but they said that the teat on the bottle was different from the nipple and if he got used to that he wouldn't go back on the nipple.

Lee could depend on her own knowledge of what was preferred but only when the staff were not looking. She did not have the power to openly challenge the staff about proposed feeding management.

*Lee* – they were positioning him wrong for a start and I thought like the nurses knew everything.

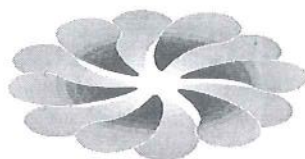
Had Lee been given the opportunity and encouragement to position her own baby at her breast, staff would not have been open to blame for positioning him wrongly and Lee would have had opportunity to learn how to do it for herself.

Bridget's acceptance of her own knowledge occurred at a point when she was feeling pushed to the limit; she had stopped considering that the staff knew best and insisted on producing evidence that supported her own knowledge.

*Bridget* – There was one night though that there was one woman who was really awful, I didn't like her at all and she kept trying to put him on the breast all the time. My breasts were actually stinging, I was so sore because he had been on them all day and I got so frustrated that I told her to go and get one of those expressing machines and I sat there for 20 minutes and showed her there was nothing there.

Tania had the support of her midwife in opposing the advice given by hospital staff.

*Tania* – Because I was really concerned about her not taking to the breast and she was taken away from me, put in the nursery for three nights I think because ... the milk wasn't coming through and she wasn't getting enough and the nurses were giving her powdered milk in a wee cup which I wasn't very happy about that either because I wanted them to bring her to me but they left her. They said no, you need your sleep but it was the fact that I wanted her with me so I could keep trying her on the breast but they gave her 10mls of formula and stuff like which, you know, I wasn't very happy about it and my midwife wasn't very happy about it. She said if she goes back in the nursery make sure they bring her to you don't let them feed her up with formula.



The *New Zealand College of Midwives Breastfeeding Handbook* (1992) is accepted as the breastfeeding policy at this hospital. Although this policy includes the importance of not separating mother and baby and not giving any fluids other than breastmilk, there was a divergence between the policy and the practices of breastfeeding support. Beeken and Waterston (1992) found in England that, in spite of the evidence that mother-baby separation and additional fluids for breastfed babies was undesirable, these practices frequently occurred in hospitals surveyed. They suggested that this may occur when the professional's own belief as to the effect of beneficial practices is weak or her attitude to breastfeeding is negative. Vares (1992), in a study in Christchurch, found that with all of the women interviewed there was a difference between the policies and the practices of breastfeeding. She found that control over breastfeeding related to economic and political dimensions of male control and that there were various discourses that promoted formula and discouraged breastfeeding.

In these quotes, the mothers' knowledge is denied, the practices are contrary to the policy and successful breastfeeding is being inhibited. The language in these discourses is caught up in domination and oppression. While women are told that they must breastfeed, some hospital practices actively inhibit effective breastfeeding. Women sometimes had to struggle to have their voices heard against the dominant discourses of the staff.

#### (b) Power and Control

Power and control are most important elements in healthcare and have, until now, received little attention. Wagner (1990) suggests that whoever

defines a problem controls the solutions. In redefining normal birth as a medical problem, rather than a normal event, medical staff took over the power and control.

This power and control over breastfeeding women has extended to other staff practising in the hospital setting.

*Orma* – Can you tell me how they [staff] put him on? [the breast].

*Bridget* – Yes. They would get the back of his head, they would lift up my dress and they would go shove. It was all awful and horrible and yukky. So eventually I'd put him on and ring the bell because it was so awful for him and me. It's [breastfeeding] supposed to be a lovely feeling, not violent. I suppose because all the books that I read said how natural it was and how nice and lovely and all these midwives were quite violent and aggressive, apart from my own midwife who put him on the breast when he was born.

Violence would not normally be considered part of breastfeeding in hospital; it is not part of the dominant discourse, but it is part of women's experience. In a technological culture staff define breastfeeding while women experience it.

*Lee* – The first week when I first had baby breastfeeding was quite difficult, it was really painful and I found in hospital when I asked the nurses for help they'd just grab my breast and grab baby and shove him on and it was really sore and I was crying and they'd say the pain will go away in a little while.

They just basically grabbed my breast and the baby's head in their hand and they just pushed us together. I thought it was really quite rough especially for a first time mother it was sort of quick here quick give me your tit and give me the baby and go. And I'm sitting there saying it's hurting, it's really painful and they'd say it's all right, the pain will go away in a couple of minutes.

Every time I had trouble the nurse would say buzz me and I'll come and give you a hand so every time he woke up for a feed I'd buzz then so they'd come and help me but no one actually really told me what to do.

