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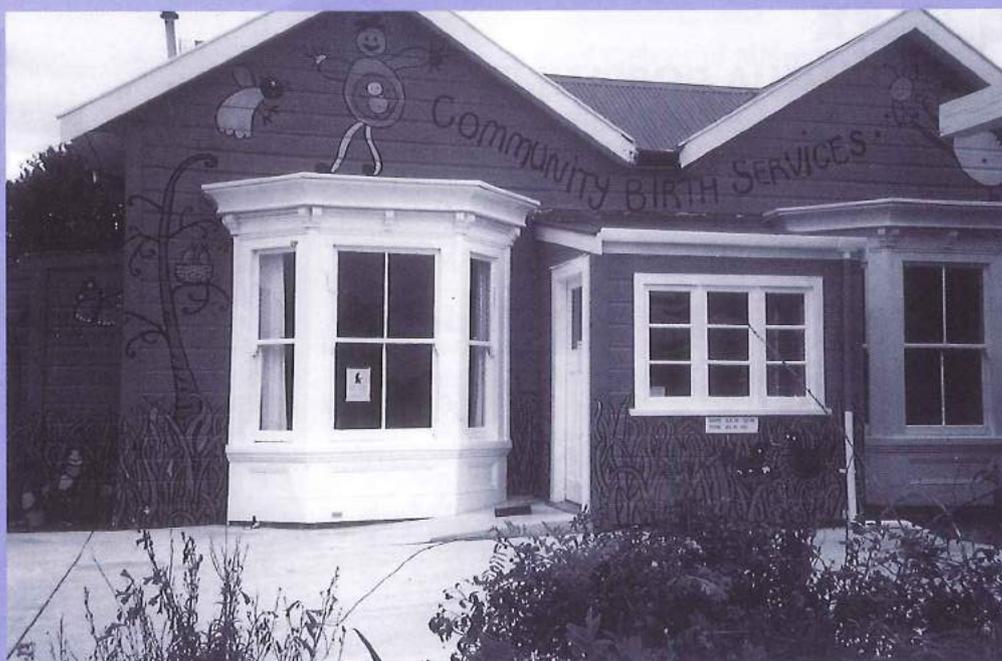
# College of Midwives



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# JOURNAL

NOVEMBER 1998



**Women-centred Partnerships**

**Informed Consent & Choice**

**User Views of Maternity Care**

**Commonwealth Nursing &  
Midwifery Action Plan (1998)**

**Pain in Labour**

**Surfing in Gisborne**

ISSUE 19



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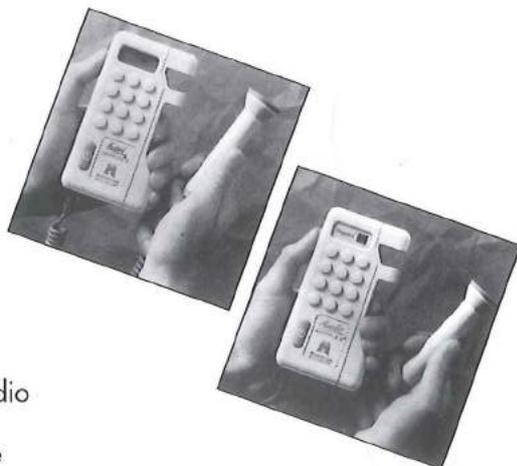
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ISSN: 0114-7870  
No. 19 - NOVEMBER 1998

The New Zealand College of Midwives Journal is the official publication of the New Zealand College of Midwives.

Single copies are \$6.00

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

**Printed by:** Hannah & Young Printers  
120 King Street  
Palmerston North  
Ph: (06) 357-9039

**Editorial Advisory Committee:**

Anne Barlow - Auckland  
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Cheryl Benn - Palmerston North  
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**Philosophy of the Journal:**

- 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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**Submissions:**

Articles and letters should be addressed to:  
The Editor,  
NZCOM Journal  
P.O. Box 249, Palmerston North

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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.

1998 has seen the completion of yet another successful New Zealand College of Midwives conference. The New Zealand midwifery community came together in the spirit of celebration of ten years since the germ of the idea that brought all the progressive strands of midwifery development together to form NZCOM.

In that ten years we have seen

- midwifery autonomy returned to the profession; the development of College structures and processes to reflect both our consensus style of working and our partnership with Nga Maia O Aotearoa Me Te Wai Pounamu and the consumers of midwifery services;
- participation in the redesigning of New Zealand's maternity services, that for all its faults, has still managed to enable 62% of New Zealand women to choose a midwife as their Lead Maternity Carer; and
- research on New Zealand midwifery which has confirmed and added to the international research that says that if you have a midwife as your lead caregiver you need fewer narcotics/drugs for pain relief, fewer perineal stitches, fewer drugs to stimulate labour, and significantly fewer instrumental and Caesarian births.

Haven't we done well !!

Helen Clark, and our kuia Joan Donley and Mina Timutimu, lit the candle that burned throughout the three days of the conference. This act symbolised for me the flame carried by each one of us that ignites and illuminates the passion we have for the work midwives do with women and their families.

Many New Zealand midwives joined our challenging guest speakers, Beverly Beech and Nicky Leap, to present their work and further stimulate and educate us. It was so affirming to see the breadth and depth of home-grown work inspiring the conference-goers to think more deeply about the work they do with the women for whom they care.

An impressive amount of New Zealand research was presented as midwives continue along their educational pathways to attain masters degrees and be awarded doctorates for their work in midwifery. We welcome our midwife scholars as they challenge, stimulate and enhance our professional development.

Yes we have come a long way indeed - we are truly growing up and taking our rightful, equal place in the world of maternity service provision. This issue of the Journal gives just a small, delectable sample of the presentations to Conference. May they continue to inspire passion in all of us who are dedicated to improving women's maternity experiences !

Bronwen Pelvin.

NZCOM Midwifery Advisor

We would like to thank the Manawatu Community Birth Services for allowing the Journal to use their logo for the front cover and Ellen Salmons for taking and submitting the photo of the Community Birth Services building. We look forward to receiving your logo for publication soon .....

## Letters to the Editor

### Midwifery Diary

Dear Editor,

I am writing to inform you we have produced a Diary specifically for midwives, with many special features. This diary is available by mail order from: Town & Country Midwives, 271 Woodend Rangiora Road, RD1 Kaiapoi. Ph. 03 313 5078

Yours faithfully, Chris Chaplin

### Confidence in Midwifery

Dear Editor,

I endorse the opinion of Sue Calvert (April 1998) that it is time for midwives to take steps to restore the confidence of the public in midwifery. The opportunity is there for the College to continue in the lead as the professional body for midwives before it is lost to another organisation to which, let's face it, the majority of CHE midwives belong. The medical profession is rubbing its hands and the media tightening its grip as midwives continue to fuss about empowerment as in the caesarian section editorial April 1998. I think it is safe to say that a fair number of midwives hold to an ideology around birth, power, and the establishment. It is important for the credibility of the College that it not do the same, and that it be seen to be providing professional representation to midwifery in all settings. Now that post-Amendment midwifery is sufficiently defined, I believe it is safe for the College to do this without compromising the underlying philosophy of partnership with women. To build on and develop the excellent and dedicated work of individuals and the membership, the College could consider updating the standards of practice into a more solid means of accountability and also consider recruiting an expert clinical midwife advisor with recognised credentials in research based clinical practice in at least two practice fields and with an appropriate postgraduate qualification. The challenge for the College and Midwifery is to work in partnership with women AND provide safe care.

Yours sincerely, Celia Butler. Nelson.

### Home Birth Video Available

Dear Editor,

I would like to inform your readers there is now a video available, presented by seven men who share their experiences of home birth from a male perspective in an humorous and informative way. The issues discussed include: Why choose home birth?, Is home birth safe? and what is the man's role? A highly recommended video for parent educators, midwives and consumers. For more information - Contact Wellington Homebirth Association, P.O. Box 9130, Wellington. phone Mandy (04) 562- 8102

Yours sincerely, R. Kent-Johnston.

### Wool Fibre Infections

Dear Editor,

Thank you for your letter, of 4 March 1998, with which you attached a copy of a survey from Ms Gelske Gardiner about wool fibre infections affecting women in wool handling occupations.

I referred a copy of your letter to the Occupational Safety and Health Service (OSH) for its information. OSH advises me that the survey highlights some potential occupational health risks to women working with wool. It also informs me that a similar issue has arisen in Australia.

In New Zealand, employers and contractors have responsibilities under the Health and Safety in Employment Act 1992 to take "all practicable steps" to prevent harm. This includes having systems in place to identify and manage hazards and the risks they pose and adequate training of workers about health and safety issues relating to their work. While a hazard might not be able to be eliminated, obviously there are some low cost but effective safeguards that employers and contractors can adopt.

You will be pleased to know that OSH will take steps to inform its occupational health nursing staff of the situation. OSH will also pass on the findings of the survey, to key stockholders in the farming industry, including Federated Farmers, the Shearing Contractors Association and the Womens Division of Federated Farmers.

I am grateful to you for referring this survey to me for attention. The author, Ms. Gelske Gardiner, is to be commended for her initiative in undertaking this survey.

Yours sincerely, Hon. Jenny Shipley. Prime Minister.

## COMING EVENTS

1999 NZLCA Conference 19-21 March 1999

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Contact - Lesley Elliott Phone- 03 471 0034 Fax - 03 4710038 or  
Jill Moore (Convenor), 37 Gaffield Avenue, Dunedin.

# Women-centred midwifery: partnerships or professional friendships?

## ■ Sally Pairman

Programme Leader Midwifery  
Otago Polytechnic Dunedin.

A paper for presentation at the 1998  
Australian College of Midwives ACT  
Branch Conference, Birth Among Friends,  
17-18 September, Canberra.

## Introduction

In 1995 Karen Guilliland and I published a monograph, *The Midwifery partnership: a model for practice* (Guilliland & Pairman, 1995). This monograph explored the development of the concept of midwifery as a partnership in New Zealand and presented a theoretical model to describe this partnership. The model arose from reflection on our personal experiences and practice as midwives, and our observations of, and discussions with, many other midwives and women. In 1996 I commenced a research study for a masters thesis and decided to further explore the nature of the relationship between midwives and women, this time using the experiences and perceptions of a small group of midwives and women. In this paper I will briefly discuss the methodology and methods used for the study and summarise the findings. I will then focus in greater depth the notions of partnership, friendship and professional friendship.

