



# JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, APRIL 1997



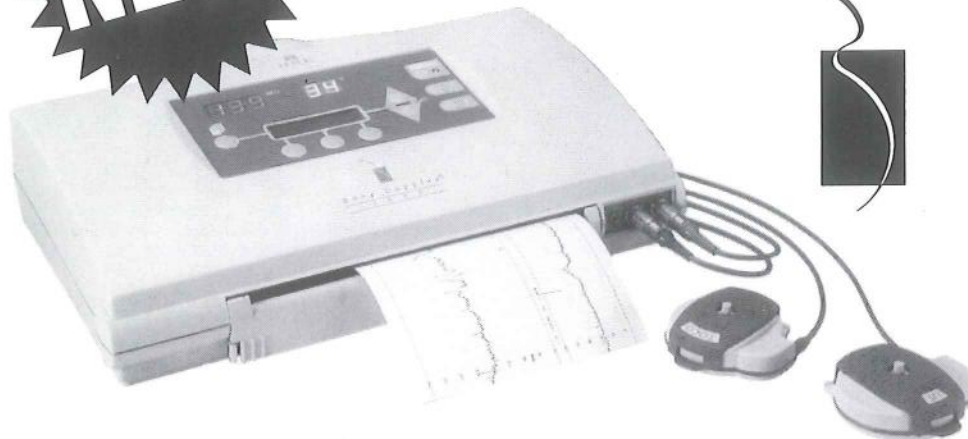


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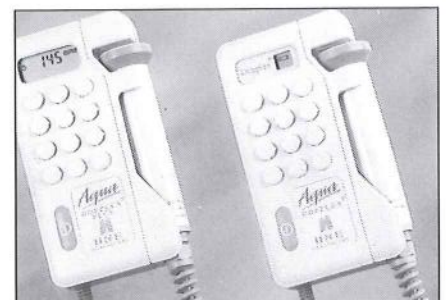
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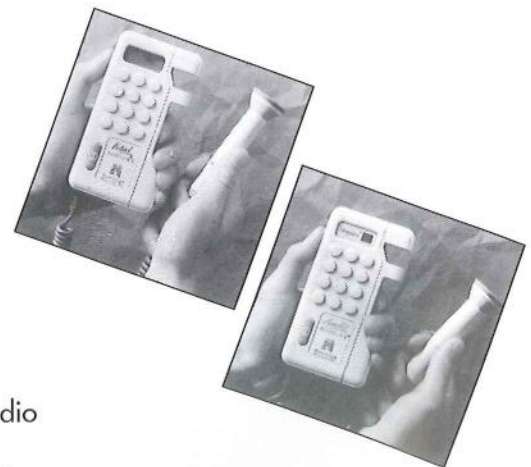
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**Editor:**  
Helen Manoharan  
PO Box 249  
Palmerston North

**Printed by:**  
Hannah & Young  
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Ph: 357 9039

**Research Editor:**  
Alison Stewart

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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.

All submitted articles are peer-reviewed within the subject area of speciality.

##### Author Details

Please provide the following details:

- Name(s)
- Occupation – if a midwife, what area of midwifery you are currently working in.
- 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

A few weeks ago I described to a class of new midwifery students the historical significance of a pohutukawa that grows in the grounds of the School of Nursing and Midwifery. As I did so, it occurred to me that the pohutukawa could be viewed as a metaphor for midwives and midwifery. What tenacious trees they are! Along any northern coastline they cling to the cliff at impossible angles and, in so doing, protect the cliff face from erosion by the elements. To survive in such harsh growing conditions, they have developed tough fleshy leaves and very strong but flexible branches as a type of armour against salt and wind. The seeds germinate almost anywhere, becoming hardy seedlings. They endure. Many trees are hundreds of years old.

It seems to me that we midwives and New Zealand midwifery are at a point in our history where similar qualities of tenacity and hardiness are needed to survive the slings and arrows of a harsh environment and to protect from erosion women's and midwifery's knowledge and ways of knowing about the processes of normal pregnancy and childbirth.

The equity and economic issues related to the Section 51 notice are an example of how difficult the current environment is for midwives and women. The recent efforts to undermine midwives and midwifery that have been published in the media are an illustration of the attacks that midwifery and individual midwives are sustaining. It seems as though there is a constant chipping away at the woman-centred heart of midwifery practice. In particular, what constitutes normal childbirth is constantly under scrutiny. The philosophical clash between the world views of childbirth as normal until it proves itself otherwise and that of childbirth as normal only in retrospect occurs every day somewhere in the country. It sometimes seems we have been answering the same questions and putting up the same arguments for ever. The constant reiteration of the same questions has a deeply wearing effect on those who constantly have to answer them. In the face of such unremitting pressure to repeatedly explain or defend their practice, midwives can begin to feel that they no longer have the energy to rebut undermining attacks and stand firm in their practice. I believe this insidious slide into apathy is a real danger.

It is at times like these that it is important to emulate the pohutukawa by clinging persistently on to the cliff face in order to protect the precious soil from erosion. It has never been more important for midwives to contribute to maintaining and developing New Zealand midwifery, even though to do so sometimes seems like the last straw.

New Zealand women, however, deserve more than a brief fiery flowering of a midwifery

summer. They deserve a profession that endures through difficulties and emerges more strongly at the other end so that woman-centred childbirth and continuity of care remain a choice for all women.

New Zealand's women put their faith in midwives and midwifery to provide the type of maternity care that they desire. They continue to demonstrate that faith by increasingly selecting a midwife for all their maternity care or for continuity of care. The NZCOM figures for 1994 support the trend. In 1994 a total of 36 per cent of women in New Zealand chose an independent midwife for continuity of maternity care; 15.5 per cent of these women opted for midwife only care throughout the pregnancy, birth and puerperium. Since then, many Crown Health Enterprises have developed continuity of care schemes so that this choice is now available to more women. It is easy to lose sight of these changes in difficulties of the day-to-day environment.



\* New Zealand women deserve that midwives and New Zealand midwifery protects their right to choices in childbirth and that midwives fight to preserve women's ways of knowing in normal childbirth. They do not deserve to be abandoned in the storm. Hence the need for tenacity. Tenacity is always easier to achieve if everybody participates. Women and midwives deserve a participatory midwifery profession. In order to stay flexible and strong, midwives need to cooperate with one another, to support one another, to draw strength from women's beliefs in midwifery and to work together at all levels in order that midwifery continues to grow and develop. As individuals and as a profession, we have come a long way in a short space of time. It is less than seven years since the amendment to the Nurses Act was passed, it was inevitable that parts of our journey would be very difficult.

However, we can take heart from the numbers of women choosing midwifery care for all of their childbirth experience. We can also take heart that we now have a midwifery organisation that has developed from voluntary to professional administration, we can take heart that education for direct entry to midwifery is now available at

all midwifery schools in New Zealand, and we can take heart from the high profile that midwives now have in the community. These are no mean achievements in such a short space of time.

We must all participate in midwifery's development in order to retain the progress we have made and to move forward into the future. We must preserve the precious gifts we have received; women's knowledge about birth, women's faith in midwives and midwife's skills and knowledge, so that they can be freely passed on to new generations of midwives and women. When pohutukawa hold on to the cliff face their roots intertwine to form a network in which the source of each root becomes difficult to determine. The resultant lattice work is very strong and protects the precious soil from erosion. If every midwife in New Zealand adopts some of the tenacity and interlinked support demonstrated by pohutukawa, woman-centred childbirth and midwifery will endure just as the pohutukawa endure.

Jackie Gunn – Midwifery Teacher  
Auckland Institute of Technology

## LETTERS TO THE EDITOR

Dear Editor,

An unusual family statistic from the *Devizes and Wiltshire Gazette* 19 June 1828:

Recently at the house of Mrs Furnell in Limerick, her three daughters had their accouchements on the same day and almost within the same hour. This coincidence has blessed the grandmother with three grandsons nearly at the same moments.

Published in September 1996 *Family Tree Magazine*.

Yours sincerely,  
Christine Barbour. Hamilton

P.S.: I wonder if any midwife can better this?

# "When you're pregnant who needs heartburn?"

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# Section 51: Contract for Autonomy

**Karen Guilliland**  
**Rational director**

The underlying belief structure of the women and midwives who fought for the midwifery profession over the last decade was that the midwives ability to practise autonomously improved the experience and the birth outcomes for women and their babies.

Midwifery's collective autonomy meant freedom from the authority of the medical profession concerning the provision of normal maternity care. It was considered essential that the women-intensive midwifery profession controlled midwifery in order for women to control childbirth.

When the Nurses Act changed in 1990 practice autonomy also meant financial autonomy, as midwives gained entitlement to claim from the Maternity Benefit Schedule. This fee-for-service schedule was not popular within the Department of Health at the time as it was considered over utilised and abused by claimants. With the inclusion of midwives into its negotiation process, the Department of Health openly confided to the NZCOM that they hoped to restructure the whole method by which maternity services were paid. This was well before the health reforms. The Department of Health had long favoured a global fee but had had no lever to change the medical commitment to fee-for-service.

The College had some sympathy with this view because a global or total fee recognised the whole maternity experience rather than its components. We planned to encourage an indepth review of international payment mechanisms and their advantages or disadvantages before committing ourselves to any one mechanism for payment. With the passing of the Health and Disability Services Act in 1991, the RHAs had an open and explicit commitment to extinguish fee-for-service, and not only in maternity services. Health by contract or capped budgets was the driving force behind the reforms. Midwives were not the trigger for change, 'blowout' or no 'blowout', the agenda had been set years previously and midwives were one vehicle for bringing about government's fiscal policies. It suited the government and the RHAs to allow midwives to be scapegoats in the plans to reform payment mechanisms.

The first RHA drafts of Section 51 failed in our view to recognise women as central, continuity of care, maternity services as a core service and midwifery as autonomous. There were many issues which the College membership and its negotiators found unpalatable and unworkable in those first meetings. These are all outlined in NZCOM's submissions and newsletters. The final draft addressed many of our concerns but there still remains issues which concerns us, not least of which is 48 hours funded postnatal 'in-patient' care with inadequate funding for the follow up community support midwives provide with home visits. We have succeeded in increasing the funds and setting up processes for individual assessment of need. The door for further negotiation is still open and the College is vigorously pursuing the issues which concern midwifery and women.

It was this decision to continue working with the RHAs which threatened to divide midwives. We decided on this path because we considered the framework had the potential to empower women and protect the autonomous role of the midwife. However, the College, in the end, had no choice as the NZMA reneged on its agreed position over the structure of Section 51 (we had both always said the final acceptable structure would depend on the prices attached). They embarked on a media campaign which was not only a massive misrepresentation of the Section 51 structure, but one which was demeaning to midwives and our ability to provide safe and competent care. We couldn't support or ignore the doctors' public statements about safety but neither were we completely happy with the final advice notice.

The National Committee debated this dilemma at length and it was decided that we would continue to negotiate. Paradoxically, Section 51, considered the mechanism to preserve midwifery autonomy and consequently women's control over childbirth, also has the propensity to tear the profession apart if midwives fail to understand the principle and politics behind the College's position.

Section 51 is a collective, nationally agreed contract which is the foundation for all other contracts negotiated with smaller groups of midwives including CHE midwifery services. It is its collective and combined professional strength which gives midwifery negotiating power. Most midwives are not yet strong enough to guarantee that negotiating power when fragmented into multidisciplinary groups. Neither is society ready to fully stand behind our embattled profession. The public is easily and constantly swayed by the medical opinion which the media reports as absolute truth. If feminists like Sandra Coney cannot see our issues then what hope has the average person when regaled by biased and inaccurate reporting. The medical profession has taken swift and clever advantage of the media's faith in their honesty and knowledge. They have used their social status as a mandate to protect their

interests. The fact that the College's voice has been consistently sidelined, ignored and misquoted is ample evidence of our vulnerability in the overall scheme of this. We would be foolish to underestimate the strength of the medical profession which is why Section 51 is still a very important part of our evolution as the RHAs are also neophyte in experience and vulnerable to the political pressure the doctors are exerting.

It is therefore not incidental that doctors are fighting so vigorously and so collectively against the Section 51 changes. Regardless of their public concern about safety and quality, their real concern is about control. They know that whoever controls the budget controls the service. That is why there are dozens of IPAs all over the country working to secure jurisdiction over the total health service and its budget.

The hypocrisy over the doctors media cries of concern for the 'experiment' and budget holding nature of the new Section 51 is transparent to midwifery at least. It is not that doctors don't want the budget, it's that the budget is not large enough and they often don't hold it at all!

Fighting against Section 51 buys doctors time and political will to disenfranchise midwifery and claim back the total budget under GP cartels or organised collectives (IPAs).

There is plenty of evidence that those cartels will be medicine led, managed and driven. Lannes Johnson, Chairman of IPCS (Auckland's largest IPA) says in an urgent fax to all his members.