What is described by Lee here as 'help' is really control. While the staff did the attaching of the babies to the women's breasts, they did not share, show or empower them, the women remained powerless and dependent on the staff at every feed.

*Bridget* – Occasionally when they came they would take him off and check that he was on right so they would put him back on themselves so that they could see that he was on right ... I could tell [when baby was well attached] because otherwise he would be nibbling away on my nipple and it wouldn't feel right.





Staff have the power here to stop the feed by taking the baby off the breast to check if he had been on right in the first place. Bridget's knowledge of whether he was on right or not was clear, but not considered. Foucault claimed that power's relation to knowledge was never separable (Diamond and Quinby 1988, p. XII). In these stories of women's breastfeeding experiences, knowledge is retained by staff and not shared.

We need to stop blaming women for their failure to breastfeed but acknowledge that their failure is really a result of our ignorance and to work with women in overcoming their breastfeeding difficulties (Minchin 1985).

*Bridget* – [They] just wouldn't listen to what you wanted or how you wanted to do things.

*Tania* – I fed her in bed and she said I'll be back in 10 or 20 minutes. Two hours later I had to ring the buzzer and tell her to come and take Kelly off me because I couldn't sit up ... I was quite annoyed about that. I just left it, I didn't say anything but I thought jeepers, you're not that, they weren't that busy in there that they didn't worry about me.

I think that's why it was so hard for Kelly to latch on because no one had shown me what to do.

*Shirley* – It was almost restrictive in a way within a certain period of time he had to eat, sleep, change the nappy and then be put down again. I think that was frustrating for me ... don't keep him up for too long because it would tire him out too much.

Well, the nurses would give you the child, to be honest depending on which nurse and sometimes they would say that's enough period of time, 10 or 15 minutes ... and whisk him away to be tube fed.

But the thing is I'm going oh, the nurses know what they're doing ... do what they say.

*Lee* – Well my midwife although she's really nice she said because I was giving up breastfeeding she said oh no, breastmilk is the best milk for baby and she was pointing out all this stuff and I was saying to myself, I know, but it's just so sore and so hard. I can handle pain but this pain is – I'm getting headachy and I feel really sick sometimes and I was thinking to myself I don't have to put up with this.

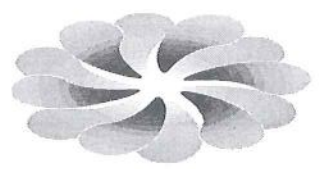
The midwife was telling Lee what she should be doing, but Lee could talk only to herself, not able to express her real reasons for giving up breastfeeding. It seems in this context that the midwife is adding to Lee's guilt by giving her information that she already has, rather than finding out what information she needs, such as how to deal with hard breasts and illness.

The women in these stories display a loss of power and a dispossession of motherhood

knowledge causing increased anxiety and guilt and loss of self-confidence (Guilliland and Pairman 1994). One of the very features of patriarchy is its ability to present as the 'natural' and inevitable form of social organisation. But although the effects of patriarchy are everywhere palpable, they are not necessarily visible to most women (Eisenstein 1984).

Is talking of patriarchal power relevant in a maternity ward where there are apparently few male influences and those who wield power appear to be the midwives and nurses? Both nurses and midwives have been subject to patriarchal medical power for decades. The medical model of childbirth is the one that is most familiar in Aotearoa/New Zealand. The medicalisation of childbirth and breastfeeding and the colonisation of midwifery by the new medical specialities of obstetrics and paediatrics have reduced and changed the role of midwifery. Conditions in hospital settings and midwives' oppressed status within it, aligned them with the medical profession rather than the consumer. The fundamental issue in midwifery seems to be women gaining control of their bodies and recognising, then utilising, their choices. But this means challenging dominant discourses (Russell 1990).

The power to exercise autonomy requires the existence of supporting cultural, institutional and economic structures; until very recently, medical definition has determined actual cultural practices, structural alternatives and economic incentives (Treichler 1990). By maintaining the client's ignorance, the hospital staff are in control, and by controlling information women become dependent on 'experts'.



Some of the comments made by the women reflect institutionalised abuse. Kitzinger (1992) explored the language that women use when they describe their experiences of sexual violence and compared this with women's descriptions of traumatic birth experiences where they had been robbed of control of their own bodies and all used the words 'rape', 'abuse', 'assault' or 'violence'. Violence here is described in relation to their breastfeeding experiences by a number of the women. Kitzinger (1992) further suggests that pushing for alternatives in breastfeeding support does not come to grips with the central issues of who is in control in hospitals.

**Conclusion**

Feminist poststructuralist discourse analysis has offered a framework for the discussion of discourses surrounding breastfeeding experiences of

women following childbirth, discussion of influences on those discourses and suggestions for ways in which those discourses can change.