## Overview of the study

This study was designed to explore both the nature of the relationship midwives and women have together during pregnancy, labour and birth and the postnatal period, and the understanding women and midwives have of this relationship. The outcomes of this study were then used to refine the theoretical model of midwifery as a partnership (Guilliland & Pairman, 1995).

The design for this qualitative exploratory study was underpinned by a feminist philosophy. In particular, it drew upon the work of Patti Lather (1986, 1991) by integrating her notions of reciprocity and dialogical theory-building in the methodology of the study, thus allowing the theoretical model (Guilliland & Pairman, 1995) to provide the 'a priori' theoretical framework for the study without predetermining the outcome.

Six independent midwives and six of their clients explored their experiences of the midwife/woman relationship through individual semi-structured interviews and then through two focus group meetings of participants. Participants were actively involved in analysis of the data and identification of the emerging themes. On completion of this process the model of midwifery practice previously developed (Guilliland & Pairman, 1995) was shared with the participants who collectively explored areas for refinement in light of the findings of the study.

The midwife participants were all self-employed midwives working independently who volunteered to take part. The criteria were that the midwife provided continuity of care throughout the childbirth experience; that at least 70% of her practice in the previous year was total midwifery care; and that she provided both home and hospital services. The women were clients of these midwives. The women volunteered in response to information given to them on my behalf by the midwives. One woman from each midwife was chosen by ballot. The criteria for the women were that they had given birth between six weeks and four months previously and that the woman and baby were both well at the time of the study. The final group consisted of six midwives aged from 33 to 43 and with 4 to 19 years' midwifery experience, 1 to 5 of these in independent practice. Five midwives identified as Pakeha New Zealanders and one as Maori/Pakeha. Two midwives worked in mainly home birth settings, two had rural practices and two had urban-based practices. There were six women participants ranging in age from 27 to 34 years. Three had just had their first child, two had had their second and one had had her fifth. All the women identified as Pakeha. Two women had home births and four had hospital births, two of these were in small rural maternity units, one in a level three hospital and one in a city based level two unit.

As the participants are not representative of all midwives or the wider birthing population, the results cannot be generalised to all midwife/woman relationships. The study deliberately chose participants who were engaged in midwife/woman relationships based on continuity of care and independent midwifery practice. These factors were identified by Karen and myself (Guilliland & Pairman, 1995) as essential to the practice of partnership, and it was anticipated that this study would examine this partnership in more depth, from a practice base, and then enable refinement of the midwifery model of partnership if necessary. Thus, whilst the findings are not applicable to all midwife/women relationships, they do provide valuable insights into the practice of partnership. In so doing they have confirmed the literature, practice and experiences which were the basis of our development of the midwifery partnership model and they have enabled refinement of the midwifery model of partnership.

This study does not set out to explore the relationship of midwives and women working within a 'shared-care' model with another practitioner. Some 'shared-care' will occur within an independent midwifery model as midwives must involve obstetricians when women's needs move beyond the midwifery scope of practice. This type of 'shared care' relies on equal status, equal involvement in decision-making with the woman, equal responsibility and good communication. Other 'shared-care' models place the midwife in a dependent position with medicine as the primary decision-maker. To date there has been no research which examines the relationship between midwives and women in these kind of arrangements, or explores whether or not there are any features of midwifery partnership in these relationships.

Karen Guilliland's (1998) associated study has identified that clients of midwives working

independently and in continuity-of-care have significantly better outcomes than those of midwives working in 'shared-care'.

Another future study could examine whether or not it is the practice of midwifery as a partnership between the woman and the midwife which is the critical element in achieving these positive outcomes for women.

### Summary of the findings

The data which emerged through this research provided richness and depth to discussion of the midwife/woman relationship. The midwife and the woman contribute equally to the relationship and value what each brings to the relationship. The woman, with her knowledge of self and family, also brings an expectation of trust, equality, respect and openness to the professional care she seeks from the midwife. The woman brings a willingness to actively participate in her care, sharing responsibility for her decisions and assuming control over her experience. The midwife, from her foundation of professional standards and ethics, brings her ability to be 'with woman'. In this she utilises her knowledge, skills and 'self' in practice, and is accessible and supportive to the woman. The midwife also brings her ability to practise independently and to develop practice wisdom. Both the woman and the midwife bring themselves as women to the relationship and the shared experience of being female contributes to the nature of the relationship. The midwife and the woman work together in a particular way, which integrates the notions of 'being equal', 'sharing common interests', 'involving the family', 'building trust', 'reciprocity', 'taking time' and 'sharing power and control'. Through the relationship both the midwife and the woman are empowered in their own lives. The relationship also has emancipatory outcomes as new knowledge of childbirth and midwifery are generated. This new kind of professional relationship challenges the dominant medical model of childbirth.

The study teases out 'midwifery partnership' to mean 'professional friendship'. It advances understanding of the relationship midwives and women have together, including its significance at a personal, professional and political level. Midwife with woman: "the professional friend".

In the study the women and the midwives used the terms 'friendship' and 'partnership' to describe their relationship. Initially each appears to have different meaning. When examined more closely, however, it is apparent that the women and the midwives are describing a relationship with the same characteristics. The different terminology, therefore, stems from the different contexts within which they operate. The midwives work within a professional context where a partnership relationship is seen as an important aim and the notion of partnership underpins the professional guidelines which direct their practice. The women are not constrained by professional dictates and describe the relationship as they experience it, as a friendship. They too, however, recognise the professional focus of the

## Maternity Care Provider and Outcomes - 1996

| Sample Size/Total Number of Births 2212  |     | Births | % of Sample |
|--|-----|--------|-------------|
| Number Choosing Full Midwife Care  |     | 1,094  | 49.5%       |
| Vaginal Birth  | 964 | 88.0%  |             |
| Caesarean Section  |     | 68     | 6.2%        |
| Forceps/Ventouse   |     | 62     | 5.7%        |
| Breastfeeding at two weeks   |     | 1,030  | 94.1%       |
| Breastfeeding at six weeks   |     | 944    | 86.3%       |
| Perinatal Mortality  |     |        | 3.6/1000    |
| Number Choosing GP/Midwife Shared Care   |     | 605    | 27.4%       |
| Normal Birth   |     | 496    | 82.0%       |
| Caesarean Section  |     | 53     | 8.8%        |
| Forceps/Ventouse   |     | 56     | 9.3%        |
| Breastfeeding at two weeks   |     | 563    | 93.1%       |
| Breastfeeding at six weeks   |     | 508    | 84.0%       |
| Perinatal Mortality  |     |        | 11.5/1000   |
| Number Choosing O&G/Midwife Shared Care  |     | 134    | 6.1%        |
| Normal Birth   |     | 81     | 60.4%       |
| Caesarean Section  |     | 28     | 20.9%       |
| Forceps/Ventouse   |     | 25     | 18.7%       |
| Breastfeeding at two weeks   |     | 117    | 87.3%       |
| Breastfeeding at six weeks   |     | 106    | 79.1%       |
| Perinatal Mortality  |     |        | 14.9/1000   |
| Other Combinations of Care giver where LMC changed during one or more module of care |     | 379    | 16.0%       |
| Perinatal Mortality rate/1000 for total study  |     |        | 5.8/1000    |
| National Perinatal Mortality Rate  |     |        | 6.0/1000    |

Source: Guilliland, KM. Demographic profile of self employed/independent midwives in New Zealand and their birth outcomes. MA Thesis. Victoria University of Wellington. Wellington 1998

*Client Selection:* All self employed midwives in NZ were surveyed; 321 were eligible to participate (i.e. had a case load). Of those 59% returned birth outcome forms on their last 15 clients or all clients they attended from December 1995 to March 1996. Clients matched for age, parity, socioeconomic and risk status.

relationship and its time limited nature. For both groups the use of the term 'professional friend' captures the unique nature of the midwife/woman relationship.

### Friendship or partnership

All the women described their relationship with the midwife as one of friendship. Implicit in these descriptions of friendship are characteristics of the midwife/woman relationship already mentioned. These characteristics include knowing each other, women with women, equality and trust. It is the presence of these characteristics in the midwife/woman relationship which led the women to describe the relationship as a friendship. These characteristics are clearly not expected by the women in their relationship with other health professionals.

Amy: *She was more of a friend than a nurse, that's what I liked about her ... I felt like we were friends, not nurse-patient relationship. She was just good to talk to, we got on well, we were just like two good friends. And she was supportive* (AA 1.1 - 8).

A survey on women's friendships amongst nurses carried out by Peggy Chin, Charlene Wheeler, Adrienne Roy, Elizabeth Berrey and Christine Madson (1988) in America found that respondents believed their close friendships with women gave them the freedom to develop as whole and autonomous individuals. Respondents agreed that with women friends they can talk openly and freely, don't need to explain themselves, are not judged, and gain a sense of self worth. Friendships provide opportunities for mutual nurturing and sharing (Chin et al, 1988).

This personal knowing of each other is enhanced by the midwife visiting in the woman's own environment or the woman visiting the midwife. Seeing a woman in her own home allows the midwife to get to know the family better and see the woman within the context of her home life.

Juliet: *Especially doing home visits and being involved in the home birth setting you get to know their neighbours and their dog and their children (not in that order) and their partners and you get to know a little bit about their lives as well, it's the whole family* (JT 1.2).

Heather: *Most women find that you end up getting quite close to and there is a strong bond between you ... often it's not only the woman herself either, you get involved with the children and often the partners as well ... some partners take time off around the time of the birth and you obviously get to know some a lot more than others. Often extending to friends and grandparents and you find you get introduced as 'this is my midwife' and that you seem to end up taking a special part in their family (HA 1.2).*

A further characteristic of the midwife/woman relationship is its women-centred nature. This, too, links with the notion of friendship between two women. Linda describes how much she looked forward to the midwife's visits, because for that period of time each visit she felt 'special', the midwife's attention and concern on her as a person rather than on her as a pregnant woman.

Linda: *It's nice to actually sit down and have some attention paid to you. I mean you do from work colleagues and family and that but it's nice to be able to talk to somebody other than that ... I used to write in my diary for two or three days before she'd come 'MW's coming on Friday' and then I'd have it in my diary at work 'MW's coming, meet her at 1.30' or whatever, and I'd really look forward to her coming. Really look forward to it, it was great ... She made me feel special ... That's another thing I didn't expect MW to be ... I thought she was there for the baby and not for me and that if I was feeling depressed I couldn't talk to her about it because it was me and not the baby - but I could (LF 1. 4 - 13).*

Bizz and Sarah reiterate this feeling of being seen as an individual with the midwife's attention on them alone.