There are two issues:

1. Support for the NZMA and their concerns for obstetric safety.
2. Looking after our own patch and moving to a comprehensive obstetric contract as soon as possible.

He adds:

The more fuss the more gain to our competitors, the CHes and independent midwives (at least those who will not work for us).

Furthermore:

In any case we will be negotiating a contract for primary care obstetrics including the CHE facility budget as soon as possible. Later we can look at the Secondary Care Budget. The most sensible way of handling competition in obstetrics, is by holding the (total) obstetric dollars.

The rhetoric from health reformers, funders and politicians is that deregulation will open up possibilities for other health professionals and managed care will produce team work amongst equals and new innovative ways of working. The only professionals the Ministries of Health and Education have any intention of deregulating, however, are non-medical professions. It's called

multiskilling in the jargon. The Medical Practitioners Act remains firmly and strategically placed to put all the rest of us in our place – under the control and supervision of medicine, the budget holder managing the whole health process. A major task for the College currently is to make sure midwifery registration is retained under the occupation regulation review. If we have any doubts about the likelihood of other professions providing alternative care models just look back on the personal and professional struggle of midwives over the last six years. Midwives are the only group to challenge and compete with doctors on statutory equivalent terms. To medicine we are a dangerous precedent in this new health environment and must be undermined at all costs. Tauranga midwives have it right when they asked for discussion with the IPA on their own terms. They had 'no intention of joining a managed care company and risk loosing the independent practitioner status granted by law only six years ago. It sounds like Prime Health (IPA) want to employ us, we don't want to be employed' (BOP Times, 10/7/96).

The success midwifery has had in providing an alternative to the medical model is due to midwife solidarity and belief in their ability to provide a good service. In the presence of this offered service women have responded quite remarkably and by 1996 80 per cent of women in the Northern RHA area have a known midwife.

In Midland RHA it is 82 per cent, Central 72 per cent and Southern RHA 68 per cent. Throughout New Zealand 20 per cent of women choose only a midwife for their care provider. Most midwives today provide a mixture of midwife-led and shared care options for women. Remember too that payment for this service while handed to us in 1990 was argued and fought for in 1992 at the Maternity Benefit Tribunal. This Hearing lasted seven days and heard sworn testimony from 11 obstetricians (professors and otherwise), general practitioners and paediatricians, five midwives and two economists. The Tribunal accepted the evidence of the NZCOM and the Department of Health that midwives' education and practice produced safe, effective and competent midwives who provided an equivalent maternity service to GPs. It was on the proven principle of equal work being of equal value that the Minister of Health at the time, Bill Birch, approved that midwives be appropriately paid, the same as doctors. We earned the right to our current payment schedule. RHA pilots (Wellington Domino Midwives, Avonlea Birthing Centre, Christchurch) have further demonstrated midwifery care as safe and effective with similar or better outcomes to the other care options.

The dismissive, often slanderous anti-woman nature of this recent flurry of medical media frenzy follows the same pattern as the outcry in 1990 following the Nurses Amendment Act, and again in 1993 with the publication of the Maternity Benefit Tribunal's findings. It also emulates the same patterns exhibited by doctors in other nations where midwives are endeavouring

to reinstate midwifery and woman-centred maternity services.

Tessa Turnbull, Chairperson of RNZCGPs, when quoted on the new arrangements in the press stated that they catered to '... the lowest common denominator – the midwife ...' (Gisborne Herald, June 1996).

It was also the RNZCGPs who advised couples to delay conception until (what is essentially) their pay dispute was settled! The arrogance of that media statement dropped apparently unnoticed into a male-dominated media who present medical comment as fact.

NZMA Chairperson, Brian Lineham, reflects many doctors views of our 'place' (Dominion, 31.7.96):

The hourly rate was intended for doctors doing a short-term high activity task such as actually delivering the baby or sewing up afterward.

He says:

That hourly rate was used by midwives for ordinary midwifery activities which include sitting with the mother and looking after her throughout the labour which may go on for 48 hours.

GP Action Group Maternity Newsletter (Dr Tim Bailey Gibson) says:

We have observed midwives accessing a system designed for episodic care from doctors running busy offices. We know this is the primary reason for the blowout in the maternity budget and the main trigger for the changes. We have seen the College of Midwives representatives insisting their members can be all things to all women. We (their emphasis) have heard, though the College of Midwives appears not to have, that large numbers of midwives are happy working with doctors, that many do not want to be 'upskilled' and that very large numbers are terrified of what the new Section 51 contains.

In this sort of environment there is little wonder that midwives view group contracts and the bigger impending managed care contracts with caution. The concept of the GP as gatekeeper to the health care system underpins the managed care model. In the maternity service there are other equivalent gatekeepers and they are called midwives. No other health service has an alternative but equivalent model to offer. Midwifery's whole education system is geared towards producing the type of practitioner capable of fulfilling the client-centred health promotion, disease prevention, cost effective primary health service the ideologues believe managed care can deliver.

Why then have funders not rushed to sign us up in our own right? Could it be that for all New

Zealand's claims to be an egalitarian society, women and midwives struggle to have their voices heard and their opinions valued when money and power is at stake? Acceptance will take time it seems. Could it also be that some midwives themselves do not understand or even want the responsibility that the Nurses Amendment Act placed on them to practise autonomously? Some midwives do not understand that to be autonomous does not exclude working with others and have construed it to mean isolation. Others understand all right but have opted out of their obligations in favour of a dependent and, in their view, a less threatening role. Not one of these midwives has, however, opted out of the payment or status rewards an autonomous profession brings to them. A few have actually abused that privileged societal position. The most disheartening reaction for a woman-intensive profession however, is the ease at which some midwives accept the doctor's position and then use it against their own profession. Some have joined doctor groups and publicly disassociated themselves from their colleagues and the College's stance. No doctors have undermined their profession's public position in this manner. While there is no need or place for all midwives to agree, there are principles at stake here which hold the key to midwives survival and protection of our

professional integrity. For any midwife to believe that the medical profession has the interests of midwives at heart more than midwifery's professional body, is an astonishingly naïve display of oppressed group behaviour. It is the notion of confrontation which often offends women/midwives yet to not do so is to deny the reality of women's struggle for autonomy.

To capitulate and comfort the dominant model is to deny our own right to autonomy. It indicates the profession's insecurity, a lack of faith in the profession's ability and a lack of maturity in 'living' autonomy. Women require strong midwives, strong enough to enter into a true, informed and negotiated partnership with them during their childbirth experience. Women and midwives need to believe in their own personal autonomy and rights to self-determination or Tino Rangitiratanga. We all have a role to play in this struggle and Section 51 provides a framework for all midwives to be nurtured towards and secured in their ability to be autonomous practitioners. It allows individual midwives to take that responsibility at a pace which strengthens rather than weakens their resolve. It also allows those unable to accept the challenges to continue to practise in their comfort zone with both of these positions appropriately financed. Individual midwives, group practices

and midwifery collectives or MPOs will then evolve towards other contractual models in a position of strength and power. Some of course are ready now.

Nelson Mandela's 1994 Inaugural Speech says it all:

Our deepest fear is that that we are inadequate.

Our deepest fear is that we are powerful beyond measure.

It is our light not our darkness that most frightens us.

We ask ourselves, who am I to be brilliant, gorgeous, talented, fabulous?

Actually, who are you NOT to be?

Your playing small does not serve the world.

There is nothing enlightened about shrinking so that other people won't feel insecure around you.

We were born to make manifest the glory that is within us.

It is not just in some of us; it is in everyone.

And as we let our own light shine, we unconsciously give other people permission to do the same.

As we are liberated from our own fear, our presence automatically liberates others.

## TIMELINE OF MATERNITY BENEFIT NEGOTIATIONS

1989: Unresolved Maternity Benefit negotiations between New Zealand Medical Association (NZMA) and the Health Department (DOH).

1990: Nurses Amendment Act:

- midwives able to claim from the Maternity Benefit
- New Zealand College of Midwives (NZCOM) and NZMA as agents for negotiating fees
- NZMA still at loggerheads with DOH over their lack of progress with a fee increase
- NZMA refuse to negotiate with the NZCOM to recognise the tri-partite process.

1990-1992: DOH and NZCOM attempts to negotiate with NZMA unsuccessful

1992: NZMA calls for a tribunal and Simon Upton appoints Helen Cull as President, along with representation from NZCOM, NZMA and the public.

1993: Tribunal report published - endorsed by Bill Birch. Tribunal upheld statutory equivalence of GPs and Midwives in provision of primary maternity services and said:

*... both practitioners are able and competent to provide a maternity service and achieve what has been described as a 'positive outcome' by different*

*styles of practice. To continue the choice of service available by law to pregnant women the tribunal sought not to differentiate between practitioners by placing a higher value on one over the other.*

The Tribunal increased the set fees for service and decreased the labour and birth and mileage fees. The decrease affected mainly midwives because of the nature of their practice (continuity and home visits) and resulted in a 30 per cent drop in income for midwives.

1993-1996:

Increasing co-operation between doctors and midwives as both were able to claim in their own right from the same benefit for the actual work provided by each. During these years increasing numbers of midwives moved from employment within hospital maternity units to self-employment within the community. The resulting cost shift from hospital funding to the Maternity Benefit funding was apparent in some of the increase in Maternity Benefit, but it was difficult to identify the total budget as the CHEs costing systems were not transparent at that time. The CHEs, because of their bulk funding arrangements, were able to shift savings made in maternity services (midwife's salaries) into other areas. The so-called 'increase' in the Maternity Benefit was also due to increased servicing and claiming by doctors, a back-pay to doctors, a general increase in



the fees and the shift of ultrasound scanning from bulk funding to the Maternity Benefit.

By 1997 the nature of the CHE maternity service is significantly different as services changed in response to the changed role of the midwife. CHEs now operate with significantly less midwifery staff as women using the CHE facilities now usually have their own independent midwife to provide their care whilst in the facility. The CHEs have also established their own independent midwifery services, further increasing women's choices, family involvement and integrated maternity care.

1993: Health and Disabilities Services Act - RHAs take over funding of primary maternity services. Coopers and Lybrand produce the framework for the modular system which was presented to the NZCOM and NZMA as non-negotiable.

1993-1996: Discussion and negotiation over the content of the modules and the service specifications for the maternity service. The Lead Maternity Caregiver (LMC) concept strongly endorsed by the NZMA as someone 'being in charge' was seen to be a panacea to all problems. The principles and modular framework were accepted by all parties by the end of 1995 with some reservations until prices were attached to the modules.

1996: RHAs release Section 51 without agreement by either NZCOM or NZMA over the modular prices. NZCOM only accept (albeit with some major reservations) on the understanding that refining negotiations would continue and the notice amended accordingly. In particular the cost structures for rural services and postnatal home visiting and the watering down of the LMC concept to one of budget holder rather than primary caregiver. The NZMA's membership rejected it outright with some GPs boycotting services and others charging women for their maternity care.

August: RHAs propose some changes to address doctors' concerns. These proposals never formally discussed with NZCOM although comments were submitted. Proposals withdrawn when NZMA rejected them.

September: NZCOM met with NZMA to assess the common ground over Section 51 and the direction NZMA was pursuing (return to fee for service). No consensus as NZCOM supported the continuity of midwifery care under the more flexible modular approach.

October: Doctors presented their proposal to RHAs. This followed considerable assistance from the RHAs, particularly in regard to calculating the effect of their proposed fees on the total budget allocation. The NZCOM had no input into these discussions nor access to the same spreadsheet information and was eventually presented with the final proposal by the RHAs. NZCOM only receives proposal on day of meeting. NZCOM objects to the process as inequitable - RHA holds meeting with consumer groups for NZMA to present their proposal. NZCOM objects to the process as undermining the current Section 51 notice in favour of a proposal put forward by NZMA. NZCOM requests its position also available to consumers.

November: NZCOM re-presents proposal to RHAs on rural services and postnatal home visiting. Largely ignored by the RHAs and is not presented to the NZMA by the RHAs.

December:

Combined meeting between RHAs, CHEs, NZCOM and NZMA to present NZMA proposal. CHEs and NZCOM both outline unacceptability of a return to fee for service/module mix. Issue of underfunding of postnatal care and rural services raised by all groups.

Christmas Eve:

RHAs release their response to the doctors proposal making some radical changes to the fee structure. NZCOM submits its concerns once again and rejects proposal as reducing continuity of care and further fragmenting the maternity service. It also severely disadvantages midwives by widening the remuneration gap between doctors and midwives to an unacceptable level. NZMA rejects proposal as not going far enough to meet their proposal.

1997 - January-February:

NZMA meets with RHAs on several occasions (including one meeting with all RHA CEOs) as well as meetings with the Minister of Health. NZCOM not given meeting time with joint RHAs despite requests. NZCOM given a March meeting time with Minister of Health.