The historical influence of the medicalisation of breastfeeding is evident as women struggle within the patriarchal hospital system to establish and maintain lactation (Oakley 1993; Hood *et al.* 1978).

Oakley and Houd (cited in Enkin 1994) point out that primary prevention of problems does not necessitate surveillance and control, but support that is adapted to the individual woman in her particular situation. The support task of healthcare professionals, they point out, must be seen in the context of the woman's existing network of relatives and friends. In this study the breastfeeding knowledge of mothers, sisters and friends was valued and for some, central. A partnership between breastfeeding women, their families and staff would enable shared learning and teaching and reduce issues of power and control in relation to breastfeeding knowledge.

A return of power for breastfeeding women is related to gaining control of their own bodies and their own lives, acknowledging their own knowledge and expertise and challenging many dominant discourses. Midwives and nurses can partner women in this challenging of dominant discourses.

Some changes are evident in some of the women's stories; situations where midwives, rather than aligning themselves with the hospital staff, align themselves with the women, acknowledging the women's expertise and working in partnership. These were situations where the breastfeeding woman maintained her own power and control.

As the existence of oppression is acknowledged, the first step is taken in a process that allows for the development of the capacity to resist oppressive social expectations. This is not easy for either women or midwives because all have been part of a long process of socialisation designed to promote docility and trust in the unassailable objective authority of the so called 'expert' (Cheek and Rudge 1994, p. 61).

It is not helpful for us to accept the status quo in healthcare as natural and immutable, or to blame individuals or groups of people. If we are to successfully reconstruct our worlds, we need to understand how the system works and that includes understanding past actions that contributed both passively and actively to the system and then:

... through new or fuller understandings of the nature of institutionalised healthcare, how we ourselves supported and still support the status quo in which the abuses occurred, we may begin to find ways to reconstruct our own worlds in new, less oppressive, more just ways.

(Hickson 1990, p. 13)

This study reveals a need to further listen to women's experiences of breastfeeding. The



stories of these six women provide a wealth of information about difficulties with breastfeeding following childbirth. The numbers in this study are small: it is necessary to have further studies of women's experiences of breastfeeding. In these days of continual health restructuring, women are perfectly able and willing to explain what they need in the way of breastfeeding support. This, in some cases, may be different to what hospital staff think that they need. It is imperative that women's voices are heard and that breastfeeding support services are changed according to the needs of breastfeeding women.

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## Bounty Scholarships and Awards

*Bounty* has recently celebrated its first birthday in New Zealand. Thanks to the tremendous support and input from midwives and other health professionals both prior to first publication and for the following three reprints, the guides are now acclimatised to New Zealand and are extensively used as an educational resource.

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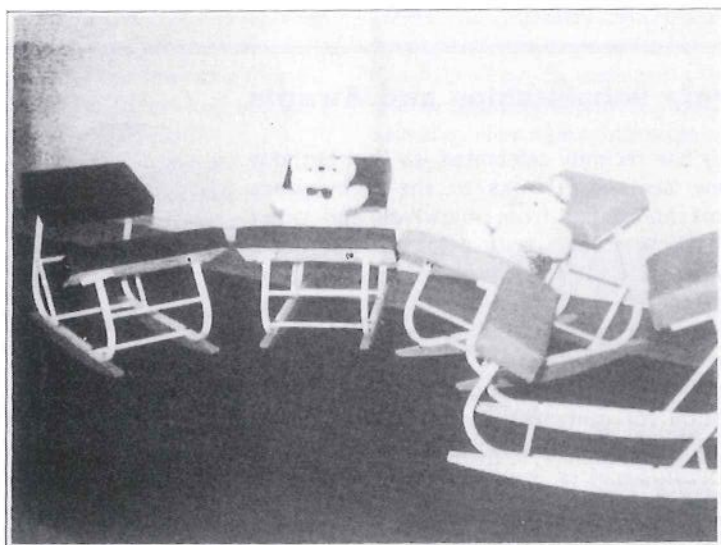
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**BOOK  
REVIEWS**

**Book Title:** *Baby Friendly Mother Friendly*  
**Editor:** Susan F. Murray  
**Published:** 1996  
**Publisher:** Mosby, England  
**ISBN No:** 0 7234 2123 4  
**Reviewers:** Barbara Wright, Lactation Consultant  
 Helen Manoharan, Midwife

This excellent text offers willing travellers a road map back to the point where common sense and respect for nature prevail over our fascination with medicine.

This book is divided into two sections:

**Section 1**

(Baby Friendly gaining its title from the Baby Friendly Hospital Initiative – UNICEF 1991.)