Bizz: *Every antenatal meeting she always asked initially how I felt and what I'd been doing. And even after the baby was born it was how I felt and how are you, which was really good. Yes, she was very concerned about what I wanted. It was very important (BF 1.4).*

Sarah: *It was more the confidence, that they were so friendly, and that they were interested solely in you when they came for that hour, hour and a half or half an hour. No matter what time it was they just made you feel that you were the only one on their books. Nothing was a problem in that you could deal with it together (SC 1.7).*

Most women with busy lives and many roles such as wife, mother, sister, worker find themselves focusing their concern on others and trying to juggle the needs of their children, partners and families. The only time they may have to focus on themselves may be time they spend with close friends. For the women in this study it seems as if the time they spend with the midwife is unique in that they are seen as themselves and their concerns are validated. Thus their relationship with the midwife shares characteristics of other friendships they may

## The midwife, from her foundation of professional standards and ethics, brings her ability to be 'with woman'.

have in their lives.

The midwives themselves are conscious of the woman-centred nature of their relationship with the women they care for. Chris made the distinction between a pregnant woman and a woman who is pregnant. The subtle difference in language carries much deeper meaning and shows that the midwives see themselves primarily in relation to another woman for whom pregnancy is only one part of what is happening in her life. This understanding of a relationship between two women brings with it recognition that these two women are also equal and both contribute to the relationship.

Chris: *You are caring for a woman who is pregnant, not a pregnant woman, and although it's a very subtle difference, to me that really is the essence of it. So you are actually working with the woman and it is almost as if the pregnancy is a small part of it. It is really her and her life you become involved with and be a sounding board for. (CS 1.4).*

Juliet believes that because of the intimate nature of the midwife/woman relationship, it is essential that the woman and midwife feel comfortable with each other. Inevitably the midwife becomes emotionally involved with the woman and this also contributes to the notion of the relationship as one of friendship.

Juliet: *I find a lot of women want quite a close relationship, want to build up a relationship where you get to know each other really well, where there's maybe more than being a midwife, where there's actually being a really good friend ... it's hard to cut off where your role as a midwife stops and where your role as a friend ... where they cross over. But I think they need to cross over... especially being involved in such an intimate time in a woman's life there's got to be a close relationship, you have got to feel good about each other. She's got to feel okay about you being there at that time in her life and you are emotionally involved (JT 1.2).*

Chris describes the relationship they have with women as one of partnership. For her the relationship develops over time and is characterised by a sense of equality between the two 'partners', both of whom make different but equally important contributions to the relationship.

Chris: *Well I guess it develops. The initial visit is often at the very beginning not quite formal but, as the session or visit progresses, becomes a lot more relaxed and I guess that it's almost like a friendship developing really*

*... like a working partnership with women. I see them very much as my equal and think that they feel the same and certainly a lot of them would consider it a friendship. Partnership's a really good description to me but it sort of gets a bit used and so I'm trying to think how to describe it in a way that's not sort of quite so hackneyed I suppose.*

The women know themselves better than anyone else and they need to share themselves with me for me to get to know them and I share what the professional knowledge I've got with them so it's sort of a round in circle sort of link and I certainly don't see it as an up/down relationship... Sometimes maybe it's a tiered sort of relationship but that levels out as the relationship grows really (CS 1.2).

The reason the midwife and the woman get to know each other is only because the woman is pregnant and seeks professional care from the midwife. As Heather describes, the relationship forms for the specific purpose of ensuring midwifery care during pregnancy and childbirth which will lead to a healthy mother and a healthy baby through a positive birth experience.

Heather: *We are a partnership working towards an end really, a healthy mother and a healthy baby. That's what the mother has brought you in for, to ensure that happens, to give them a good experience (HA 1.2).*

Because of its specific nature the relationship is time limited. It lasts only as long as the pregnancy and birth and through to about six weeks postpartum. Once the shared need for the relationship has passed it is over. The relationship may continue for some midwives and some women, but it continues on a different basis and for other reasons.

Linda: *It's not an ongoing thing which is quite sad. But you can't expect it to be. You have got to realise it's not going to be like that (LF 1.9).*

As Juliet says, it would be unrealistic for her as a midwife to try and maintain an ongoing relationship with all women.

Juliet: *I have had situations where it's been really difficult to let go of that relationship at the end ... where woman have expected the visits to keep on going because we are friends. And having to say I'd really like to see everybody all the time, I'd love to be able to come to the christening of your baby, I'd love to come to all the birthday parties and all those things, but if you did it for everyone you wouldn't be doing anything else. It's really hard, it's hard for the woman and it's hard for me as well (JT 1.2).*

As was agreed by all participants at the second group interview, most do not want the relationship to continue. Once the focus of the pregnancy and birth is past and the midwife has fulfilled her professional function, the relationship naturally changes. Some may continue a different relationship, but for most it is over until the next pregnancy and this is appropriate.

Linda discovered that the relationship differed from friendship when she tried to buy a gift for the midwife and realised she didn't know her as well as she thought. Whilst she and the midwife shared the intimate experience of childbirth together they focused on this rather than the personal life and tastes of the midwife. Thus the personal knowing the woman has of the midwife does not necessarily extend into all aspects of her life.

*Linda: I never felt like a client ... It's quite funny because I wanted to get MW a gift and I went shopping and I thought I don't want to get her a box of chocolates, I don't want to buy her a bottle of wine or anything like that, I wanted to get her something that she can keep because just to show her how much I really did appreciate her. And I went out and look I spent a good two days trying to find something because I didn't know...I had never been to her house and I don't know what her taste was, and that I felt really strange. I said to my partner 'It's really weird you know, she knows me intimately and we've known each other now for a good six or seven months (six months I suppose) and I still wouldn't have a clue what to get her', and I did find that very weird. I ended up getting her some moisturiser - a special thing from one of these authentic, alternative places which she did like, well I think she did. But you know you have got to pick out something that I'd like myself. That was the funny thing. It sort of honed in on me that I don't know MW that well - as well as I thought I probably did (LF 1.8).*

### Friendship

Harlene Caroline (1993), a psychiatric nurse, used concept analysis to explore the characteristics of close adult friendship and its distinguishing features. The most distinctive feature of friendship is that it is voluntary and friends choose the extent to which they will accommodate each other. In addition, friendship is primary in that it is broad and involves significantly large parts of a person's life. Friendships are possible at any age, unlike other social relationships such as spouse, worker or parent, which tend to be limited by age. There is always a quality of exchange between friends and this reciprocal exchange includes intimacy and love. Close friendships are enduring with a sense of history involving intense intimacy and love (Caroline, 1993). Friendship is preceded by certain conditions. These are proximity, the developmental capacity for friendship which includes being trustworthy and able to share information about themselves, the current ability to commit resources to the friendship, a feeling of liking or attraction and a 'getting to know you' transition (Caroline, 1993). Being involved in friendships has a variety of consequences for the participants which include feeling loved, connected, enhanced self-esteem and empowerment. Friendships also help meet cognitive needs, provide companionship and social support and provide a frame of reference for social behaviour and judgment of one's own abilities

(Caroline, 1993). Caroline (1993) uses illustrative cases to further explicate the concept of friendship. A model case is one which has all the attributes of the concept whereas contrary cases have none of the attributes. Borderline cases have some of the attributes but are different in at least one way. A related case shows a similar concept to the one analysed but without the essential attributes and an illegitimate case example is one where the concept as it has been defined is used inappropriately. The midwife/woman relationship fits the category of a borderline case. The relationship has intensity, mutuality and meaningfulness but the bond between the woman and the midwife is their shared experience of childbirth. Once this need for the relationship is over, the individuals do not have the bond of affection or commitment to each other necessary for the relationship to endure. An example of a related case is acquaintanceship which is superficial and casual and lacks the intensity of friendship. Caroline (1993) believes the nurse-patient relationship represents a contrary case as the majority of nurse-client relationships are neither voluntary, chosen nor enduring. The relationship does not occupy a primary part in either's lives and it is founded on the legal and moral responsibilities of the nurse to the client.

The notion of friendship as an inappropriate description of health professional relationships is supported by Sarah Bignold, Alan Cribb and Stephen Ball (1995) in their exploration of the relationship between specialist paediatric-oncology nurses and the families for whom they care. Whilst recognising that the relationship between these nurses and the families they work with often contains elements of friendship such as affective involvement and committed concern, it is not voluntary, having been entered into because of the family's need for the nurse's professional care and support. Bignold et al. (1995) suggest, instead, that the relationship is one of 'befriending'. Befriending entails affective and concerned involvement of the professional in the lives of the patient and family, but does not necessarily involve the client entering substantially into the life-world of the professional. In other words, befriending is a predominantly 'one-way' relational process which in no way diminishes the authenticity and genuineness of the relationship (Bignold et al., 1995, p178). Befriending involves *emotional labour which is defined as listening, being there, talking and waiting mixed with giving direction, advice or actively making plans* (Bignold et al., 1995, p178). It involves emotional as well as physical presence, involved concern, warmth and empathy. Bignold et al (1995) suggest that friendship is not an appropriate description of most nurse-patient relationships, but that befriending may describe some specific nurse-patient relationships. Such relationships occur when there is long-term involvement and extended contact, including time in the patient's home. In particular, they believe, befriending relationships are based on a 'real partnership'

where both partners work together mutually acknowledging respective expertise and responsibility (Bignold et al., 1995).

Using this definition, 'befriending' is a term which may capture the characteristics of the midwife/woman relationship. The midwives and the women in this study use different words, friendship and partnership, to describe the same relationship. It is the same relationship but from different perspectives. The characteristics of personal knowing, equality, trust, intimacy and reciprocity which develop over time, are described by both the midwives and the women. The different words used, however, carry different meaning and reflect the different perspectives of the midwives and the women.

### Partnership

For midwives in New Zealand the term 'partnership' is very much part of the midwifery culture. 'Partnership' as a concept underpins the NZCOM Philosophy, Code of ethics and Standards for Practice as well as the relationship between the woman and the midwife (NZCOM, 1993). In our model of midwifery as a partnership Karen and I define partnership as:

*a relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding* (Guilliland & Pairman, 1995, p.7).