January:

RHAs present NZMA with a response to their proposal - copy sent to NZCOM. CHEs denied access to proposal. NZCOM raises serious concerns about the proposal and its consequences for women and midwives.

February:

NZCOM meets with two RHA representatives to discuss rural definitions and postnatal funding. NZCOM to work in consultancy role to each RHA in order to further progress on rural and travel issues. RHA response to NZMA proposal discussed as unacceptable.

February:

RHAs further modify their proposal and present this to the NZMA. NZCOM and the CHEs denied access to this proposal. Rationale given is that the NZMA need to be happy with the proposals before they are presented to the NZCOM or any other interested party - NZCOM informs RHA amendments unacceptable. RHAs presented another rural proposal thereby rejecting NZCOM's proposal based on miles travelled.

March:

NZCOM requests informal meeting with NZMA to discuss the process and to try to find common ground for further discussion as both are increasingly concerned about the affect of current uncertainty on maternity services. Both groups also concerned about demoralising affect on the professions. NZCOM meets with Associate Minister of Health, Neil Kirton, to voice its concerns.

10 March:

NZCOM still have not seen the new RHA proposal for discussion at their 12 March meeting with RHAs. Does not allow any time for consideration. NZMA has had discussions with RHA re more money and has had opportunities to proportion it into the Benefit Schedule. They have also defined guidelines for midwifery fee service specifications when purchased from the CHE.

NZCOM requests meeting with Minister of Health, Bill English, to halt process and request a return to Section 51 prior to July 1996 while maternity packages developed between NZCOM and NZMA.

11 March: NZCOM investigates injunction to halt process.

# Breastfeeding: A Dying Art?

**Marcia Annandale**  
Lactation Consultant

*Breastfeeding: A Dying Art?* is a complex question and in this brief session I wish to raise a number of issues including some of the threats to breastfeeding and then look at ways in which midwives can become involved in arresting these threats.

I am working from the belief that we are far from reclaiming the breastfeeding culture in New Zealand as long as influential people, including midwives, do not truly recognise breastfeeding as an important public health issue. A myriad of lip service to breastfeeding protection, promotion and support exists and advancement is unlikely if we abide by existing materials and practices.

Threats to breastfeeding in New Zealand today include:

- \* the Infant Formula Companies (Bevin 1995)
- \* the lack of resources allocated to it by the government
- \* failure of government to enact the Goals of the Innocenti Declaration 1996
- \* failure to implement the Baby Friendly Hospital Initiative (World Alliance for Breastfeeding Action 1992, A Joint WHO/UNICEF Statement 1989)
- \* again at a national level, the Health Sector Code of Practice (Public Health Group, Ministry of Health 1996)
- \* for breastfeeding in New Zealand, Section 51 Provision of Maternity Services 1996 (Southern Regional Health Authority Southern Regional Health Authority 1996)
- \* the privileged Lead Maternity Carer's who play such a key role because of their scope of practice.

The main thrust of this article deals with the latter topic.

Are midwives keeping up-to-date with breastfeeding information and research and incorporating it into their practices? Recently the Canterbury West Coast Region of the New Zealand College of Midwives (Inc) cancelled a clinical practice workshop on breastfeeding due to lack of interest (New Zealand College of Midwives (Inc) 1996). What does this say about midwives and breastfeeding? (Jones 1996). How many workshops have been held by midwives in the last four years to first utilise then consider updating your Breastfeeding Handbook? (New Zealand College of Midwives (Inc) 1992).

Are midwives, continuing to practice the 'do-it-for-women' not 'with women' way? It is disturbing that lack of time, arguably lack of skills, in the early postpartum periods contribute to mothers losing confidence to breastfeed their babies without 'hands-on' assistance (Kyenkyia-Isabirye and Armstrong 1992, Watson Driscoll 1992, Kennell 1994, Righard 1996).

The powerful hands-on model commenced, possibly to an initially grateful mother in hospital, has a huge and detrimental effect on her continued efforts to breastfeed at home; as seen and heard from women's stories (Bradfield 1996).

Have midwives become the 'one stop shop'; the new gatekeeper for maternity services?

Without keeping accurate data on the incidence, exclusivity and duration of breastfeeding, it will continue to be believed that midwives do a wonderful job with infant feeding issues right through to the dissolution of the midwife/consumer partnership. However, I ask you, what meaningful information do you gather from the present tick in the box system – Fully Breastfed, Breast + Comp, Fully Artificially Fed? (New Zealand College of Midwives (Inc) 1996). These definitions are inaccurate, inadequate, misleading and prevent breastfeeding in the long term.

While I fancy, in my ideal world, that all women breastfeed *exclusively* to six months and continue breastfeeding while appropriate other foods are introduced, this just is not so in reality.

We need to honestly learn how much, how often and with what women are feeding their babies so that research needs can be identified and eventually clinical practice can be influenced and changed. It is up to mothers to judge their own 'success' of breastfeeding but we do need to know how they arrived at that point and what it means for them.

The current climate for breastfeeding is seemingly so pro that it is creating pressure on women to breastfeed because they wish to please the caregiver, not because they know it is an important health decision for themselves and their babies. For example, why aren't women being told that the incidence of Acute Otitis Media, Insulin-Dependent Diabetes Mellitus and Lymphomas are less likely to develop in breastfed children? (Davis, Savitz and Graubard 1988, Mayer *et al.* 1988, Aniansson 1994).

Or that they have greater protection from Breast Cancer and Osteoporosis and a delay in the return of fertility when they breastfeed their babies? (Gross 1991, Yang 1993, Blaauw *et al.* 1994).

The way feeding issues are being approached and the lack of accurate data collection are creating judgement and an unsafe discussion environment for women and also preventing us obtaining a true picture of infant feeding in New Zealand. From my committee experience of

seeing many Standards Review Reports, feeding percentages are seldom recorded or commented on in ways that may identify midwifery education needs. A recent midwife's report indicates an annual figure of 74 per cent fully breastfed. One can only hope this figure was recorded at six weeks postpartum and that it means breastfed exclusively from birth. However, it begs many questions not least of which is what happened for the other 26 per cent of women who were mixed or artificially feeding? It may be entirely due to women's informed choices but it does require justification. Data extrapolated from the Royal New Zealand Plunket Society indicates a six-month postpartum rate of exclusive breastfeeding of 2.5 per cent (Essex, Smale and Geddis 1995).

While lack of accountability for breastfeeding continues, midwives annual statistics will be part of perpetuating the myth that 'we don't have a problem' with breastfeeding in New Zealand.

This conspiracy of silence, attempting to relieve the burden of guilt for mothers who 'fail' to breastfeed is now making these same mothers angry about their lack of control and choice during the breastfeeding crisis period (Minchin 1989).

If midwives were to read the College standards outlined in the *Midwives Handbook for Practice* from a breastfeeding perspective they may find their practice begging in a number of areas; particularly Standards 6 and 7 (New Zealand College of Midwives 1993). In being remiss about certain criteria in their standards, the midwife leaves herself wide open to complaint. The very document that is 'for the profession and the public to be able to judge both individual practitioners and midwifery services' could be used against her to comprehensively demonstrate where she has failed to 'deliver' for the woman and her breastfeeding experience (Moniz 1992).

Breastfeeding problems, in fact, can render parents helpless, frightened and grieving and what had seemed like a natural event – a progression from the months of planning with their midwife for a natural birth, in the place of their choice, suddenly all 'hits-the-fan'! Have women said to you that they would rather go through labour any day than go through the complications of breastfeeding? It shouldn't be this way!

It is clear that, just like the three-legged stool, protection, promotion and support for breastfeeding are needed collectively and require equal allocation of resources. No one leg will work without the other two.

The College and individuals anywhere can be involved in minimising the threats to breastfeeding by:

- Accepting that breastfeeding rates in New Zealand are falling and that we do have a problem.
- Co-operating with other organisations to foster an awareness in the importance of breastfeeding and the hazards associated with artificial feeding.
- Accepting responsibility to consult and refer

care to appropriate others when the limit of their expertise has been realised.

- Lobbying government to fulfil the goals of the Innocenti Declaration. This includes the International Code of Marketing of Breastmilk Substitutes and the Baby Friendly Hospital Initiative.
- Taking responsibility for becoming familiar with and understanding the intent of the documents that protect, promote and support breastfeeding. This includes the *College Breastfeeding Handbook* (1992).
- Initiating or accepting ongoing breastfeeding education and exchange of knowledge.
- Learning more about how to convey infant feeding information to enable women to make comfortable sustaining choices.
- Improving documentation of feeding interventions and related outcomes by urging the College to extend its data collection.
- Upholding the standards of the College as outlined in the *Handbook for Practice* including taking part in annual Peer Review.
- Conducting research in infant feeding and incorporating the findings into practice.

### Acknowledgement

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# SMOOTH TEXTURE METAMUCIL NATURAL DIETARY FIBRE



***A natural way for pregnant & post-partum women to stay regular***

## **57% of pregnant post-partum women reported an increase in feeling constipated.**

Constipation occurs when waste products pass too slowly through the bowel causing too much water to be absorbed, this results in dry hard stools.

During pregnancy high levels of hormones can relax the bowel making elimination sluggish and less efficient. Pressure from the growing uterus and some medications eg. iron tablets can also have an effect on the function of the bowel.

1. Bounty Services Report (Australia) Jan, 1996 (Research by Wilkins Research for Bounty Sept. 95)

## **Fibre can help.**

Fibre consists of undigested plant residue that passes almost intact through the digestive system. Fibre is either soluble (gel forming) or insoluble (non-gel forming), both are important to bowel function. Metamucil is made from natural grain, the husk of the psyllium seed, it is one of the world's richest sources of soluble fibre.

Metamucil absorbs water to form a gel to help soften, add bulk and lubricate the stool in its passage through the bowel. It does not contain chemical stimulants, it works in the same manner as other high fibre foods. One dose of Metamucil mixed with water contains 3.4 grams of fibre.

## **Smooth Texture Metamucil,**

Metamucil Natural Dietary Fibre has launched a new variant "Smooth Texture", it has been triple ground to a fine texture, so it is easy to mix and drink. It is the only Metamucil variant that is sugar free and suitable for diabetics.

It is suitable for pregnant and lactating women as it does not enter the blood stream or pass into breast milk. It has a new orange flavour and is available in 175g & 315g tubs. Sachets are also available for Hospitals.

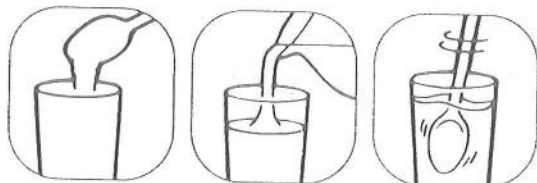
## **Fibre Therapy in the Post-partum period.**

The passing of the first bowel movement is a milestone in the post partum period and there is often voluntary avoidance at this time. Reduced muscle tone can also make bowel elimination sluggish. A daily dose of Metamucil is recommended for the first three days post natively to soften and ease the passage of the stool.

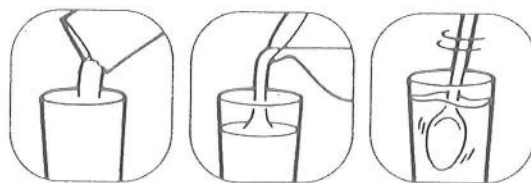
## **How to administer Metamucil.**

Add 1 1/2 level 5ml, measuring spoons or one single use sachet of Smooth Texture Metamucil to 250ml of cool water and stir briskly, Administer immediately and follow with an additional glass of water. An adequate fluid intake is a requirement when adding fibre to the diet, a minimum of 1.5 litre per day is essential. Give one dose of Metamucil per day, gradually increase to three doses per day if needed or recommended by a Doctor. It can take two to three days to get the full benefit of Metamucil. If minor gas or bloating does occur, reduce the amount given for several days.

### **Smooth Texture Tubs**



### **Smooth Texture Sachets**



## **Questions or Comments?**

**Phone Toll Free - NZ 0800 441 058**

# Baby Skin Care

Joan Donley O.B.E.

The importance of baby skin care cannot be overestimated. The living, breathing skin is the largest organ in the body. Sensitive to touch, heat, cold and pain, it responds to stress and reflects bodily conditions. It protects the body from injury and bacterial/parasitic invasion and as an organ of excretion it plays a role in moderation of temperature and prevention of dehydration.

The skin is composed of three basic layers: the epidermis, the dermis and subcutaneous tissue.