This section explores what can be achieved in practice in ways of protection, promotion and support of breastfeeding. Case studies are presented from Botswana, Australia, Myanmar and Namibia which, with their implications for breastfeeding, can only serve to assist midwifery in the empowerment of women by education. These case studies give unique insight into what is being done globally. The achievements, cultural aspects, barriers, mothers' feelings, all explicit, are well documented and well researched.

**Section 2**

This section concentrates on the needs of the mother. It brings together theory and practice of midwifery, not only the theoretical concepts in midwifery but theory about midwifery; not only clinical midwifery practice but the practice of midwifery policy and midwifery research.

Much of the material highlights the ways in which women across the world still lack power in relation to their own bodies, their own fertility and their own babies. These issues are addressed head on and challenges for midwives to pursue are offered.

This book provides sensitive, responsive comprehensive strategies to enable midwives and health professionals to address society in preserving nature's natural nutritional rights for infants.

A really excellent book for all who are interested in extending their knowledge of midwifery and childbirth.

**Book Title:** *Midwives and Safer Motherhood*  
**Editor:** Susan F. Murray  
**Published:** 1996  
**Publisher:** Mosby, England  
**ISBN No:** 0 7234 2122 6  
**Reviewer:** Sue Crabtree, Midwife, Palmerston North.

The dedication for this book reads:

The women whose deaths make up the maternal mortality statistics are daughters, sisters, wives, lovers and mothers. Their loss is deeply felt by those around them.

The Safe Motherhood Initiative was launched with the support of WHO and many other agencies at the 1987 Nairobi Conference and it challenged the world to halve the maternal mortality figures by the year 2000. This initiative has highlighted the levels of maternal mortality in developing countries and the terrible disparity between rich and poor countries. This book draws together the work being undertaken by midwives and others around the world. It is divided into four key areas, exploring:

- Research for Safer Motherhood,
- Midwives' Changing Roles,
- Midwifery Education, and
- The Midwifery Profession Internationally.

I found this book to be informative and challenging. It provides a fascinating overview of the struggles and achievements of midwives around the world, including African, Asian and Latin American midwives. Although the problems vary widely, midwives world-wide face similar challenges. Women across the world still lack power in relation to their own bodies, their own fertility and their own babies. All healthcare providers, including midwives and maternity service managers, must examine their role in contributing to this powerlessness.

The editor's challenge to midwives is this:

Midwives have the potential of a unique and privileged relationship with women during important life events. This is something to be treasured. However, to my mind it is increasingly clear that we cannot confine our horizons to the provision of good individual care alone. Unique and privileged relationships bring with them wider social responsibilities and functions, to document, to research, to debate, to defend and to advocate.

The first section concerns maternal health research in developing countries. It takes as a starting point some of the major direct causes of maternal mortality and morbidity in the world today. Cross country data reveals that there are five major direct causes of maternal deaths: obstructed labour, maternal haemorrhage, sepsis, hypertensive diseases of pregnancy and the complications of abortion. Midwives have increasingly become involved in research concerning safer motherhood issues and the first

four chapters are indicative of that involvement. The use of the partograph in preventing the complications of obstructed labour is presented and an investigation in Ghana of maternal death from haemorrhage is reported. The barriers to acceptable, appropriate and welcoming healthcare are considered, including the introduction of user fees and the way services are provided.

Section 2 (Chapters 2–7) considers some of the ways in which midwives' roles are expanding, or should be expanding, in response to our greater knowledge of women's reproductive health needs. Areas considered are: the provision of abortion services and life-saving treatment after illegal abortions; appropriate postpartum contraceptive services; and the role of Chilean midwives, the matrona, who provide reproductive healthcare to women throughout most of their life span, from adolescence through to the menopause.

The third section of the book deals with midwifery education and training issues of particular relevance to developing countries. The current debate of Traditional Birth Attendants (TBAs) training and the effectiveness of TBAs is explored. The midwifery education needs of the future and the challenges of midwifery practice at community, first referral, regional and national level in West Africa are presented. The achievements of in-service training in Nigeria and the importance and meaning of supervision in midwifery practice are discussed.

The final section of the book looks at midwifery internationally. Chapter 12 gives a detailed account of the history of the International Confederation of Midwives and its current-day role in the promotion of safer motherhood. The final chapter is an overview of some of the influences on the status of midwives in different countries and how these affect their practice (New Zealand gets very little mention). Midwives across the world share the common tasks of assisting at birth and caring for the health of women, but they do not share a common status, though the problems vary widely.

*Continued on Page 24*

**COMING EVENT**

**The First World Congress on Maternal Mortality**

8–14 March 1997  
 Marrakesh-Morocco

This Congress will gather around 2,500 physicians, researchers, personalities, invited from all over the World.

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