Partnership is increasingly being seen as the ideal relationship for midwives and women because of the inherent power sharing which must occur in a partnership relationship (Karlene Davis, 1994; Gooch, 1989; Heather Hancock, 1996; Page, 1993; Parratt, 1996; Young, 1996). Partnership is a concept which is also beginning to be widely used in other health professional literature as a way of describing health professional-client relationships which are more egalitarian and less hierarchical (June Lowenberg, 1994; Gail Powell-Cope, 1994; Anne Casey, 1995). In partnership relationships the patient has more authority and control than in the traditional allopathic model and interaction is reciprocal as between two adults of comparable status (Lowenberg, 1994).

Powell-Cope (1994) identified negotiating partnership as the basic interpersonal relationship between health care providers and family caregivers of people with AIDS.

*We are a partnership  
working towards an end  
really, a healthy mother  
and a healthy baby.  
That's what the mother  
has brought you in for, to  
ensure that happens, to  
give them a good  
experience*

Negotiating partnership was defined as working out care for the common good of the person with AIDS. Subcategories of negotiating partnership included conveying information, knowing, being accessible and maintaining belief. Information flowed reciprocally between the healthcare provider and the family caregiver. In order for the partnership to be successful, family caregivers had to feel that health care providers valued their input. Partnership rested on knowing, which for this population specifically referred to the desire to be recognised as a significant person in the patient's life. Being accessible was a key component in negotiating partnership. This meant not only the health care provider being accessible and following through on actions, it also meant the family caregiver having access to the person with AIDS. Maintaining belief was sustaining faith in the family caregiver's capacity to get through specific events, thus facilitating partnership by assisting family members to continue to give care to the person with AIDS (Powell-Cope, 1994). Powell-Cope (1994) suggests that the concept of partnership may be in opposition to Kristen Swanson's (1991) definition of caring which sees caring as a process which arises from the nurse without the obligation for the client to reciprocate. Partnership in this study emerges as a more interactive process congruent with reciprocity and mutual empowerment (Powell-Cope, 1994). Reciprocity and sharing information are both concepts which are mentioned by the midwives in their description of partnership above. Maintaining belief appears a similar concept to 'being with' while the concepts of knowing and accessibility are defined differently in the midwife/woman relationship.

Partnership may be an ideal which is more difficult for nursing to enact than midwifery. In her study into partnership between paediatric nurses and parents of children in hospital, Casey (1995) found that traditional attitudes and routine practices continued to prevent progress towards equal decision-making and sharing of expertise, even in units which purported to work in a partnership model. In order for partnership to occur, both participants have to be prepared for an equal interaction and be willing and able to share their knowledge and expertise. The balance of power is fundamental and may only begin to shift when the patient is at home and the nurse is the stranger (Casey, 1995).

A New Zealand nurse theorist, Judith Christensen, has developed a theory of Nursing Partnership (Christensen, 1990). Christensen argues that partnership is an appropriate term for nursing because it implies an alliance between two or more people involved in a shared venture. Both participants are active, both recognise their rights and obligations and each has a role to play to achieve a negotiated outcome (Christensen, 1990). Christensen's notion of partnership does not require power sharing, rather she focuses on the collaborative and unidirectional nature of the partnership.

Christensen describes the patient/client experience of nursing as a passage - the giving and receiving of nursing enables the person to make optimal progress through a significant health-related experience, such as surgery. Passage involves three stages - the beginning, entering the nursing partnership and leaving the nursing partnership. Coexisting with these stages and supporting the work which occurs in them, is the phase of negotiating the nursing partnership. Christensen (1990) identifies mutual work for the nurse and the patient at each phase, which is interactional and essential to the outcome of the patient's passage. Underpinning the nursing partnership are specific contextual determinants which arise from the patient, the nurse, the community and the partnership which influence the nature of the partnership as it is experienced by both patient and nurse. Specific to the context of the partnership are the concepts of episodic continuity, anonymous intimacy and mutual benevolence. It is these

**'I'd really like to see everybody all the time, I'd love to be able to come to the christening of your baby, I'd love to come to all the birthday parties and all those things'**

underpinning concepts which highlight the greatest difference between Christensen's (1990) Nursing Partnership and the partnership relationship being described by the midwives and women in this study.

Episodic continuity refers to the way in which separate nursing episodes are integrated into an overall experience which reflects the continuity of 'being nursed'. The patient is nursed by many different nurses in individual episodes, but both patients and nurses view nursing as a continuous phenomenon (Christensen, 1990). In the midwife/woman relationship being described in this study, continuity comes from one or two midwives working with one woman throughout the length of the childbirth experience. Whilst contact may be episodic during the antenatal and postnatal phases, the midwives provide care which is consistent and integrated. Each episode of care is as long as necessary. The women and the midwives view the experience as a relationship rather than 'having midwifery care'.

Anonymous intimacy refers to the opportunity nurses have to develop close relationships with their clients. Many nurses contribute to a single patient's passage and one nurse has contact with many patients. The nature of nurses' work, however, gives them access to closeness with patients (Christensen, 1990). This intimacy is anonymous rather than based on personal

knowing of each other. In the midwife/woman relationship the midwife and the woman do know each other very well. They have an intimate relationship based on personal knowing as well as physical intimacy related to the nature of childbirth and the work of the midwife.

Mutual benevolence is reciprocal goodwill between nursing and its recipients. Nursing is an altruistically motivated profession and nurses offer compassion as well as specialised knowledge and skill. This is valued by patients and nurses are regarded by them with kindness and gratitude (Christensen, 1990). In the midwife/woman relationship the mutual regard the woman and the midwife has for each other goes deeper than benevolence. By characterising the relationship as a friendship, the women and the midwives indicate the depth of personal feeling they have for each other. There is a genuine liking which comes from their shared experiences and opportunities to really get to know each other.

Another essential difference between Christensen's (1990) use of partnership and the woman and midwives in this study, is in the power balance of the relationship. In discussing the work of the patient in the partnership, Christensen talks of becoming a client, managing self, surviving the ordeal, affiliating with experts and interpreting the experience. She uses terms such as 'acquiescing to expertise', 'fitting in' and 'tolerating uncertainty' all of which imply that the client is expected to adjust to the environment. As the client gets ready to leave the Nursing Partnership, Christensen talks of the client 'resuming control'. This is a very different partnership to the one described in this study where the women and the midwives work together, sharing power and control to enable the woman to define her own environment and experience.

It can be argued that the midwife/woman relationship is characterised by elements of both friendship and partnership. It is an intense, meaningful and shared relationship involving emotional and physical presence, concern, warmth and trust. It is a reciprocal relationship between two equal participants which is mutually empowering. It is also a relationship which forms for a purpose and ends once that purpose is achieved. The meanings of these two concepts, friendship and partnership, were discussed by the participants at the second group interview. All agreed that Bizz's use of the term 'professional friend' encompassed what they felt about the relationship they had together.

*Bizz: I think we had a really good relationship actually. It was more of a friend relationship, but a friend you could trust in - a professional friend you could rely on (BF 1.3).*

## Conclusion

Friendship and partnership are terms used by both the women and the midwives in this study to describe the midwife/woman relationship. Examination of the concepts of friendship and partnership show that the

midwife/woman relationship does indeed have characteristics of both. The relationship is not a friendship because it is not voluntarily entered into, rather the relationship forms for the specific purpose of giving and receiving midwifery care through the childbirth experience. Once this shared purpose is achieved, the relationship is not sustained. Despite this limitation, the midwife/woman relationship does have many elements in common with the notion of friendship. These include reciprocal love and intimacy, trust, warmth and genuine concern. The midwife/woman relationship as experienced by the participants in this study does fit with most definitions of partnership although it is clearly different to the Nursing Partnership described by Christensen (1990). The midwife/woman relationship is between two participants who have equal status and share power and control. Another term suggested in the literature for this kind of relationship is befriending (Bignold et al., 1995). Following discussion with the participants in this study, however, the term 'professional friend' was felt to capture the intensity and intimacy of the midwife/woman relationship. For the participants, the relationship was most like friendship but they recognised the time-limited and focused nature of the relationship and thus added 'professional' to 'friend' in acknowledgement of this.

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## Direct Entry Midwifery Education Fund

### Purpose

The Direct Entry Midwifery Education Fund was established to provide an Education Grant to students undertaking Direct Entry Midwifery registration courses within New Zealand, to assist in payment of course fees, clinical training fees or purchase of required text.

The Direct Entry Task Force set up to lobby for direct entry courses provided the ceding grant for the fund.

### Amount

Up to \$500 per applicant per year. The amount of funding available is dependent on the finances available each year and will vary accordingly.

### Conditions for Application

#### The Applicant:

- is a student undertaking a Direct Entry Midwifery Course leading to registration as a midwife
- has made formal application and has been accepted in the course of study
- is a current financial member of NZCOM

#### The Application is Assessed on:

- degree of financial hardship
- Level of income
- presentation of application
- preference will be given to applicants who have not previously received a financial grant from this fund or a like fund

### Application Closing Date:

31 January each year

#### Application Forms available from:

Judy Anderson,  
New Zealand College of Midwives,  
PO Box 21-106,  
Edgeware, Christchurch.  
Telephone (03) 377 2732

# Legal Responsibilities Related to Fetal Deaths

Bronwen Pelvin

Midwifery Advisor, NZCOM.

The New Zealand College of Midwives has been made aware that there have been two instances of Registered Midwives signing Medical Certificates of Death in circumstances where a baby has been born alive and then subsequently died. It seems that this has occurred following the lowering of the gestational age (from 28 weeks to 21 weeks) at which a baby is considered viable.

The Burial and Cremation Act Section 46A states:

"Still-born children - No person shall bury, cremate, or otherwise dispose of any still-born child unless there has been delivered to the person (a) A written certificate that the child was born dead, signed

(i) By a person registered as a medical practitioner under the Medical Practitioners Act 1968 who was present at the birth or examined the child after birth; or

(ii) If no doctor was present at the birth or examined the child after birth, by a person present at the birth whose name appears in that part of the Register of Nurses kept under section 16 of the Nurses Act 1977 relating to registered midwives."

The Births, Deaths and Marriages Registration Act 1995 defines a still born child as a dead fetus that either "weighs 400g or more when issued from its mother" or "is issued from its mother after the 20th week of pregnancy". The Act defines a dead fetus as "a fetus that, whether or not the umbilical cord had been severed or the placenta had detached, at no time after issuing completely from its mother breathed or showed any other sign of life (such as beating of the heart, pulsation of the umbilical cord or definite movement of the voluntary muscles)".