## Epidermis

The epidermis is made up of four layers. The two major ones are:

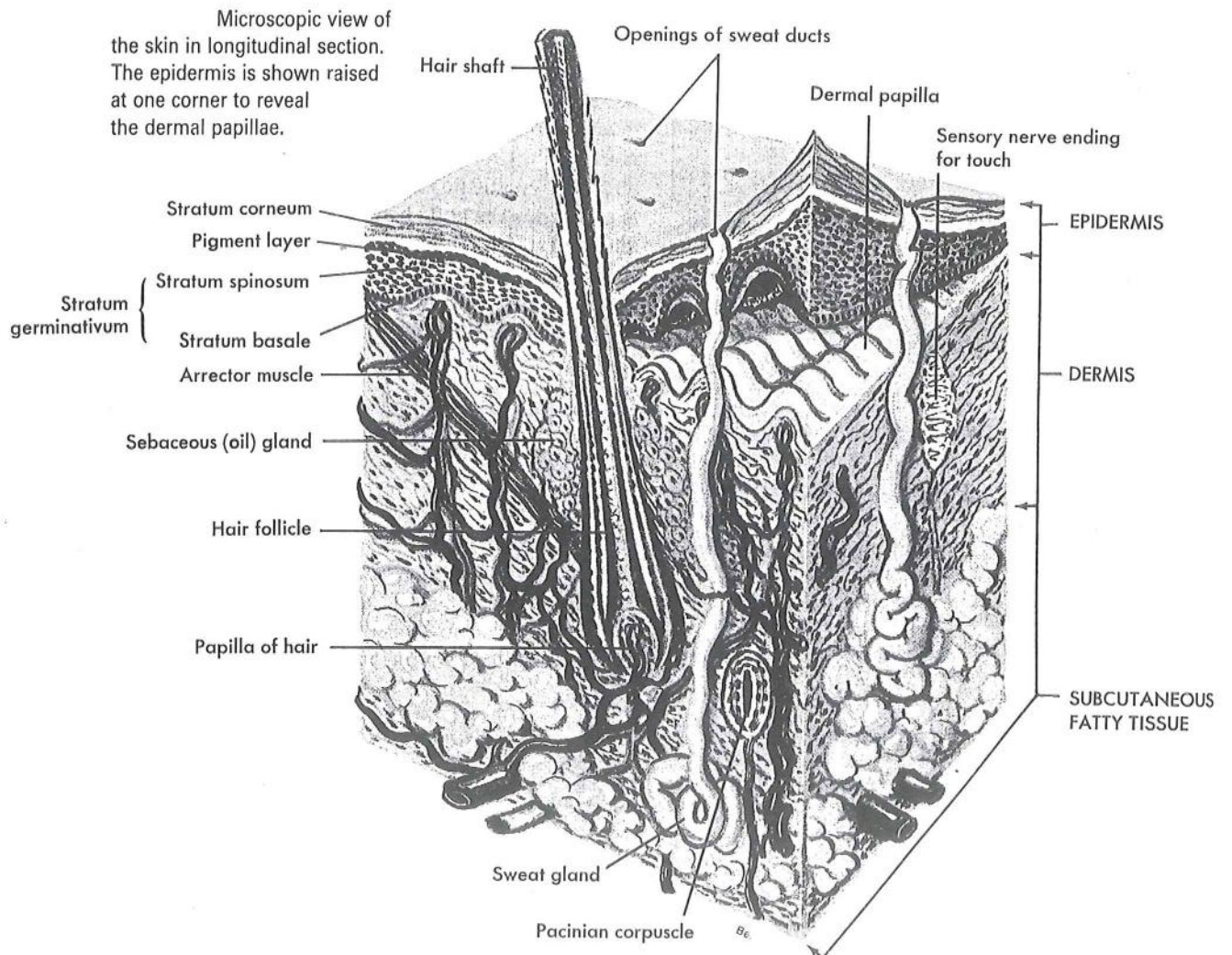
- *The outer protective horny layer – stratum corneum – made up of tightly packed flattened dead cells impregnated with a fibrous protein – keratin – which also forms finger/toe nails and hair.*

Keratin contains the necessary components to receive electromagnetic waves, capable of picking up acoustic and mechanical vibrations.<sup>1</sup>

Although only 20 to 25 cells in depth, the corneum is relatively impermeable and waterproof.

- *The innermost Malpighian layer – stratum germinativum – consists of continuously dividing cells. Over an approximate 26-day cycle these new cells undergo change as they migrate through the granular and membranous layers to replace the dead cells as they slough off.*

The stratified layers are adapted for protection.



## Dermis

- *The true skin* – dermis or corium – 1–4 mm in depth is metabolically active fibrous protein, 70 per cent of which is collagen. Collagen gives skin resistance to mechanical stress, keeping it firm and supple. It is interlaced with albumin-like elastin, richly endowed with blood vessels, which maintains skin flexibility.

The dermis also contains:

- blood capillaries which nourish the skin and give it its rosy tint
- sebaceous glands – 95 to 100 per square inch of skin – are attached to each hair follicle. These produce a slightly acidic, anti-bacterial/fungal oil – sebum – the principle constituent fluid of skin surface lipids (fats)
- lymph is the interstitial fluid which bathes the tissues, filtering bacteria and harmful substances through the lymph nodes to be ingested by white blood cells. Antibodies are produced in the lymph<sup>2</sup>
- sensory and autonomic, unmyelinated nerve endings
- sweat glands, their ducts and hair follicles
- smooth muscle fibres.

The subcutaneous (third) layer nourishes, insulates and supports the dermis.

## Protective Safeguards

The skin is the first organ to respond to its environment.

Its softness and flexibility is assisted by:

- The protective layer of the sebum, water and salts which permeate the minute spaces between the horny epidermal cells. This slightly acidic (pH 4.5 to 6.75) mixture of fatty acids, perspiration and dead cells is known as the 'acid mantle'.<sup>3</sup>
- The water balance is regulated by epidermal cells which act as a selective filter to regulate the passage of moisture into and out of the skin. These contain hygroscopic (moisture attracting) substances (humectants) protected by membranes rich in lipids.<sup>3</sup>

## Infant Skin

The velvety infant skin has a very high fat (lipid) content due to its large and well-developed sebaceous glands. It is resistant to absorption of harmful substances UNLESS these are combined with a fatty material.

Also, a baby's dermis is significantly thinner than an adult's since its collagen fibres are smaller.

Finally, a baby's large skin surface (2500 sq. cm.) in relation to its body weight, presents a greater potential for systemic absorption of topically applied substances.<sup>4</sup>

Keep these factors in mind when selecting products for baby's skin care.

## Other Factors to Consider

Depending on the vitality of the skin, it is strongly influenced by temperature, relative humidity and chemicals. Dryness can cause superficial flaking and cracks in the skin which allow access to the dermis.

Anything absorbed into the dermis can have a biological effect in the case of exposure to chemicals, DNA can be damaged. While skin can continue to repair and reproduce itself, its genetic coding may be damaged so that it is no longer perfect.<sup>5</sup>

## Care of Baby's Skin

Since the skin of the normal newborn is so naturally endowed it needs only to be kept clean, warm and dry.

Babies enjoy the relaxing effect of bathing in warm water – with the mother or alone.

This is an opportunity to handle and stroke the baby – a basic form of one-to-one communication.

Babies also enjoy the tactile experience of massage. Massage relaxes the body, increases circulation and transmits energy.

**Do not use soap as this removes the protective acid mantle layer. It then takes 70 minutes for the skin to recover its normal acidic state.**

Cutaneous stimulation is important for the immune, physiological and behavioural development.

Babies who are regularly massaged adapt more quickly to stress<sup>6</sup> thus sleep better and gain weight.

## Bottoms Up

The first dark green stools (meconium) are sticky. Dried meconium on baby's bottom can be difficult to remove. Try:

- Softening with olive oil then washing with warm water.
- A teaspoon of olive oil can be added to the bath water.

**Do not use soap** (pH generally more than 10) as this removes the protective acid mantle layer. It then takes 70 minutes for the skin to recover its normal acidic state – pH 4.5 to 6.75.

Various 'soap-free' baby bath products are also to be avoided. Although the pH of these

range from 6.7 to 7, they contain surfactants which, it is claimed, 'lift unwanted fatty residues ... can harbour dead skin cells and surface sweat' from an infant's skin.<sup>7</sup> In other words, destroy the acid mantle! Surfactants are used as foaming and cleansing agents and to increase the viscosity of a product. They are commonly combined with synthetic detergents (syndets). The most popular is Sodium Laureth (Lauryl) Sulfate (SLS).

It's a strong degreaser that dries skin and hair and has produced skin and hair damage, including cracking of the horny layer of skin and a severe inflammation of the dermal skin.<sup>8</sup>

Lauryl Sulphate (1 per cent) is used in 'in vitro' experiments to 'solubilize' cells to enhance absorption.<sup>9</sup>

## Natural Alternatives

### *Safe and Environmentally Friendly Substitute for Soap*

A spoonful of oatmeal (which is smoothing and slightly abrasive) tied in a piece of muslin is an acceptable substitute for soap.

A combination of oatmeal and rice bran soothes a heat rash or an itchy skin.

### *Baby Bath Mixture*

To prepare a baby bath mixture:

- place 2 tablespoons of each of the above in a bowl with 1 tablespoon of dried chamomile flowers
- stir in 2 teaspoons of sesame oil.
- store mixture in an airtight glass jar away from direct sunlight
- use 1 tablespoon in a muslin bag
- squeeze to release the milky cereals.

Some post-mature babies are born with a dry wrinkled flaky skin which can allow penetration of potential irritants.

Virgin olive oil which is high in vitamin E will improve this condition (see oils).

An aromatherapy option is to make up a 30 ml combination of virgin olive oil – 10 per cent, wheatgerm oil – 10 per cent and hazelnut oil – 80 per cent. To this add three drops of the following blended essential oils – Chamomile German – 8 drops, lavender – 1 drop.

Massage daily.

Any left over can be added – one drop only – to baby's bath.<sup>10</sup>

Essential oils are very potent. Use only the number of drops advised.

Other newborns arrive with varying degrees of vernix. This 'is secreted in utero by the sebaceous glands to protect the baby's skin from the amniotic fluid. After birth it is rapidly absorbed. There is no need to remove it.

## Oils

Grains, beans and seeds do not easily give up their oil. Oil from the soft olive is easy to extract by mechanical means – without resort to heat (cold pressed).

The first extraction is 'virgin' olive oil.

All traditionally mechanically expressed and unrefined oils are volatile and unstable due to their organic content. They therefore start to degrade (become rancid) on exposure to light and air, so it is important that they are kept in tightly stopped bottles and away from light.

Vitamin E in olive oil acts as an antioxidant. Addition of a few drops of antiseptic (yang), lavender oil<sup>11</sup> or tea tree oil – antiseptic, antibacterial – viral and fungal<sup>12</sup> can extend the freshness of these oils.

Commercially produced oils which can be traded internationally are extracted and refined by heat and chemicals and have petrochemical preservatives added to ensure 'shelf life'. They are therefore cheaper than natural oils.

Petrochemicals in baby care products contain more than oil – mainly mineral oil. They range from surfactants, detergents, disinfectants, preservatives, fragrances and colours.

Mineral oil is commonly used as an emollient (lubricates and softens the skin). It is poorly absorbed into the skin and by interfering with the skin's natural moisturising factor, actually causes dead cells to become over-dried so they curl up at the edges giving the skin a cracked and flaky appearance.

A mineral oil derivative, Glycerol Stearate, used in washcloths may cause skin irritation and is 'an ingredient to avoid'.<sup>13</sup>

## Healing Ointments

There are also a number of healing ointments on the market such as calendula or zinc and castor oil. (Zinc is the most important trace mineral in collagen).<sup>16</sup>

If you feel ambitious you can make a protective and healing ointment:

1 cup olive oil  
¼ cup of beeswax  
about 1 cup fresh chickweed.

When it is melted, strain the mixture through cheesecloth into a jar with a lid. Keep away from heat. It keeps for 6–8 weeks.

Or, add cornstarch to vitamin E oil 2:1  
Mix and store away from heat in a glass jar.  
Keeps for about one week.

## Nappy Rash

Nappy rash is 16.4 per cent more prevalent on babies in disposable nappies compared to those in cloth nappies plus plastic pants – 3.3 per cent.<sup>17</sup>

This may be due to the fact that disposables, being more expensive and absorptive are left on for longer.

Cloth nappies can be rinsed and placed to soak in a bucket of cold water. To 4 litres of water add 20 drops of tea tree oil as a disinfectant.

If adding bleach – ordinary bleach is much less expensive than 'disinfectants' which are basically sodium hypochlorite, e.g. bleach.

## Powder

The use of talcum or any powder is discouraged. Talcum powder is closely related to three of the five types of asbestos – hydrated magnesium silicate. There have been 30 cases of infant talc inhalation with eight fatalities.

Incidents involving baby powders account for approximately one per cent of poisoning in children under five years.<sup>18</sup>

Earlier, researchers found particles of talc in approximately 75 per cent of ovarian tumours and in 50 per cent of cervical tumours examined.<sup>19</sup> Whether the problem was due to talc or to the asbestos contaminant, it indicates that talc makes its way up the female genital tract.

Following FDA banning of talc on surgical gloves, JAMA urged removal of talc on condoms as this could cause ovarian cancer and/or fallopian tube fibrosis.<sup>20</sup>

Researchers found particles of talc in approximately 75 per cent of ovarian tumours and in 50 per cent of cervical tumours examined.

## Cradle Cap

Cradle cap can be due to a vitamin B6 deficiency, sometimes related to the mother's nausea and vomiting in pregnancy.<sup>21</sup>

### Treatment

Daily massage with almond oil (almond, calendula, jojoba or olive) to which essential oils or dried flowers have been added.

### OR

To 2 tablespoons almond oil add 1 drop of each eucalyptus, lemon and geranium.<sup>22</sup>

### OR

Cover with oil ½ cup of each dried chamomile and lavender flowers. Cap securely. Place in a sunny spot for 10 days, shaking every day. Strain through fine muslin squeezing out all the oil. Refrigerate in a clean capped jar.

To use, gently massage the oil into baby's scalp. Leave for an hour or so, then comb with a fine comb gently lifting the scales. Wash, repeat if necessary.

If using a commercial shampoo, check the ingredients. Avoid using any product that claims to prevent 'tears' as these contain chemicals that anaesthetise the eyes.<sup>23</sup> Tears contain an enzyme – lysozyme – which destroys bacteria.<sup>24</sup>

## Cosmeceuticals

The word 'cosmetic' came from the Greek 'cosmeo' meaning balance/harmony. Today, we have cosmeceuticals, a term coined by Mindell.<sup>25</sup>

Cosmeceuticals are cosmetic made petrochemicals. They contain biologically active ingredients<sup>25</sup> which can penetrate the tough keratin, especially in the presence of oils.

According to Ayurvedic medicine, oils are carriers into the nervous system.<sup>26</sup> Massage further enhances absorption.

However, the skin's absorption capability is not selective. It can absorb not only beneficial fat soluble vitamins and essential fatty acids (EFAs), it can as easily absorb harmful chemicals such as aniline dyes, insecticides, DDT and hormones.<sup>28</sup>

For instance, pesticides are often dissolved in 'inert' substances or mixed with fat-soluble syndets so they will penetrate the tough exoskeletons of insects in order to reach cell membranes.<sup>28</sup>

Inerts, such as propylene glycol, also a surfactant used in cosmetic and baby products, is of 'toxicological concern' as it can cause birth defects.<sup>29</sup>

A further problem is that exposure to more than one chemical can cause synergistic interactions ad infinitum, due to the presence of cellular enzymes which can bioactivate other compounds into toxins.<sup>30</sup>

Synthetic chemicals are more toxic for children than for adults.<sup>23</sup> Babies have been known to die as the result of absorption of aniline dye ink on nappies which were issued before being boiled to fix the dye.<sup>31</sup>

As far back as 1971, the FDA issued a warning against the use of hexachlorophene to 'clean' newborn babies as this was linked to neurological damage. (Hexachlorophene is also known as hibitane or pHisoHex.)

According to Leslie Kenton, anything which is absorbed into the dermis and has a biological effect on the skin's deeper layers is supposed to be classified as a drug.<sup>32</sup>

Another area of concern is the use of chemical fragrances. These do not have to be identified in bodycare products, having been specifically exempted from the Label Reading Act (US) 1977. They can frequently cause allergic reactions. More serious is the danger of these pungent fragrances breaching the blood brain barrier – gaining direct access to the limbic system, the emotional switchboard of the brain.<sup>33</sup>

## References

Available on request.



## Capturing the Feel of Phenomenology

4: Photographs for Daddy  
Here you see  
little round eyes  
here his sparrow mouth here  
his perfect feet  
but the special smell of him  
his warm head  
the sounds he makes when joyous  
these I cannot send  
these you must come home for

(Anne French 1987)

Does this poem written by Anne French evoke memories for you? Does she capture something in this description that is more than the words? Is there something here that has a sense of being universal, of being about all new born babies? She has called it a photograph, a photograph of the 'being' of her baby: his special smell, his warm head, the sounds he makes when joyous. It is not a photograph of a special occasion, but a photograph of everyday life. Through the skilful crafting of words, Anne French has captured the essence of her baby. *This is phenomenology.*

Phenomenology seeks to translate the felt understanding of an experience into words. Listen to these words of Lauris Edmonds as she describes her first experience of labour:

What had actually happened the night of my baby's arrival I didn't tell Fanny (her mother), or anyone. I couldn't have explained what kept me silent – it was as though some racial memory, a lesson I had learned countless generations before, instructed me; it was an instinct, I obeyed it. My labour had in fact shocked and horrified me all the time it was going on; it was an interminable nightmare, with myself at the centre roaring and shrieking to an array of busy yet impassive spectres who acted upon me as though I was a joint of meat, to be turned this way and that and carved to the bone. The puerile idea that if I relaxed all would be well lasted no time at all. Once the pains became strong and frequent, I could do nothing. I would try and relax as each began, but quite soon it would grow larger, deeper, more gripping, more savage and mountainous, until I lost all vestiges of sense or control and yelled and yelled. I'd never done such a thing before, or ever imagined doing it, but equally odd, the nurses seemed not at all surprised – as far as I could think about them, which wasn't much.

(Lauris Edmonds 1991, p. 40)

This story is likely to have remained covered up, had it not been the story of a writer. It took place in the 1950s, an era when such things were not discussed. In those days it was taken for granted that labour was an unpleasant experience and that one did not talk about it. Nobody told Lauris Edmonds that, yet she knew. She knew it from within her very being.

Phenomenology is about 'laying open and letting be seen' that which is 'taken for granted' in our everyday world (Heidegger 1925).

Phenomenology is about letting us 'see something that for the most part does not show itself at all' (Heidegger 1967). The nurses, probably midwives, in this story saw a woman in labour and 'seemed not at all surprised'. Lauris Edmonds' experience of labour was hardly seen at all.

This is the story of one woman, in a particular era of the maternity services, yet it carries with it a sense of being the story of many women, through many different eras. I hear echoes of this story still being told.

Phenomenology seeks to uncover the essence that is universal, that goes beyond any individual experience.

Essence is perhaps best captured by the artist, or the poet. There is a famous painting of a pair of boots by van Gogh. Heidegger describes this painting as capturing the essence of bootness. You can see the essence, you can feel the essence, but how much harder it is to translate that essence into words. Van Manen (1990) describes phenomenology as a poetising activity. It is about finding the best words put together in the best way to capture the experience in its full richness and depth. The words take you away from where you are. They speak to your body. They stay with you. Consider again the impact of Lauris Edmonds use of words as metaphor:

# Phenomenology: A Research Approach for Midwifery

Elizabeth Smythe

Midwife-Teacher  
Auckland Institute of Technology



... as though I was a joint of meat, to be turned this way and that and carved to the bone.

*This is phenomenology.*

## Translating Phenomenology into Research

Neither of these two examples has been of research. They have been the writing of two women, sharing their very personal experience. Yet, that is what phenomenology is about, personal experience. The phenomenological researcher seeks to capture such stories, for it is these stories which return us to 'the things themselves' and it is in the things themselves that we will find the world which precedes knowledge. It is this unpolluted, untampered with, uninfluenced, unthought about knowledge that is the quest of phenomenology.

Translating stories into phenomenological research is to feel the understanding that the story evokes and to find the words to describe those insights.

In such a way the understanding moves from being of one woman's first labour, to an understanding of the phenomenon of 'being in labour for the first time'. Lauris Edmonds' story is now taken by me the researcher and thought about.

I ask:

- what is this story really saying?
- what matters?
- what are the insights she has uncovered for me?
- what is the meaning uncovered about being in labour for the first time?

I write down my interpretations:

- \* the personal trauma of birth is heard by its silence and locked within silence
- \* there is instinctive knowing of obedience
- \* the woman labours within the discord of feeling herself savagely out of control, yet being surrounded by impassive uncaring
- \* in the midst of labour it feels as if there is no hope, no end, no recognition of her agony
- \* the power and violence of labour are beyond personal control
- \* being in labour is 'beyond imagining'.

This is the beginning of capturing the phenomenon of 'being in labour for the first time'. If we examined other women's stories, or talked with other women about their experiences, we would come closer to finding the essence, the universal theme. At the same time we would accept that each woman's story has its own place and its own right to be acknowledged.

## The Knowing of Phenomenology

The problem with finding new knowledge is that it so often has already been given to us as a pre-

packaged notion of what an experience will be like. Similarly, when we listen to the experience of others, we tend to filter what we hear through what we already know, or think we know. Phenomenology seeks to reach beyond those pre-packaged notions. It makes the assumption that our experience of 'living through' will be different from the pre-packaged understanding. Lauris Edmonds talks of the puerile idea (meaning silly and immature) that if she relaxed all would be well. Her lived experience gave her new understandings about the impossibility of being able to do anything like relaxing. In the enormity of an experience such as labour those deep understandings of what it was really like may stay as memories of the body, not necessarily translated into words. They are within us.

## The Knowing in the Being

It is this belief that understanding that is woven into our very being and is therefore within every experience that guides phenomenology. Heidegger (1967) says that knowing cannot be separated from our being. Take the example of watching an experienced midwife facilitate the birth of a baby. She knows what to do. She does what she sees needs to be done. If you stop and ask her on the way out to describe what exactly she did, she is likely to look at you blankly, for her knowing is so much a part of her being. You would have seen her hands reach out, heard her voice guiding, sensed that her very presence spoke its own message. She herself probably hardly noticed any of that. She would have been totally engrossed in 'being' a midwife.

Steiner (1991, p. 90) says 'how often the trained hand "sees" quicker and more delicately than eye and brain'. The understanding of what 'being a midwife' means is within that experience. Until it is brought to light it is taken for granted, perhaps under valued, perhaps not understood to its full potential.

## Choosing Phenomenology

Why would you choose to use phenomenology as opposed to grounded theory, or critical feminist methodology, action research, or any other? Phenomenology is about 'meaning'. Therefore to choose to do phenomenological research is to have a meaning question that you want to understand more clearly.

Van Manen (1990) reminds us that meaning questions do not solve problems, they do not offer empirical facts nor scientific generalisations. You are not going to produce the grand theory of midwifery. You are not necessarily going to uncover issues of power and control, dominance and oppression, or gender struggles unless they are within the stories that get told to you. You are not going to work closely with the participants, perceiving them as co-researchers. Phenomenology leaves the business of interpretation to the researcher. This means that while you return transcripts to participants to give them control

over the stories that will or will not be included in your research, the process of interpretation stays with the researcher. Interpretation moves the focus away from 'the person' to an examination of the phenomenon. It is the researcher who has the concern for the phenomenon and who weaves together the understandings that have been uncovered from other stories. It is my experience that participants are very comfortable with this arrangement. They value the right to have input about the way their story has been told, but they do not see it as their business to pursue the process any further.

## Defending the Choice

The aim of phenomenology is simply to reach a deeper understanding of a phenomenon. If you choose this path you will face the critics who ask 'what is the point?', who tell you that 'it won't change anything', who throw words like 'validity' and 'reliability' at you confirming for them that it is indeed a waste of time. I think back to the power of story through the generations of history. I recall parables, fables, myths and legends, fairy stories. You could all tell me some of those stories because they are within you. If phenomenology can share stories that draw you into the experience of others, that stay within you in a way that no collection of ideas or statistics ever will and if the researcher can interpret those stories in a way that enables you to understand the phenomenon with new insight, then for me that is enough. Each person then takes responsibility for their own understandings. They decide for themselves the trustworthiness of the research report. As they read or listen, the 'phenomenological nod', the sense of 'yes, I knew this, but I've never put it into words before' will be the stamp of approval. If it helps them clarify their understanding, if it provokes them to wonder, if it sets them thinking new thoughts, then it has been worth doing.

## Doing the Research

Having decided on phenomenology and having chosen the phenomenon you will explore and having tried to make explicit what your personal understanding is about this phenomenon, you then go in search of it. You are looking for people who have experienced it, who you believe will be able to describe their experience to you in a meaningful way. The phenomenon I am pursuing is 'the meaning of being safe in the maternity services'. I have talked to midwives, doctors and women. I chose the midwives and doctors on the grounds that they were the sort of people who seemed to enjoy talking about practice. I chose them from a broad spectrum of practice. I chose people I knew and found this facilitated an ease of getting to the matter at hand. I began my interviews with two women I knew well. In some ways this made it harder because I already knew their stories. Most of the other women I had never met before. Somehow they just came my way. Some of them I asked because I believed they may have felt

unsafe at some stage through their birth experience. When you have a specific phenomenon in mind, you look for participants who have been close to that phenomenon.