Any baby that shows any signs of life after being born, irrespective of gestational age, and then subsequently dies, requires a medical certificate of death signed by a medical practitioner. A Registered Midwife has no authority to sign a medical certificate in respect of the death of that baby. If the doctor is unable to sign the medical certificate, the matter will be referred to the Coroner.

All Registered Midwives are required to know and meet their legal obligations in relation to attending women who give birth to still-born babies or babies that die after being born alive.

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# User Views of Maternity Care

## ■ Beverley A. Lawrence Beech

Honorary Chair of the Association for Improvements in the Maternity Services (AIMS) in Britain  
Key Speaker NZ College of Midwives Fifth National Conference.

I am honoured and delighted to be invited to present the Inaugural Address to this NZ College of Midwives Fifth National Conference. Having travelled around the world presenting users' views of maternity care, I have found that every country, without exception, is vigorously developing and enhancing maternity care under the control and influence of medical men.

While midwifery has been described as the oldest profession in the world it has been on the slippery slope since the Middle Ages when thousands of midwives, or wise women, were burned to death. I do not suggest for one moment that prior to the 20th century midwives worked in an Arcadian world where all was sweetness and light. On the contrary, midwives have always struggled either in conditions of poverty, or battling to maintain the

profession in the face of male domination, medicalisation of birth or trying to give care to far too many women at the same time. As research has shown into community midwifery in the 1930s, some midwives committed suicide because of the pressures of the work. One should not forget the recent sad case of the Australian midwife who committed suicide allegedly because of the tensions of trying to provide real midwifery care in a hostile technological environment.

### Hospitalisation of Birth

During the 18th century the move to industrialisation and urbanisation encouraged greater interest and involvement of men in midwifery. But one of the biggest disasters for midwifery occurred when medical men realised that hospitals provided an unending source of income from a captive group of pregnant women on whom they could carry out medical experiments and "research".

I shall not dwell on the safety of hospital or home, save to say that the supporters of hospital births have never been able to produce a single valid statistic to show that hospital birth is safer for all women than home births. Marjorie Tew, in her analysis of birth outcomes demonstrated how, in every single category, hospital birth produced higher mortality rates.

| Labour Prediction Score | Perinatal Mortality | Rate per 1000 births |
|-------------------------|---------------------|----------------------|
|                         | GP/Midwife          | Hospital             |
| Very low risk           | 3.9                 | 8.0                  |
| Low risk                | 5.2                 | 17.9                 |
| Moderate risk           | 3.8                 | 32.0                 |
| High risk               | 15.5                | 53.2                 |
| Very high risk          | 133.3               | 162.6                |
| All risks               | 5.4                 | 28.0                 |

Interestingly, the 1970 statistics upon which this analysis was based was the last opportunity to evaluate maternity statistics in this way. The medical profession abandoned the system of Labour Prediction Scores and were, therefore, able to dismiss future comparisons on the spurious grounds that centralised maternity units admit a greater proportion of high risk women, therefore comparisons could not be made. A very convenient excuse to bedevil any future analysis of birth outcomes!

In 1987, a comprehensive review of the medical evidence comparing the safety of home and hospital birth was published by the National Perinatal Epidemiology Unit in Oxford. It concluded:

"There is no evidence to support the claim that the shift to hospital delivery is responsible for the decline in perinatal mortality in England and Wales nor the claim that the safest policy is for all women to be delivered in hospital."

In 1996, the British Medical Journal published an unprecedented set of four research studies on home birth in the UK and other European countries. The overall conclusion was that for low risk women birth at home is safe, if not safer, than birth in hospital. I do not have to tell an audience of midwives about the circumstances that empower a woman to give birth successfully - birthing in her own surroundings, attended by people she knows and loves, having confidence in her ability to birth the baby and having confidence in a skilled practitioner who is responsive to her needs and supportive of her decisions.

In our society we have lost the community rituals and rites that acknowledge a woman's passage from girl to woman. For many women even the rite of birth has been taken over by a set of rituals and practices which have nothing to do with her empowerment and a great deal to do with medical power and control.

No one denies that there are women and children alive today thanks to obstetricians and modern technology. However, over the past ten years obstetric claims have come under scrutiny. The evidence increasingly suggests that the major cause for the fall in mortality has been better housing, better sanitation, fewer children and a more educated population - and the continuous support of a midwife during pregnancy and labour.

Women are inveigled into hospital by honeyed word of safety and technology - just in case you need it. The reality is somewhat different. Marjorie Tew's analysis of the infant mortality statistics in Britain revealed that had the same number of women stayed at home as they did in the 1950s, our infant mortality rate would be four times lower than it presently is. This means that over 3,000 British babies die each year as a direct result of mothers choosing to give birth in hospital. (Tew, 1985 & 1990)

A flaw in the statistical data presentation also clouds the facts. Babies aborted for congenital abnormality are not included in perinatal mortality statistics. The resulting fall in statistics is then claimed to represent improved obstetric care when, in fact, a significant part of that decline has been

due to increased detection and abortion. Not mentioned is the unknown number of babies with no problems who have been falsely diagnosed and aborted.

Universal hospitalised birth also has a profound effect on midwives. They become 'hospitalised'. Instead of being 'with woman' they become 'with machine' and spend time trying to mitigate the adverse effects of technology controlled by doctors. Doctors have the ear of Ministers and social access to the corridors of power. They determine the protocols, conduct the research and dictate the care each woman should have. Birth for the majority of women has changed from an active, participatory and intensely emotional and empowering experience to an inactive, prone extraction. Women lost confidence in their bodies and were grateful that the doctor had saved them from the disaster he had just caused. Meantime, midwives are doing their best in the face of staff shortages and unethical protocols to help women cope.

One of the effects of 'Changing Childbirth' has been that everyone is really nice to women who are now "consenting" to even more interventions - to the extent that obscene levels of unnecessary caesarian sections are now justified on the grounds of 'women's choice'.

### Appropriate Technology Induction of Labour

Technology has a place. Most of it was developed by caring doctors trying to help those women and babies with problems. The tragedy is that once a breakthrough is announced, every unit which prides itself as being 'a centre of excellence' rushes to introduce it and extend its use to everyone. Unless of course, it is something women want, such as water birth in which case every obstacle possible is put in the way.

One of the worst and most intrusive practices which we Europeans have enthusiastically exported all over the world is the ritual of Active Management of Labour. As Jean Robinson, a UK childbirth campaigner has said "it is the greatest export to come out of Ireland since Guinness". The manufacturers claim that 'Guinness is good for you' although an excess is most definitely bad for you. So too is active management of labour. It has a function in very specific instances, but unfortunately for reasons that have nothing to do with the well being of mother and baby, it is used excessively. Meantime women have little or no knowledge of the real reasons for its use.

### Effects of Hospitalisation of Birth

While the medical profession all over the world took up this intervention with enthusiasm (often on the grounds that it reduced caesarian section rates) they had little understanding of how Active Management of Labour came about.

During the 1960s home birth in Ireland was discouraged. Small maternity units were closed down and women were 'encouraged' to deliver in large centralised obstetric teaching hospitals. This amounted to 5,063 births in 1965 and 8,964 in 1981. This gave the

medical profession plenty of women upon whom to practise medicine. During the 1960s it was accepted that a woman would deliver within 36 hours; by 1970, this was reduced to 24 hours: by 1975 the hospital was promising that no woman would have to labour longer than 12 hours. A very enticing offer, but the women were not told this would result in much more painful labours.

No one denies that there are women who will need to have their labours induced or accelerated. While promoted as beneficial and guaranteeing one-to-one support for every woman in labour, few understood that the only option considered was to reduce the woman's time allocation on the labour ward. No study was ever mounted to find out if women wanted shorter but more intense and painful labours.

O'Driscoll's nightmare vision for the future was of large units, not less than 5,000 deliveries annually where, within a few years labour would be completely controlled and managed like a military operation. It has been suggested that O'Driscoll's low caesarian rates were achieved because each woman had the continuous presence of a trained midwife. Hospitals all over the world introduced the active management package without proper midwifery support and none of them achieved the desired results.

### Electronic Fetal Monitoring

An intrinsic part of Active Management of Labour is continuous electronic fetal monitoring. Since the 1970s AIMS has been questioning the validity of this technology. There have been nine randomised controlled trials showing that EFM does not work, cannot be interpreted properly and is associated with increased risk of cerebral palsy. (Shy et al, 1990). By relying on monitors, midwifery auscultation skills are undermined. Instead of providing women with essential continuous midwifery support, monitors overcome staff shortages. A study at the John Radcliffe Hospital - one of the most prestigious in the world - showed that the staff failed to react more quickly in dangerous situations than they did when less risk was indicated. They failed to carry out further tests which were indicated and very abnormal tracings were not recognised for almost eight hours. If the staff at this hospital have difficulty interpreting EFM, what chance do staff have in less prestigious units? And if a midwife is desperately trying to look after three women in labour at the same time, is it any wonder that she overlooks even the most obvious adverse monitoring trace?

The women have not been told how painful, disempowering and intrusive continuous EFM is, or that the benefits derived from this technology are minimal. (Thacker et al. 1995). For the baby, EFM can be fatal. Few women realise, or are told that a fetal monitoring electrode is a double-ended needle that is screwed into the baby's scalp. It can be responsible for permanent scarring and/or bald patches on the baby's head. Few mention the risk of the baby contracting HIV infections via the scalp electrode. Occasionally a baby dies as a result of

infection entering through the wound and mothers have suffered internal injuries as a result of having the clip attached to them instead of to the baby.

Part of 'Active Management' relies on use of the partogram. Birth by graph. Every woman is required to fit into an artificially constructed straight jacket which presumes that all women will labour at a particular rate and within a particular home period. It does not allow for the 'deviant' woman who gently labours in fits and starts, whose body decides to take a break. Women are no longer allowed to have long labours. Short and painful is the order of the day, and it has become so common that public perception is that labour is continuous excruciating pain from beginning to end. And, if women have 'Active Management', that is exactly what it is.

### Drugs

Few women are able to cope with the added pain of induction and electronic fetal monitoring without resorting to pharmacological drugs. Throughout their pregnancies, women are exhorted not to smoke, take drugs or do anything to harm their babies. In America it has reached such a pitch that a pregnant woman having a glass of wine will be berated and considered totally irresponsible. However, when a woman is in labour, obstetricians and midwives have few qualms about using powerful synthetic drugs.

Now, there is evidence emerging of possible serious long-term effects of these.