### Gathering the Data

What happens between you and that person in the name of 'doing the research' is described by some as an interview, by others as a conversation. For myself, I have learned it is a time to listen and let them tell their story in their own way. I learned by hearing on the tape the participant pausing to take a second's thought, only to have me jump in with the next question. I wonder what tentative description was about to be expressed, perhaps for the very first time, to be lost forever in my rush to fill the silence. I now try hard to keep a still tongue until the person looks to me for guidance. It is your approach to facilitating this dialogue that makes it phenomenology as opposed to another methodology. You want them to tell you, in detail, about their experience. You want to know what it is like, what they thought at the time, what they felt, what they did, what they said. You want them to recreate the many dimensions of that experience. I have learned that if I sit quietly and nod, that is exactly what people will do. If I start asking too many questions it is easy to fall into the trap of asking 'what do you think about?' type questions which move away from what actually happened to them. As researcher you must try not to take your pre-understandings with you. This means you are not asking questions to justify your opinion about supposing what the experience was like for them, you are not blocking new insights by telling yourself 'that can't be true'. You are open to hearing whatever you are told.

### Transcribing the Data

The interview is transcribed. In earlier days I did this myself. A one-hour tape took me an entire weekend to laboriously transfer to paper. The advantage of this word-by-word encounter was that the transcript became embodied within me. I knew it. As I grew more weary a faithful typist was employed. This costs money; there is a time lag between the interview and getting the transcript back to work on and at the end of it all I still find I need to put myself through a word by word encounter. I perceive the balance swinging in favour of doing your own transcribing, yet I know a reluctance within my body of such concentrated effort.

### Interpreting the Data

Next comes the challenge of doing something phenomenological with the data. Van Manen (1990) talks of a process of 'reflective grasping', of deciding what of all that has been told to you actually has some special significance in describing what it is that you are exploring. The

challenge is to uncover its essence, to find the things that makes something 'what it is – and without which it could not be what it is' (Husserl, in van Manen 1990, p.10). I ask myself 'what is the essence of being safe without which being safe would not be what it is?'

### Writing and Rewriting

Once you have dwelt with the data and come to a sense of understanding the essence of the phenomenon of your study, the challenge is to then capture that in writing. Van Manen (1990) describes the work of phenomenology as 'the art of writing and rewriting' (p. 32). Ray (in Morse 1994, p. 116) describes good phenomenology as having a beauty criteria, being artistic, being knowledge generating and being complex. That is the challenge of the writing.

At a workshop I went to run by van Manen (1995) I came to understand that the rewriting includes rewriting the stories as told by the participants. At first I was shocked by the mere thought of 'tampering with the data'. Then I tried it and realised not only the effectiveness of doing it, but the respect it gave to those stories. I am quite sure that Lauris Edmonds wrote and rewrote the story I read earlier. When we speak, we are thinking as we go. We stumble, we hesitate, we add in the 'you know's' and the 'sort of's'. We don't always tell a complex story from start to finish. We are more likely to give an overview and then go back and retell bits as they come back to us. Rewriting in the phenomenological sense means telling the story in the way that best captures what it was like. It does not mean adding new meaning, or changing meaning. It is the same story, told in a way that lets its meaning shine through.

### A Story of Intuition

Let me share with you one of the stories from my study. It is a story of intuition. It was transcribed from my conversation with a woman. I then rewrote it from the transcript and returned it to the woman. She added in her own changes to grammar, reordering of words and other minor changes. It was as though we have both polished the meaning to enable it to reach out to the audience as best it may. To place the story in context: this woman had a twin pregnancy, with ruptured membranes at 21 weeks. Regular scans showed that there were two sacs, that they both had the same amount of fluid around them and they were both babies were quite normal. At 27 weeks she went into labour.

I suppose it always does go through your mind that it is a high risk pregnancy. I don't think I ever really knew that this baby would die, but then in other ways in the very back of my mind I always knew that she was the one that wasn't going to make it, if that is what was going to happen. It is hard to

describe why you think things like that but... It was always difficult to get the CTG on the baby that died. I think it may have been because she didn't have the fluid around her because you need the fluid to make it work. May be that was part of why she was difficult and she always really got annoyed too. I think it was because she didn't have any fluid to cushion her and the monitor was pressing into her or something. We used to call her the trouble maker because you would just put the CTG leads on and she would duck and dive away as if she was trying to hide. They always said that the other baby was the leading twin because she had her head down and that she would be the one with the ruptured membranes because it is usually the leading twin that has the ruptured membranes. I remember thinking 'I just can't imagine that the head down twin is the one that is like that' because she always seemed to be so peaceful and stable whereas the breech twin seemed to have something bothering her. And we always joked with them all and said:

- [us] well how do you know?  
[them] well it is always like that  
[us] and how do you know that the one that has got its head down is going to come out first?  
[them] well it just always happens like that

And then the day that I was in labour I could tell they were having a big fright about who was going to come out first because they were juggling positions. They had stayed in quite stable positions all the time and then suddenly they seemed to be wriggling and moving, as if they were deciding who was going to come out first. And when we did the CTG the position of even the leading baby had changed and moved upwards. I told them that I was sure they were fighting about positions. You always had this feeling in your mind about what is going on.

They don't always listen to you. They think that the mothers are silly or something and they don't know. And I said 'I am sure that this time it is not like that'. They do change positions and so I don't know if she was always the leading twin but she was the breech one. They always assumed that it was the other one.

When they did the Caesar the baby they took out first wasn't the one who had had her head down. It was the breech one. She was the one that was engaged. She was the one who had no liquor. She was the one who died just a few hours later. It was as I thought.

The doctor came afterwards. He was really helpful all the way through. He had

tears in his eyes. It made me cry just seeing the tears in his eyes. He said 'I am sorry we couldn't have warned you what was going to happen'. I said, 'well, don't worry because I wouldn't have wanted to have known, this is the best way that it could have happened'.

Let us consider this story in terms of the phenomenon of intuition. This mother knew her unborn twins. She knew them as separate individuals. She knew their behaviours. She recognised their responses to what was 'going on'. Even deeper than that, she knew which one she was most concerned about. She knew that one was bearing the consequences of the ruptured membranes. Her knowing was so sure, that even when the scan and the doctors told her otherwise, she still knew she was right. She recognised that the people making the decisions did not respect her knowing. It was discounted as being silly. When it was the health professionals themselves whose knowing was found to be wrong, this woman knew that it had happened in the best way. She wouldn't have wanted the knowledge of what was going to happen told to her. Some how her own knowing was different. It was very personal. It was about the relationship she already had with her baby. It suggests that the source of knowing influences the response. Intuitive knowing is within. It belongs. It speaks gently. It is able to be lived with in a different way.

The words this woman used were 'you had this feeling in your mind'. Perhaps that is what intuition is. That seems to me to also be the knowing at the heart of phenomenology. Research takes on the challenge of translating that 'feeling in your mind' into words. Perhaps it is in phenomenology that research and intuition are at peace with each other.

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## Primigravida Women Aged Over Forty

Sue Walker and Nicky Costello

Research Assignment

(Diploma of Midwifery, Wellington Polytechnic) 1996

*We are the primip's aged over forty;  
Yes, still in our prime and enjoying a naughty.  
The decision we made we're sure was the best;  
The conception was easy, now it's into the nest.*

*Swimming, walking and tennis are our game;  
We reckon just as active as a young dame.  
We were medically sound before we conceived;  
Trimester one ended and we were relieved.*

*The professionals involved were a mixed bunch;  
Some were quite cautious and had a bad hunch.  
So off to the obstetrician because we're so rare;  
For close observation - what do they fear?*

*The amniocentesis was a bit of a worry;  
Risks for abnormality put us into a flurry.  
Results, they were fine - but you still never know;  
This baby feels healthy, and is beginning to grow.*

*We continued to work and we coped well with this;  
Though come 5 o'clock, going home was just bliss.  
Towards the end, we admit, it got tough;  
By 36 weeks, we'd all had enough.*

*The time is near we think we're prepared;  
Soon we will know, was there reason to fear?  
Of course we're excited, and can't wait to see,  
A boy or a girl - what will it be?*

*The labour was different for all four of us;  
We feel quite pleased, despite the fuss.  
Three of us caesared, and one a NVD;  
The specialist shocked - "but how can that be?"*

*The years we have waited, but boy was it worth it,  
A family at last, and loving every last bit of it.  
One comment made in public we thought was quite  
fun;  
"Oh my, haven't you got a sweet little grandson!"*

*We take these comments with a grain of salt;  
The public not aware, it's not their fault.  
A bit of adjusting, though we admit it did take;  
But, totally happy - sure we made no mistake.*

*A wonderful experience for all, we agree,  
We took our time, the way it had to be.  
It's not too late to have another, said two;  
Time's running out - so goodbye, we've got business to  
do!*



# Wendy's Story

Joyce Cowan

Midwife



Wendy, Finn and Evan

Wendy's story is a dramatic case history of Hellp syndrome. As a midwife I found what was to unfold was to be a very frightening, enormous challenge.

To be caring for a young woman in her first pregnancy over several months and to have a share in some of her plans for the birth and care of her baby and then watch her condition deteriorate rapidly almost to the point of death, was, to say the least, devastating.

However, due to Wendy's personal strength and determination, the support of her husband, family and friends, the prayers of many and the skills of the specialist staff she is now well and has a beautiful healthy son.

In this case study I will look at what happened to Wendy in relation to the available literature on Hellp Syndrome and throughout the text I will include comments from Wendy and her husband Evan, describing their personal experiences.

Wendy was a 31-year-old European primigravida. She was fit, healthy and excited about her planned pregnancy. Her medical history was uneventful but her mother had had pre-eclampsia in both her pregnancies and was now medicated for hypertension.

With this strong family history of pre-eclampsia Wendy's likelihood of developing it herself was increased 5-6 times (Redman and Walker 1992).

However, according to Sibai (1990), Wendy wasn't altogether a typical Hellp Syndrome as he stated that the woman presenting with Hellp is typically multiparous, with a poor obstetric history. He has also stated that the woman presenting with Hellp is usually white, over 25 years old and less than 36 weeks pregnant, which all applied to Wendy.

## Antenatal History

On booking at 12 weeks, Wendy weighed 60kg, urinalysis was negative and her blood pressure was 120/70.

By 31 weeks and three days she weighed 70.9 kg, urinalysis was negative, her feet and ankles were moderately oedematous (it was mid-summer) and her blood pressure was 125/70.

By 33 weeks and six days -Wendy's weight was 72 kgs, a trace of protein was present in her urine, her feet were slightly oedematous and her hands were stiff in the mornings, symptomatic of carpal tunnel syndrome.

### Wendy

*After completing a five-month assignment with Ansett on 10th March 1994 I was feeling excited and semi confident at the thought of becoming a new mother.*

*All my life I had dreamed of the moment due to occur at the end of April. I relished buying all the trimmings for our new arrival and was organised in every aspect. I was not, however, prepared at all for the events that occurred on 21st March and the harrowing five weeks that followed.*

*We had had a busy weekend and on the Monday I was a little tired but thought nothing of it and decided to just take it easy for rest of the day. As the day progressed I regressed. By midday I was feeling over distracted - I could not settle to any particular thing - this is not in my nature. By the time Evan came home it was 6 p.m. and he walked in the door to find me straddled across a dining room chair - I had severe abdominal pain.*

Around 7 p.m., Wendy phoned to say she was worried. As soon as I saw her I knew she was seriously ill. She was oedematous, restless and had the most intense upper abdominal pain.

Wendy had obvious oedema of the face and legs and feeling very unwell. Her blood pressure (BP) was 170/90 and urinalysis showed protein +++.

She had experienced visual disturbances (flashing lights) and was concerned about reduced fetal movements. Her epigastric pain was becoming increasingly intense.

Wendy presented as a classic case of Hellp Syndrome. Weinstein (1982) who first named the syndrome, found that 90 per cent of the women presented with epigastric pain. Sibai (1990) who has published the largest study on Hellp found that 80 per cent of the women experienced this symptom. The BP is not always high which has lead to delays in correct diagnosis in many cases. (Proteinuria is not always present either.) Wendy reported feeling quite tired the previous day and in Sibai's study 90 per cent of the women experienced malaise for a few days before



presenting with symptoms. Sibai's study reported 50 per cent of women had nausea and vomiting and 60 per cent had significant weight gain with oedema. Weinstein's findings were similar, with 69 per cent in his study having oedema. Wendy's weight gain had been within normal limits but on the day she became ill her oedema was very obvious, both on her face and up to her knees. The time of onset of Hellp syndrome in 313 out of 442 women affected by the condition in Sibai's study was between 27 and 36 weeks, so at 34 weeks and six days Wendy presented with Hellp at the most common time.

#### Wendy

*I can still see Joyce and myself in the ambulance. All I could concentrate on was knowing that Evan was right behind me in the car – probably feeling like I was – alone, scared, unsure and very vulnerable.*

#### Evan

*The ambulance seemed to take an age to arrive and the trip to the hospital seemed painfully slow and following in my car I could see Wendy sitting on the edge of the stretcher. The pain was too great to lie down. I knew that all was not well and not knowing whether all was going to turn out for the best was a terrible feeling.*

*Upon arrival at the hospital the delivery room was not the place I really wanted to be ... preparing for a possible emergency caesarean section sent normal emotions into overload and then shutdown. It was important that Wendy remain calm and if I cracked, then it certainly would not be beneficial to her and her condition.*

On arrival at hospital ... 2100hrs.

By this stage Wendy's blood pressure was 190/105 and her epigastric pain was worsening. Her uterus was very tense and it was suspected that she was having a placental abruption. The blood pressure reached a maximum of 200/105 before being controlled with Nifedipine. By 2200 hours, Wendy had become hyperreflexic and a Dilantin infusion was commenced.

Controlling the blood pressure is crucial in order to avoid intracranial haemorrhage. Some drugs may lead to too rapid a drop in BP which can harm the fetus. Nifedipine is convenient as it can be given orally or sublingually and it is quick acting. It is also considered to be safe for the fetus as doppler studies have shown that maternal BP can be controlled without compromising the fetal blood supply (Brown 1991).

An ultrasonic scan showed no sign of placental separation and the C.T.G. was normal. In Sibai's study 16 per cent of the women suffered placental abruption.

Blood results – Hb 140g/L (cf. 125 at 28 wks).

PCVie ratio red cell volume/whole blood volume 0.41 (cf. 0.38 at 28 wks).

Mean Platelet Volume 11.1f/L (N=7–10.4).

The blood film showed increased numbers of

cell fragments and poikilocytes, suggestive of haemolysis.

Haemolysis considered to be the hallmark of the Hellp syndrome.

Renal Function tests –

Uric acid 0.36 mmol/L (N=0.20–0.42 mmol/L)

Creatinine 0.060 mmol/L

(N=0.05–0.12 mmol/L)

Serum Albumin 32 g/L (N 35–47 g/l)

It is interesting to note that uric acid level may not be a reliable indicator of the severity of the Hellp Syndrome. Wendy's level was normal even though she obviously had severe pre-eclampsia as well as Hellp Syndrome.

Liver function tests were grossly abnormal:

GGT – Gamma glutamyl transpeptidase

43 Iu/l (N=0–50)

ALT – Alanine amino-transferase

240 Iu/l (N=0–40).

ALP – Alkaline phosphatase

234 Iu/l (N=25–120)

AST – Aspartase 239 (N = 0–45).

The bilirubin level was 8 µmol/l (2–20 µmol/l).

The bilirubin level may often be normal initially even though other liver function tests are grossly abnormal.

The liver enzymes increase when there is cell damage in the liver. Liver damage tends to be a fairly late feature of Hellp Syndrome. Micro-embolism causes ischaemia and tissue damage in the liver. Hepatic distension follows obstruction of the liver's blood flow and the continual deposition of fibrin. Increasing intra-hepatic pressure may lead to rupture. There may also be haemorrhage under the liver capsule.

The coagulation screen was normal and the platelet level was  $180 \times 10^9$  (cf 204 at 28 weeks).

All the literature agrees that in Hellp Syndrome immediate delivery is indicated.

Wendy's cervix was unfavourable and the baby's head was unengaged so a caesarean section was indicated.

Wendy and her husband Evan requested an epidural anaesthetic rather than a general anaesthetic. However, her specialist was concerned that this was not the best option. Epidural anaesthesia is contraindicated because of the risk of bleeding into the epidural space and around the insertion site if the clotting system becomes deficient.

#### Wendy

*It seemed like hours had passed when the anaesthetist came to give me the epidural I had requested as an alternative to the general anaesthetic. I wanted to be present at the birth of our child and no one was going to take that away from me. The epidural was rather painful and I can recall I was completely still – the anaesthetist had requested this from me and I guess when you are in a position of absolute uncertainty – you don't argue!*

#### Evan

*The caesarian was completed at 11.53 p.m. and we were the proud parents of a baby boy – Finn, weighing in at four pounds. Wendy did realise at that point that she had a son but was not with it enough to cuddle him or hold his tiny hand. I, on the other hand, was able to identify that he was all there and looked to be in reasonable shape, albeit a bit on the small side.*

Wendy's baby Finn, was approximately 200 gm less than the expected weight for his gestation. In Weinstein's (1982) study 55 per cent of the babies born to women with Hellp had significant growth retardation. The disease may be affecting the placenta for some time before the woman presents with symptoms. According to Redmond and Roberts (1993), during the prodromal stages most women are free of symptoms.

The operation went relatively smoothly. Total blood loss 1000 ml. A clot of old blood (50c size) was located behind placenta, indicating that a small abruption had occurred.

Wendy was transferred to ICU post operatively, with the expectation of being transferred to the postnatal ward later in the day. However, it was to be three weeks before Wendy left ICU and a further two weeks before she would leave the hospital with her baby.

#### Evan

*Wendy was transferred to the intensive care unit straight from theatre and I considered that to be a little strange. After all, women have caesareans all the time, but did they all go to intensive care? My tired brain puzzled on this and the doctors told me that they considered it a good idea given the condition she was in on arrival at the hospital. Of course, I thought better to be safe than sorry. How right they were, the next few hours led into the most harrowing four weeks of my life.*

### Complications

At 0300 hrs the situation changed. PV bleeding increased and uterine atony was noticed. Bleeding from epidural site commenced and there was moderate bleeding from operation site. A pressure bandage was applied.

#### Evan

*The phone call to Wendy's parents in Dunedin to announce the arrival of our son was repeated again, to announce the deteriorating condition of their daughter and the very strong suggestion that they catch the next flight to Auckland to be with her. I couldn't bring myself to tell them the worst possible scenario but I know that they realised what that was by my insistence that it had to be the next flight.*

Blood results confirmed the worsening picture. The bilirubin level had risen to 46  $\mu\text{mol/l}$ .

Liver enzyme levels were rising dramatically – the ALT had risen 735  $\text{IU/l}$  and the ALP was 269  $\text{IU/l}$ . The Hb had dropped to 88  $\text{g/l}$  and the platelet level had dropped to  $65 \times 10^9/\text{L}$ . At this time the urine output was 60  $\text{ml/hour}$  and the BP was 120/60, pulse 105.

Coagulation screen was also becoming abnormal ...

In Sibai's (1990) study 21 per cent developed DIC. This is the most serious complication of Hellp.

The APTT (activated partial thromboplastin time) was 105 seconds ( $N=25-37$ )

The Prothrombin ratio 2.2 ( $N=0.8-1.2$ )

and the D-Dimer was 2000  $\mu\text{g/l}$  ( $N=0-250$ )

Wendy was given a platelet transfusion and intravenous vitamin K.

By 0600 hours the urine output was decreasing and it was feared Wendy was developing renal failure. A renal physician was consulted. Wendy's BP was rising – BP 140/90 and pulse 120.

Sibai's (1990) study reported only eight per cent developed renal failure.

By 0700 hours vaginal bleeding was becoming heavier and large clots were being passed. Because of abdominal swelling Wendy had an ultrasonic scan and a litre of free intraperitoneal fluid was seen. This later was found to be blood. There was also a haematoma forming in the soft tissues around the suture line. The liver appeared normal on the scan.

It is interesting to note that even though the liver enzymes were grossly abnormal indicating liver damage the liver appeared normal on the ultrasound scan. In a study by Barton *et al.* (1992) it was found that the histopathologic condition does not correlate with the laboratory findings. The conclusion was that the laboratory findings do not accurately reflect the severity of the underlying histopathologic condition. Liver damage may also be worse than indicated by the laboratory findings.

Both kidneys were swollen with loss of cortical-medullary differentiation.

According to Redman and Roberts (1993) the renal changes seen in women with pre-eclampsia and eclampsia provide special insights. Electron microscopic examination reveals changes seen in no other form of hypertension. The primary pathological change is in the glomerular capillary endothelial cells.

The cells are greatly increased in size with electron-dense cytoplasmic inclusions that may occlude the capillary lumen. These changes support the idea that vascular endothelial damage is a key factor in the pre-eclampsia disease.

Wendy became more unstable over the next few hours. She was able to see her baby briefly twice during the first few hours after he was born, but she was becoming increasingly breathless and in need of oxygen.

Evan brought Finn to see her.

In Sibai's (1990) study six per cent developed pulmonary oedema and six per cent developed pleural effusion.

A chest X-ray confirmed that both lungs were filling with fluid so Wendy was sedated and ventilated and had bilateral chest drains inserted. A dialysis was commenced as urine output was very poor.

By late afternoon Wendy was cold and very oedematous. She was now bleeding from her ET tube and gastric tube as well as her epidural site. A blood transfusion was in progress.

Blood results showed that her Hb had risen to 90  $\text{g/l}$  and the platelet level was  $67 \times 10^9/\text{L}$ . The APTT was 48 seconds. However, despite the improved coagulation screen Wendy continued to bleed. A syntocinon drip was commenced. Blood was transfused at one unit/hour.

During the night Evan was told that Wendy may be dying and Finn was brought to be with her. Wendy recalls an 'out of body experience when she was above her body looking down on Finn and Evan'. She can recall having Finn beside her and being aware of his smell. She believes that her will to live was strengthened by knowing that her baby needed her.



Wendy was dangerously close to death but held on to life and although her condition remained critical, she was taken back to theatre the following day for reopening of the wound to investigate the source of bleeding and ligate any bleeding vessels. No specific bleeding sites were identified but 'general' blood loss was observed.

#### Wendy

I was not aware of it, but my condition hours after the caesarian was critical. I had severe internal bleeding. I remember hearing talk of a possible hysterectomy and Evan not wanting to sign the papers for authorising a laparotomy. I said to him that we had one beautiful baby now and that we had to think of me! He signed the form.

The next two-and-a-half weeks are a blur, a mixture of being in a drug induced coma, periods of semi-consciousness and hallucinations. I vaguely remember Finn was bought up to see me in ICU on the odd occasion – this I loved. If not to cuddle, kiss and nurture my baby as any new mother would naturally do, at least I could smell him and feel him against my body and my face – our pride and joy.

Sibai (1990) recommends that the bladder flap be left open for up to 96 hours as with Hellp Syndrome the incidence of post-caesarian haematoma formation is very high.

Two large drains were placed in the abdominal and pelvic cavities and the wound left open and covered with tegaderm.

Massive bleeding continued at a rate of 500  $\text{ml/hr}$  and the open wound needed frequent redressing.

By day three, the rate of bleeding had decreased but Wendy continued to lose 250  $\text{ml}$  of blood/hour. The platelet level had dropped again to  $49 \times 10^9/\text{L}$ . An arteriogram was performed to exclude arterial bleeding, no bleeding arteries were located but Wendy was still bleeding from all her puncture sites.

On the fourth day, Wendy returned to theatre again. Several bleeding areas were located in her abdomen. Redivac drains were sited and the wound resutured. This time the post-operative bleeding was less and her coagulation screen was improving. Oedema was increasing and dialysis continued.

Over the next three days Wendy became very jaundiced and extremely oedematous. Her liver enzymes remained elevated and her bilirubin level reached 23  $\mu\text{mol/l}$ . Her ALP reached 868  $\text{IU/l}$ . She also started to show signs of infection with a fever and tachycardia.

While under sedation Wendy suffered bizarre hallucinations which she found very frightening.

#### Evan

*The excitement of becoming a father left me as I watched Wendy, instead of getting better, becoming more ill basically by the hour. Wendy continued to bleed internally for the best part of a week and each time I was advised that a further operation was required and a release form signed, it dealt me a real blow. Three operations carried out to try to source any bleeding sites were not conclusive – they did not guarantee that she would stop bleeding.*

By the eighth day after her caesarian, Wendy returned to theatre for the third time as a further ultrasound scan had shown another large clot of blood in Wendy's abdomen. A 600  $\text{ml}$  clot was removed and the wound was packed with a McFarlane roll and left open at one end. Signs of sepsis were still present adding fears that she would succumb to massive infection. Her temperature was  $38^\circ\text{C}$ . and pulse 130. However, over the next 10 days Wendy gradually improved. The infection, which was a U.T.I., responded well to antibiotics. Renal function improved and dialysis was discontinued. Packing was removed from the abdominal wound and the bleeding settled. Wendy had received a total of 55 units of blood during this ordeal. Wendy's chest cleared after two weeks and extubation was attempted but as this was difficult due to oedema so a tracheostomy was performed. This allowed the sedation to be reduced and ventilation was alternated with C.P.A.P. until Wendy was able to breathe independently. At times Wendy became confused as the sedation was reduced.



### Evan

Slowly but surely the various lines that were supplying Wendy with the blood and other products were removed. The false kidney that had done the job of her own kidneys during the period of renal failure was discontinued and the fluid that her body had retained was drawn off. The last major hurdle was to wean her off the ventilator. That tube was the lifeline but it also was the bane of her life ... it had bitten and pulled at by Wendy in her brief moments of semi-consciousness and had been cursed by all those close to Wendy for the obvious discomfort and distress it was causing her.