In a well designed case control study, children exposed to pain relieving drugs in labour were discovered to have an increased risk of drug addiction later in life compared with those who were not exposed (Jacobson et al, 1990). In a more recent paper in the British Medical Journal, patients who died from opiate addiction were compared with siblings. It was found that if mothers had opiates or barbiturates or larger doses of nitrous oxide the risk of opiate addiction to the child in later life was increased 4.7 times (Jacobson et al, 1990).

A recent study of pethidine and morphine (Olofsson 1996) revealed how ineffective they were and suggested that their continued use is unethical. Sadly in drawing attention to these issues the researchers suggested that epidural anaesthesia was an effective alternative and was "good for the baby". Clearly, they had not read the research.

### Epidural Anaesthesia

When women clamour for epidural anaesthesia they often do so in the belief that this wonder drug will remove all pain, will not get through to the baby and will ensure that they have a tranquil, placid, pain-free birth during which they can do 'The Times' crossword or catch up on their knitting.

In the first edition of my book *Who's Having Your Baby?* I drew attention to the problems women experienced following epidural anaesthesia.

"Little is known about the long-term effects of epidurals but following the public attention given to a mother who was paralysed and in a coma as a result of an

epidural, *Health Rights* received letters from 70 women describing their experiences. One of the major complaints was backache, ..Many of the women had very serious headaches and for some the headaches continued at intervals for years. Some of the women complained about tingling sensations in their limbs or areas of numbness.

Had there been adequate research into this technique we would now know whether any of these conditions were a direct result of epidural anaesthesia and how many women it affects each year."

Studd demonstrated that epidural anaesthesia was responsible for a 20-fold increase in rotational forceps deliveries. Other studies have shown an increase in caesarian section rates. Rosenblatt, in her study showed that the drug has significant effects on the baby in the short-term. It showed that the babies at six weeks suffered decreased visual skills and alertness, poorer motor organisation and physiological response to stress and control of their own state of consciousness. She checked only up to six weeks. What are the long-term effects over the next 20, 30, 50 years?

Epidurals have also been shown to cause intrapartum fever greater than 100.4° in 11.5% of women. (Lieberman et al, 1997). It is interesting how the introduction of pools for pain relief and birth has been blocked, or withdrawn by many hospitals on the grounds that the temperature of the water could cause a rise in the mother's body temperature and cause brain damage in babies. Not a single paediatrician has suggested withdrawing epidural anaesthesia because of this risk of brain damage in babies.

### Episiotomy

Women in developed countries express horror at genital mutilation of women in third world countries. But women in the developed world have suffered genital mutilation for decades. This came about, not from a long-standing custom, but because American obstetricians vigorously promoted it and its use as routine in the majority of hospitals.

At one time almost 95% of women in Britain had an episiotomy undertaken by midwives. Some women even had one after the baby was born, because midwives were afraid of the disciplinary action they would face should they refrain from doing one.

It was due to consumer pressure that midwives were able to undertake research into the value of routine episiotomy. They found there was no justification for its routine use. When a follow-up study was done of perineal pain, they found that one in 10 women had problems and one in five had pain with new suture material.

### Ultrasound

In the past it was difficult to examine the baby in utero. Doctors and midwives had to rely on what women told them. Before the development of ultrasound, women relied on their feelings, intuition, knowledge of their own bodies and old wives' tales. Today, they rely on doctors to tell them about their babies

"Little is known about the long-term effects of epidurals but following the public attention given to a mother who was paralysed and in a coma as a result of an epidural,...

just as they rely on the doctor to confirm they are pregnant. They rely on ultrasound to reassure them that their baby is all right. Few understand that the purpose of ultrasound is the opposite - it screens for specific abnormalities with a wide range of accuracy, in order to abort the defective fetus. It is also possible that the baby may have problems which ultrasound cannot detect.

Women are not told when they have an ultrasound that they and their babies are taking part in the largest unevaluated medical experiment in the world. Although it has never been subjected to a large scale randomised controlled trial to establish its safety, it is widely used for research - monitoring development of the fetal brain and organs from the earliest stages. We see many published research papers where studies have been done on movements of the fetus in utero e.g. breathing, thumb sucking, swallowing etc. Although these can be carried out for up to an hour or more at a time, no concern is expressed about possible damage or the need for long-term assessment of exposed infants.

When we talk about 'diagnostic levels of ultrasound' we should make it clear that these are usually not measured and vary widely between different makes and machines. Users do not actually know the extent of exposure a baby is receiving from any individual machine. It is being developed so quickly, trials published today are already out of date and difficult to apply to current machines.

Since Lieberskind published her paper showing that ultrasound can alter the structure of cells for up to ten generations, AIMS has been worried about the proliferation of ultrasound. Jean Robinson's and my booklet 'Ultrasound Unsound?' spells out the adverse effects of ultrasound and consumer anxieties.

Thacker, in his review of ultrasound concluded that there is 'no statistically significant reduction in perinatal morbidity and mortality associated with the routine use of ultrasound.' (Thacker, 1985). I would suggest that not only is there no reduction in perinatal morbidity and mortality, but that ultrasound is one of the reasons why it is not falling.

Since 'Ultrasound Unsound?' was published Doppler ultrasound, the most powerful form of ultrasound used in obstetrics, is now universally employed. We are worried because there have been three randomised controlled trials of Doppler ultrasound which showed significant increases in perinatal deaths and miscarriages:

\* Four times increase in perinatal death,

(Davies, 1992)

- \* 20 miscarriages in the Saari-Kemppainen (1990) large randomised controlled study, but none in the controls:
- \* a doubling of preterm labour 52% v 25% in the Lorenz study.

None of the researchers have adequately explained these outcomes.

Trans-vaginal ultrasound, where a Doppler probe is inserted into the vagina so it is nearer the baby, is being enthusiastically promoted. There is no research looking into the potential or long-term adverse effects of this new development. (Incidentally, those useful hand-held Sonicoids use Doppler. At least they are used for relatively short periods). So busy are the medical profession, researchers, pharmaceutical companies and electronics firms at promoting the benefits of these interventions and technologies, the adverse effects are constantly minimised or trivialised.

### Effects of Medicalised Birth

No one has yet researched and collated all the adverse effects of medicalised maternity care. Were it to be done, I suspect the shock would be enormous. Let me highlight two examples: An evaluation of the benefits of ventouse delivery compared with forceps delivery, showed very clearly that the use of forceps should be phased out except for very specific cases. Based on the assumption that about 50,000 UK women will require instrumental vaginal delivery every year the doctors conducting the study concluded:

"the continued use of forceps as the instrument of first choice results, every year, in about 12,000 unnecessary pudental blocks and other forms of regional anaesthesia for delivery; about 10,000 women unnecessarily experiencing moderate or severe pain during childbirth; 5,000 more women with severe perineal or vaginal trauma than there need be, and 3,500 women suffering unnecessarily from severe pain for several days after delivery." (Chalmers & Chalmers). And that is just the mothers! The study did not examine the babies. Women are told a caesarian will protect them from perineal damage. No one has suggested women should avoid hospitals which use forceps.

### Ethical Research

One of the great advantages of large centralised maternity units is that it offers doctors the opportunity to undertake research without too much trouble. They have a captive collection of guinea pigs. As New Zealand women who had the misfortune to be involved in the unethical cervical cancer research found to their cost, they were treated as guinea pigs (Coney, 1988).

All over the world, women in pregnancy and labour are recruited into medical research - much of it unethical and of little value. The research agenda is set by the medical profession. Any doctor who wishes to climb the professional ladder has to undertake research. Now that midwives are taking degrees they too are under pressure to do research.

Trying to get research that consumers want is an uphill battle. As consumers, AIMS decided it was time that women set standards for research. So we invited representatives from other childbirth and ethics groups in UK to discuss a Charter for Ethical Research on Maternity Care. (AIMS & NCT, 1997) This Charter sets out standards which consumers expect when invited to take part in research.

When a pregnant woman consents to be a research subject she is consenting for two people - herself and her baby - the full effects of which may not be known for years.

While midwives may not be undertaking their own research, they are nearly always required to assist informing women, undertaking some of the necessary procedures and supporting the doctors' efforts.

When that research is unethical, a midwife has a professional responsibility to speak out. How many do?

It took almost two years to develop this Charter. Some of us underwent a very steep learning curve. Some of our Committee had already served on local ethics committees. One of us is on the national Multi Centre Ethics Committee and most of the committee had long experience of patients' rights and research issues. So, when some professionals criticised the Charter as having been produced by people who had little understanding of the difficulties, we were able to refute their criticisms.

The Charter had been widely distributed and welcomed by the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners and a large number of ethics committees throughout the UK. I would suggest that it be used in New Zealand. We have deliberately refrained from copyrighting it so it can be developed to suit conditions which apply in other countries. I hope midwives will adopt it as a basis for their involvement in research, and by so doing, may well change attitudes to research on pregnant women and babies.

As the Charter says: '*Research should be undertaken with women, not on women.*'

### The Propaganda Machine

The public presumes that the technology and routine interventions used in maternity care have been properly evaluated. In fact, very little has, and even when information is available about adverse effects, very few women are told about it. Hospitals produce glossy booklets promoting the advantages of epidurals, ultrasound whatever. None of them make more than oblique reference that these all have adverse effects to a greater, lesser or unknown degree.

The successes of obstetric care represent the tip of a very large iceberg. Under that tip are massive amounts of iatrogenic morbidity. The technologies developed to protect and save the few, when used on the majority, create their own morbidity and mortality. Women who feel that they are getting substandard care when they have not had their routine ultrasound or electronic fetal

monitoring, are almost always unaware of the disadvantages and are uninformed about the very real risks.

While women leave hospital with their newborn babies for all to see, few will see the damaged perineums or the emotional trauma. Women who complain are dismissed as a minority - but no one has researched the extent of the damage. No one has investigated how many marriages have broken down because childbirth has resulted in their sex lives having become difficult or impossible. How many women leave hospital convinced that the doctors saved "my baby's life", unaware that the doctors had unnecessarily put the baby's life in peril and were saving it from the potential disaster they had caused? How many women leave hospital convinced that they had to have their labour induced or accelerated because the labour had stopped or was not progressing when in fact, their bodies wanted to take a well-earned rest? They were in no danger, neither were their babies. Neither would they be aware that staff needed to get them through the system as they needed the bed; or as a result of staff shortages and too many women coming into hospital too early.

### How Can We Affect Change and Deal with the Myriad Problems?

Midwives all over the world are daily facing these issues. It is clear that the only way we are going to improve maternity care for the benefit of all mothers and babies, is to ensure that the majority of women are offered continuity of care by midwives who carry their own case loads.