Signing authorisation for a further trip to the theatre (the fifth) for a tracheostomy was in some ways more difficult than having to sign the very first authorisation for the laparotomy. She had come through everything that had been thrown at her, but my concerns were that if she could not achieve self-support with her breathing, then the progress that had been made would be wasted.

As it turned out, from the moment Wendy had her tracheostomy, her progress went ahead in leaps and bounds, just as I had been told. To see her awake and alert and able to communicate and actually speak was a huge relief to myself and all those who had seen her in the early period of her illness, when occasionally she would open her eyes, not to acknowledge our presence or hear our words of encouragement, but to look only for some of the horrific images conjured up by the drugs being administered.

On the sixteenth day, Wendy was able to eat a small portion of jelly and yoghurt for the first time since Finn's birth. Two days later she got up for her first shower and on day 21 was transferred to the postnatal ward with Finn. She was still very weak and had to teach herself to speak again as the tracheostomy wound healed. After a week on the postnatal ward she was transferred to a small maternity unit for a further week to rest and gain confidence with Finn before being discharged home on day 33. Her abdominal wound took several more weeks to close completely.

### Wendy

Day by day I gained more strength to enable me to finally come home. ... The home we had made for Finn to grow up in. My initial reaction was to cry. I realised that I may never have set foot in this house again, never seen grass so green and sky so blue and my cat – so loving and full of personality and my friend, our baby – my lifelong dream. And, of course and most importantly, my cherished husband, who was at my side every day and night for the entire time I was in hospital and every day since this ordeal – sometimes I think I could not have got through this without him. He was a

tower of strength. But when it all boils down to it, we are all fragile creatures, we need to be loved and life is for living and loving.

Six weeks after the birth of Finn, Wendy returned to the hospital to see her obstetrician. In a letter to the GP he wrote:

I saw Wendy today 26th April, which incidentally was when her baby was due and I can hardly believe my eyes, her renal function looks as if it has returned to normal. She is slightly jaundiced but this is improving and haemoglobin is 94 g/l. I believe she has an appointment to see the renal physician some time in the near future, but I'd anticipate no further treatment.

Wendy has continued to improve and is now completely well. I feel privileged to have witnessed the miracle of Wendy's recovery. I think I will probably always think about the last antenatal check and wonder if I missed anything. I know I intuitively felt that Wendy would develop pre-eclampsia at some stage and I did have an uneasy feeling about her in the days proceeding her presentation with symptoms of Hellp. Perhaps I should have made contact then – I don't suppose I will ever know if it would have made any difference.

I know that the onset of Hellp can be very rapid, sometimes within a few hours. The obstetrician in charge of Wendy's case considered this was, in fact, what happened to her.

However, at the time it was hard not to feel personally responsible for what had happened. I certainly experienced the weight of responsibility that midwifery autonomy carries with it.

It hasn't all been negative though – I have learned much about Hellp through my involvement with Wendy. We have founded an organisation called NZAPEC (New Zealand Action on Pre-eclampsia), an organisation which aims to provide information for consumers and health professionals, supports women who have or have had pre-eclampsia and raises funds for education and research for pre-eclampsia. We were challenged to set up NZAPEC after reading about the original group in Britain (APEC) and we work closely with them.

I thank God that Wendy and Finn are alive and well and that from the crisis Wendy has emerged strong and radiant, with a faith in a power greater than herself.

Wendy and Evan have the final words ...

### Wendy

Looking back on everything, I do not feel bitter. I guess I feel we have been cheated of a normal childbirth and the joy that goes with it and the possibility that there will be no brothers or sisters for our little boy. Time will heal things and with further research into pre-eclampsia and associated conditions such as Hellp Syndrome, you

never know ... I had a fight on my hands and the support of family and friends, a highly respected midwife and other health professionals and also the people we don't even know, I had to and I did ... WIN!!!

### Evan

I have never been religious and don't ever intend to be, but I do believe that there is a power greater than mere mortal can comprehend and that belief is held by everyone we know. The positive thoughts that friends, family and people we have never met helped Wendy get through the terrible ordeal that she has experienced.

There is much that has been pushed into a far corner of my memory. Sometimes just a glimpse of Finn sleeping peacefully in his bassinet, or Wendy doing something that I wondered if she would ever do again, brings it all back. I guess that this will always be.

### Acknowledgement

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

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# The Second Stage of Labour Whose Urge to Push?

Tricia Thompson

Midwife

The first (human) baby I saw born was in a small country hospital in May 1976. There have been huge changes in maternity care since then. For example, women no longer have a shave and enema on admission. What exactly brought about that change, I wonder? Was it women saying 'NO!' Did people start to say 'Why do we do this?' Did maternity caregivers say, 'The research says ...'? I'm fascinated how change comes about.

One of the biggest changes about society, as well as about maternity care over these twenty years, I believe, is a general sense that the status of women has changed. The woman in labour is no longer the 'passive recipient' of the 'standard institutional care'. This change of status of women in maternity in the modern world may range from: 'the woman is *allowed* to make choices', to: 'the woman is *in partnership* with her caregiver'.

Thus, in the first stage of labour, a woman 'is allowed to' or chooses to, do just about anything she likes. She may pace the floor, or float in a pool; have soft music, quiet lights, aromatherapy, massage, hot towels; she can have whom ever she wants with her. The first stage of labour, it seems to be accepted, 'belongs' to the woman.

WHY then, does this suddenly change in the second stage? If the first stage of labour 'belongs' to the woman, to whom does the second stage 'belong'? Control often seems to be 'snatched back'. Why, when women tell the stories of their births, is it so common to hear '... and then they said I could push' or '... and then they told me to push~'. **Whose urge to push?** Thus the title of this paper!

A young 16-year-old woman was describing her birth to me recently. She only had an eight-hour labour; she had been pacing up and down between the bed and the window for four hours since she came to the hospital. She leaned forward onto the bed or the windowsill for each contraction and groaned. She said it had felt really good! Then she told the midwife of her feeling of needing to poo. 'Oh great, you must be fully dilated. Hop on the bed and start pushing.' An hour-and-a-half later, from her half propped-up sitting position on the bed, she was put into lithotomy position and had a forceps delivery because she was 'too tired' to push her baby out. We will never know what would have happened if this fit, strong young woman had been 'allowed' to continue pacing the floor. Would her body have continued to guide her in what to do? Would the baby have slid down and out in a continuation of the normal physiological process? *Whose urge to push was it?*

In issuing a challenge to all midwives to check our practice against the research, there are several issues about the second stage that need to be looked at:

1. the definition of second stage,
2. the physiology of second stage and its 'phases',
3. time limits on second stage and
4. the 'management techniques' commonly employed in second stage.

In the following reference list, I would direct your attention particularly to an article by Mayri Sagady. She issues midwives with an 'invitation to step back and review the basic physiology of second stage, to create our faith and trust anew' (Sagady 1995, p. 313):

1. *Definition of second stage:*  
From full dilatation of the cervix until the birth of the baby?  
The descent and expulsion of the baby? (Expulsion from where - school?)  
The pushing stage?  
From urge to push until the birth of the baby?  
From appearance of the presenting part until birth of the baby?  
What is right ??? What are the implications of each definition?  
How is second stage diagnosed?  
When is it appropriate to do a vaginal examination to confirm diagnosis?
2. *The physiology of second stage:*  
Sagady describes three phases in second stage. The latent or resting phase, an active or pushing phase and a transition or crowning phase. Some women move quickly through all three phases, some have variations.



I particularly want to mention the latent or resting phase, as this is often misunderstood, I believe. The latent phase has been described as the 'rest and be thankful' time, a chance to rest or even sleep, when the contractions decrease in both timing and intensity. Sagady explains it as a period of readjustment of the uterine muscle, when the upper segment muscle fibres have to shorten and thicken because of the decrease in volume in the uterus, when the fetal head moves down into the vagina. She describes it as lasting 10 to 20 minutes, but notes that some midwives report it occasionally lasting an hour or two.

Making women push in this latent stage has been shown to increase strain and damage to the muscles of the vagina and perineum and the uterine support ligaments (Beynon 1957). It may also lead to transverse arrest if pushing is made to start before internal rotation has occurred.

### 3. Time limits in second stage:

Arbitrary imposition of time limits can not be justified and 'such (time) limits should be discarded'. 'If the mother's condition is satisfactory, the baby's condition is satisfactory and there is evidence that progress is occurring with descent of the presenting part, there are no grounds for intervention.' (Enkin *et al.* 1995, pp. 230 and 234)

### 4. Management of second stage:

When I was a student midwife, I remember one midwife who used to tell women to 'hold your breath and push until you are blue in the face'. Very descriptive!

There are two common approaches to pushing which are taught and practised these days: directed and spontaneous.

Spontaneous pushing is 'in essence, the absence of a superimposed technique over the spontaneous, physiological efforts the mother makes on her own', by following her own instincts (Sagady 1995, p. 317). It requires patience on the part of the caregiver, as watchful, encouraging inaction can be hard. It requires the caregiver to have faith in the process of labour and faith in the woman and her instincts.

Directed sustained pushing may be with closed glottis (hold breath for 10 or more seconds, with three to four pushing efforts in each contraction) or with open glottis (same pattern, but only hold the breath briefly - three or four seconds, then continue to bear down while slowly letting the breath out). In both these methods, someone else directs or coaches the mother in what to do.

Why do we teach or coach a woman in how to have her baby? To beat an imposed time limit? To get the baby out, because if it doesn't we'll have to transfer (to hospital or to a base hospital)? Because the woman 'doesn't know what to do'? Because 'she isn't pushing effectively'? Because she is fully

dilated and 'she could push, therefore she should'? Because it will make the second stage shorter? Because that is what we were taught to do?

Because that is what the woman expects us to do (or the doctor expects us to)? Because that is what happened last birth? Because it gives us something to do?

The very notion of a *technique* for pushing implies that something needs to be done in addition to the body's own effort.

(Sagady 1995, p. 316)

What does the research say about directed pushing? Should we be pushing it? (Sorry about the pun!)

What are the disadvantages of directed pushing? Valsalva or breath held pushing can lead to greater fetal heart rate abnormality, yet similar mean duration of second stage compared to exhalation pushing (open glottis) (Knauth and Haloburdo 1986). Caldeyro-Barcia (1979) reported that those pushes last three times longer than women's spontaneous pushes. Bassell *et al.* (1980) reports the potentially harmful haemodynamic consequences. These in combination with maternal breath holding may compromise fetal oxygenation as they appear to predispose to lower cord pH, abnormalities of fetal heart rate and depressed Apgar score. In women with an epidural who were encouraged to push early, rotation forceps were more commonly used. Early pushing and forced pushing may cause more perineal trauma (Beynon 1957). Held breath pushing can lead to facial oedema, headache, burst blood vessels in the mother's eyes and maternal hypoxia (Alexander *et al.* 1990, Enkin *et al.* 1995, Sagady 1995).

Both Alexander *et al.* (1990) and Enkin *et al.* (1995) conclude that: 'Despite the limitations of the available evidence, a consistent pattern emerges. The widespread policy of directing women to use sustained and early bearing down efforts may well result in a modest decrease in the duration of the second stage, but this does not appear to confer any benefit; indeed it seems to compromise maternal-fetal gas exchange'.

So why are women so commonly still directed in how and where to push?

While one might want to stuff this discussion into the old medical model versus midwifery model construct, this is unfortunately not the case. The drive to intervene, usually at the expense of disempowering a woman's own pushing instincts, creeps to the surface equally as well in homebirth, hospital and birth centre. It is, in a sense, the practitioners own 'overwhelming urge to push'.

(Sagady 1995, p. 313)

Should we never give input to a woman who is pushing? Sagady says 'No, but that we should not tell women how to push without serious considerations of the risks and benefits involved'.

Directing a woman in how to push should be kept in the kit bag of second stage interventions, which may on occasion be required.

As Tatje-Broussard (1990) writes:

Second stage labour: You don't have to push. It can be a gentle unfolding in harmony with the natural rhythms of life.

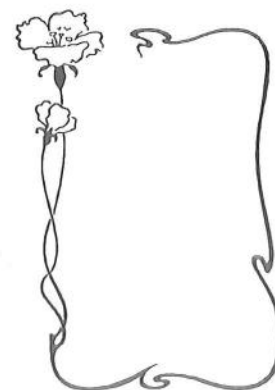
To conclude, paraphrasing the final words of Sagady (1995):

We as midwives, need to invent new ways to put second stage back into the mother's power. In antenatal visits, in classes, where ever we can influence, we must give out a loud and clear message:

Your body knows how to give birth: You can trust your body ... I do.

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*Continued from Page 4*

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*Yours sincerely,*  
*Mary Cumming RGN RM*  
*President, New Zealand Nurses Memorial Fund, Inc.*



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Weleda NZ Ltd, PO Box 8132, Havelock North. Freephone 0800 802 174