When I received the invitation to give this Inaugural Address, I was honoured and thrilled and looked forward to learning more about the enormous progress you have made. I note that your problems are still almost the same as ours. While you have incorporated consumers into your College, Sally Pairman (your Past President) has clearly identified how your profession has to strengthen its partnership with women. (Pairman 1998). Also, you still have a profession divided and squabbling amongst itself and a largely silent membership. Why is it, when there are difficulties, when individual midwives are targeted and bullied the majority tend to stay silent?

I personally, have deep suspicions of our genes. When I was in Australia in 1992 I spent some time with Ina May Gaskin who had been to Europe researching the witches trials. She found that in some towns in Germany, practically the whole female population had been burnt at the stake. The only ones to survive were the 'wee timorous beasties' who did not speak out and who did not question. Hundreds of thousands of European women died in that madness. And, we are descended from the women who escaped - the ones who kept their mouths shut and who did not question.

Midwives frequently claim to be the woman's advocate. But, to do that successfully, midwives have to be strong themselves. Weak women make weak advocates. Bullied midwives often bully

women, and a profession whose members are willing to let "someone else" speak out, stand up or challenge is a profession which will not achieve its objectives.

During a conference last year, a Metropolitan Police officer who specialises in countering bullying commented that in her view midwifery was more macho than the police. Midwives will soldier on in circumstances where any other group would have collapsed long ago. Those midwives who complain, or whose practice deviates from the hospital 'norms' are often isolated and bullied. Bullying is endemic in the midwifery profession and it is time it was dealt with effectively. If you fail to deal with it you will not achieve a strong, independent and caring profession.

One of the mistakes a bullied midwife makes is the belief she can justify her actions and when the bullies understand her position they will modify their behaviour. In far too many cases they won't and they don't. You can only challenge a bully from a position of strength. Being nice to a bully only confirms her belief in her own superiority, strengthening her behaviour. Don't deal with the problem on your own or you will find yourself picked off.

First of all, gather support. There will be midwives who will support you. Encourage them to make it clear that they do. Bullies hate publicity, far better to do their dirty work behind closed doors. Never go to a meeting alone. Write up your experiences immediately after a meeting and send a copy of what you perceive happened to the bully. Keep a file of what is happening. This is invaluable if, months or years later, you are asked to produce evidence.

Many years ago my and my children's lives were made hell by a new neighbour. Because I had kept a file of all her activities and what I had done about it, I was able to persuade the police to act. Eventually, I prosecuted her for assaulting my son and she was convicted of a criminal offence of Actual Bodily Harm. Without carefully documenting exactly what was happening, I would never have succeeded.

If you are told that you must not speak to anyone about what is happening, remember there are always consumer organisations or individuals who can speak out. In a recent case in the UK the midwife was so naive and cowed by threats of confidentiality she did not even give her lawyer a copy of the Trust's allegations and was then surprised when they ran rings around him and succeeded in persuading her to resign. Which is another point, never resign. By resigning, they have won, they have got rid of the thorn in their sides and will then be able to pick off the next one.

The second problem is midwifery training. I hear it said that '*a midwife is a midwife, is a midwife*'. But, they are not. Midwives come into midwifery for a variety of reasons. In the UK we have midwives who are more than happy to work from nine to five, collect their pay and turn off their thought processes once they step outside the

maternity unit. We have midwives who joined midwifery because they wanted to help women give birth. They may have had a wonderful birth experience themselves or they may have had a rotten time, recognised why and wanted to do something to change the system. And then, the most dangerous group of all are the midwives who, just like the obstetrician, see childbirth as an ideal opportunity to exercise power and control, and are not going to give that up for anyone. Then there are the midwives who have trained as nurses and see childbirth as a mechanical process - and like the current President of the Royal College of Midwives sees childbirth complications as "challenging, exciting, fulfilling and demanding" and the time between calling a doctor and his/her arrival as "golden" (Muirhead, 1997). I wonder how women see that "golden" moment?

The midwife who seeks to reclaim her real role not only threatens the medical profession (they can see control and money disappearing fast) but also threatens those midwives who are content to work in the present system.

Whichever way a midwife practices, the vast majority does so in the belief that they are acting in the best interests of mother and baby. If midwifery is to progress, all midwives have to work together and every single midwife has to stand up and be counted. Petty jealousies will impede the development of real midwifery practice. Those midwives who are working in independent practice should not be seen as aberrations but as leaders who should receive support and encouragement

Not every midwife will want to practise independently. Hospital care has a place and those women and babies at high risk need to be there. They too need good midwifery care. This should not be perceived to be in opposition to the care offered to the majority of women and babies who have no problems.

Throughout the world large centralised maternity units suffer staff shortages. Some of that is due to the administration's failure to recognise that good midwifery care cannot be offered on a shoestring. The costs of poor care are reflected in the law courts and high levels of iatrogenia. The irony is that the money is there, the problem is its misuse. Hospitals are more than willing to spend millions of pounds on fancy new equipment or even old equipment much of which is overused and inappropriate. They have to be challenged constantly. Unfortunately, they have media support.

I believed that the UK press was probably amongst the worst in the world. But I discover that the New Zealand press deserves that brickbat. The UK medical profession has been very successful in infiltrating the media. It can have quiet discussions behind closed doors and can challenge or dismiss criticism without their statements being available for public scrutiny. Few magazines are without a regular 'medical' column where the medical profession pontificates, even on midwifery, about which it has no training and even less knowledge. In my role as Chair of the leading

The successes of obstetric care represent the tip of a very large iceberg. Under that tip are massive amounts of iatrogenic morbidity.

UK campaigning pressure group I spend a great deal of time giving free tutorials to journalists who ring me up with some story line wanting a comment. Changing press attitudes is a lengthy process. Never allow an incorrect or adverse article to pass without comment. That means that every one of you has to respond. When newspapers are deluged with letters, they start to take notice. If you personally cannot reply, make sure you encourage someone else to do so. Don't let it lie.

### New Zealand Midwifery

In the past eight years New Zealand midwives have been the envy of the world. Your 1990 pay equity with general practitioners was a groundbreaking recognition of the true worth of midwives. You have given enormous hope and encouragement to those of us who are campaigning to change the medical centred midwifery service. You have won some significant battles, but you have not won the war. There are battles ahead. These could be difficult as too many will be content with the gains already made and all is well. Also you are facing a medical profession which is a past master at gorilla warfare.

If midwifery is to be strengthened, it has to have its own independent status. A separate Midwives Act is essential. Midwives have to have control of their own training. The present system of two different education systems is inappropriate and must stop. It is unfair to the nurses who struggle through it and unfair to the tutors who struggle to help them acquire the skills and knowledge in the limited time frame.

To win these future battles, every single midwife has to address that which she knows is wrong with the current provision of care. Midwives, wherever they work, be it centralised maternity units, the community or in independent practice, have to support each other. You have to help those who are threatened by the changes. You need to foster contact and support for those medical practitioners who do support midwifery. They are a rare breed and deserve support and encouragement. Most of all you have to continue to inform women so they continue to give their support and speak out where necessary. By working together you will be able to counter the medical profession's determination to undermine your considerable achievements.

We know that good midwifery care achieves good outcomes and strong mothers and babies. The women of New Zealand deserve nothing less. Together you can ensure that the Millennium is celebrated by a strong, independent, financially secure midwifery profession.

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# A Fresh Approach to Pain in Labour

■ Nicky Leap

- Independent Midwife  
London, U.K.

Key Speaker - NZ College of Midwives Fifth  
National Conference. Abridged Version Of Paper

**P**ain is never the sole creation of our anatomy and physiology. It emerges only at the intersection of bodies, minds and cultures. (Morris, 1991-1).

Being with women in pain is one of the few experiences that all midwives share. Working with our own discomfort at being with women in pain and not offering to dull or take it away is understood by midwives the world over. However, we live in a society that sees the relief of pain as a major benefit of modern living. Many people see the role of the midwife as someone who is trained to produce what I call 'the menu' of what is on offer in order to facilitate 'informed choice' for women. Any midwife who does not subscribe to this approach is swimming against the tide and is at risk of being called 'cruel'. I wanted to develop a clear rationale to respond to accusations such as: "Why should women suffer pain in childbirth in the 1990s?" and "Why on earth would you not offer pain relief?"

My fascination with this topic led me to choose 'A Midwifery Perspective on Pain in Labour' as the topic for my MSc dissertation (Leap, 1996). I had previously carried out some research that included interviewing women about their experiences of pain in labour. This work had highlighted the impact of midwifery 'interventions' on women's experiences. I decided to build on this work by interviewing midwives who had developed a rationale for not routinely offering pain relief to women in labour.

In order to formulate some open-ended questions as a starting point for the interviews and thereafter throughout the study, as a response to issues raised, I carried out an extensive literature search drawing on multi-disciplinary discourses on pain. Besides midwifery texts, I drew on material produced in the disciplines of physiology, anthropology, psychology, sociology, philosophy, palliative care and nursing. I also included explorations of pain in the form of novels, poetry, short stories, plays, biographies, oral history and books on childbirth aimed at pregnant women. Some quotes from this literature search will be shared during this presentation.

The ten midwives who participated in the study had considerable experience of home birth. I knew that I would be working with an articulate group, used to reflective practice and expressing their ideas and experiences. My hypothesis was that they would be likely to work within a paradigm of 'working with pain' as opposed to that of 'pain relief' and I expected that we would be able to explore ideas regarding practical, emotional, cultural, ethical and philosophical aspects of pain in labour. Apart from a midwife from Ontario and one from Amsterdam, all of the midwives

were currently practising in Britain.

The methodology I employed was a modified version of the grounded theory approach developed by Glaser and Strauss (1967) combined with thematic content analysis similar to that suggested by Burnard (1991). This allowed for data collection and analysis to occur simultaneously and for the development and refinement of categories both during and after the interviews. With the midwives, I was able to develop hypotheses and theories as they emerged during the taped interviews and this meant that these ideas were strongly grounded in clinical practice.

The questions that I used to trigger discussion were:

- How does your own experience or lack of experience of giving birth affect your attitudes to pain?
- How do you discuss and describe labour pain with pregnant women?
- How do you help women cope with pain in labour?
- What can we learn from listening to women's accounts of their labours?
- Why not offer pain relief?
- Has anyone ever suggested that you're 'cruel' because you have not offered pain relief?
- How have your attitudes towards pain in labour changed since your training?
- What might be the purpose of pain in labour?
- How does your observance of women's response to pain in labour affect your practice?
- How are you personally affected by being with women in pain?

The midwives believed that the midwife's attitudes to pain and the messages she gives to women in pregnancy and during labour make a difference to the woman's experience, especially where a relationship has developed through continuity of care. They described two distinct paradigms around pain in labour: the pain relief paradigm and the working with pain paradigm. Their descriptions can be summarised thus:

## The pain relief paradigm

- The offering of pain relief is seen as an essential role of the midwife
- It's a lot more work to interact with someone who is agitated and making a noise
- We should make full use of the benefits of modern technology
- The 'menu' approach to give women informed choice

- Women can cope with the pain of normal labour
- The need for pain relief is abnormal and is associated with pathology
- Pain is a stimulator of endogenous opioids
- The midwife's role is to reduce stimulation to the senses to facilitate endorphin release
- The expression of pain gives clues to progress

The midwives described their rationale for not offering pain relief as being based in responding to feedback from women. All of them worked in situations where they hear from women how it was for them, either in groups where women tell their stories to other women, or in situations where continuity of care offered the opportunity of exploring these experiences on a one-to-one basis. Their philosophy was also informed by their beliefs about the purpose of pain in labour.

- Pain as pure physiology
- Pain stops women and allows them to find a place of safety to give birth
- Pain marks the occasion
- Pain summons support
- Pain develops altruistic behaviour towards babies
- Pain heightens joy
- Pain as a transition to motherhood
- Pain as a trigger of neuro-hormonal cascades
- The triumph of going through pain (The notion of triumph played a large part not only in the stories told but in the literature search so time will be given to sharing some quotations during this talk).

The midwives also believed that an understanding of the concept of 'normal' pain helps midwives to "sit back" and deal with their own discomfort and pain. This understanding also provides a rationale not to offer pain relief as long as they can interpret what they see as being part of a 'normal' process.

All the midwives expressed a degree of caution about developing theories that are didactic or stereotyping and saw the need to avoid creating new dogma. This was directly linked to stories told with relish about being proved wrong when predicting how women will cope with pain in labour.

The question of whether all women can cope with the pain of normal labour - posed by the ultimate logic of purist endorphin theory and a belief in 'nominal pain'

promoted wide debate on whether, once labour is well established, "physiology overrides psychology" or vice versa. Opinions ranged over a spectrum from one midwife with a strong conviction that all women can cope with the pain of spontaneous labour where there is no malposition, and the Dutch view that "mental pain that warrants pain relief is pathology" to midwives who thought that there will always be some women who will need pain relief because of their personal circumstances and way of being in the world. The midwives were all aware of different cultural expressions of pain but were anxious to avoid ethnic stereotyping when talking about their experiences of working with women from different cultures. What emerged was a belief that, although women's response to labour pain is culturally conditioned, there is possibly a certain degree of universality about this response in terms of noise and behaviour even when women are relatively non verbal. However there was a perceived universality to the midwife's response to cues, even when the cues vary.

Some key issues arising from the research can be summarised thus:

- Do midwives working in hospital settings share the ideas and philosophies described by this select group of midwives [Preliminary findings from workshops in Britain and Australia suggest that many do
- Can a philosophy of 'withholding' drugs in a woman's best interests be justified or implemented in a culture that prioritises notions of 'choice and control'. It is our responsibility sometimes to "believe women can do it and to protect them when they don't believe in themselves"
- Is the concept of 'normal and abnormal' pain central to the debate about what constitutes 'the normal' in childbirth and is this therefore an important issue when defining midwifery knowledge and culture?
- If physiology is the key to understanding pain in labour, how can we apply our knowledge of it to practice.

Clearly we need a full description of the role of endogenous opioids in spontaneous labour if endorphin theory is to be given credence. We also need more debate and an understanding of how midwifery interventions - whether in the form of offering pain relief or facilitating 'normal pain' - can make a difference to women's experience of childbirth.

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# "What does the New Zealand College of Midwives do for me?"

The NZ College of Midwives (NZCOM) has been accused by some NZNO members of failing to meet their needs. If we are to understand the complexity of the current issues, we need a comprehensive overview of the connections between these problems and the past events.

The interaction between midwives and nurses in New Zealand has a long history. The Midwives Act 1904 established state control of maternity care in St Helens Hospitals for the 'deserving poor' and the training and registration of midwives. Being few in numbers, New Zealand midwives never formed an independent organisation to represent their interests. Nurses, registered in 1901, formed the New Zealand Trained Nurses Association in 1909. Not many nurses had a midwifery qualification, but midwives with a nursing training were entitled to join the Nurses Association. Later, the direct entry midwives were encouraged to join. There were 700 RNs and 214 trained midwives. Including midwives was seen as strengthening the nursing profession and effectively eliminating midwives as a pressure group who could be used by doctors in future political manoeuvres. This de facto relationship was legalised in the Nurses and Midwives Act 1925. This provided training and registration for two classes of maternity carers: a large number of maternity nurses (RMN) trained for 18 months in public hospitals and a limited number of midwives (RM) trained at St Helens Hospitals who would specialise in obstetric practice and provide a service where medical assistance was difficult to procure.

It was not until 1969 that midwives formed the Midwives Section within New Zealand Nurses Association (NZNA) in order to join ICM. Even at that time the Section did not promote the specific interests of midwives who were seen as nurses with a postgraduate diploma in midwifery. The Nurses Act 1971 reduced the midwife to an obstetric nurse. Henceforth the registered midwife could only carry out 'obstetric nursing' where a medical practitioner had undertaken responsibility for the patient. The only exception was in 'an

# A response to the New Zealand Nurses Organisation

Joan Donley. O.B.E.

emergency'; otherwise she was liable to a fine of \$200. (Section 52(1)). There was not a murmur of protest from midwives! The NZNA Members Handbook (undated) stated NZNA is "concerned specifically with nursing issues related to maternal and infant care".

A number of factors contributed to undermining the status of the midwife per se. The 1970 Carpenter Report recommended transfer of nursing education from hospitals to technical institutes. Midwifery education was a non-issue. 'Certified (midwifery) courses' needed to be 'examined in the light of the roles nurses are expected to fill'. There was no specific midwifery opinion solicited - if such existed.

The need for 'obstetric nurses' was reinforced as a result of the establishment of the Postgraduate Chair of Obstetrics and Gynaecology at Auckland University and the building of its clinical school - National Women's Hospital at a cost of \$3.3 million subsidised by the taxpayer. Professor Dennis Bonham who held the Chair from 1963 promoted 'regionalisation' to provide the necessary 'clinical material' in order to train future obstetricians. This resulted in closure of cottage, rural and private hospitals (Bethany, Mater). To Bonham's chagrin there was an increasing demand for home births - over which he has no control! Domiciliary midwives (DMs) were still under Department of Health supervision. In fact, until 1986 DMs' contracts were signed by Peter Fraser, 1939.

1979 Nurses Regulations (S. 26) reduced the status of the midwife to a mere member of the obstetric/nursing team and any 'nurse' could carry out 'obstetric nursing' under medical supervision. There was no outcry from NZNA.

As early as 1933, Sir Bernard Dawson, first professor of Obstetrics and Gynaecology at Otago University, told a meeting of the Obstetrical Society that the results of midwifery care were statistically superior to those of medical personnel. He suggested doctors should make a 'colleague' of the midwife, 'incorporate' her as part of the medical team. He was reassured that the Government was already training three

maternity nurses to one midwife. (NZMJ, 1933 Obstetric Society Section, vol.32 p21.) This 'incorporation' into the medical team was facilitated by the Social Security Act, 1938 which provided women with free birth in hospitals under the doctor of their choice. This also included 'twilight sleep'.

In December 1979 the final midwifery class graduated from Auckland St. Helens. Henceforth, midwifery 'training' consisted of an 8 - 12 week midwifery option within the Advanced Diploma of Nursing (ADN) at technical institutes. Most nurses wanting to train as midwives went either to Australia or United Kingdom. The NZNA did not support the Midwives Section's concerns over the ADN as an inappropriate education for midwives.

In April 1981: the NZNA Policy Statement on Maternal and Infant Nursing acknowledged 'there is failure to agree to the most basic question - "Who is a Midwife?" The Association considers a midwife to be a nurse.... who is qualified to care for women during pregnancy, delivery and the postnatal period, and for the neonate.. The detection of problems either actual or potential..requires that the midwife obtain medical assistance, although she is qualified to carry out emergency assistance in the absence of medical help' (p 19). The Statement went on to express nursing ambition for 'recognition as a powerful political group advocating changes and innovations in the delivery of maternal and infant care' (p 20). This would be achieved through the comprehensive 'family health nurse' providing continuity of care from birth to menopause. Bear in mind that many of the "nurses" making these decisions had a midwifery qualification! They had been 'incorporated' as a medical 'colleague'.

Throughout 1982 midwives were suffering an identity crisis. Seminars examined 'What is a Midwife?' In April Regional Section members formed a Working Party on Midwifery Education which came up with a number of progressive recommendations. At NZNA Conference the Midwives Section put a remit for a separate midwifery course, which the NZNA President was to discuss with the Ministers of Education and Health. No midwives were represented at these discussions.

In September 1983 the Nurses Amendment Bill was passed. It revoked Section 26 of the Nurses Regulations, cementing it into the Bill. Now, any nurse could carry out obstetric nursing under medical supervision. It also prevented a direct entry midwife from registering as a domiciliary midwife. Suddenly, midwives became aware that the threat to midwifery was real. The Auckland 'Save the Midwife' Task Force was formed by home birth activists to fight the Bill. The Auckland Midwives Section prepared a submission to the Select Committee based on the WHO definition of a midwife. It asked that 'the term midwifery practice' be written into the Act to replace 'obstetric nursing'. They said:

"Midwifery practice is not the same as obstetric nursing." This Submission had to go via the NZNA National Executive - who embargoed it as it conflicted with their policy.

This struggle for survival of midwifery not only united the hospital and domiciliary midwives it also made midwives aware of the value of consumer support. In submissions to the Select committee the electoral power of Save the Midwife resulted in direct entry midwives being able to register as DMs.

At the 1984 NZNA Conference (May) a unified Midwives Section demonstrated their power. They defeated Section 17 of the 'Review and Statement of Policy on Nursing Education in New Zealand', and demanded that it be amended. As this was slow in happening, in June, Canterbury/West Coast Section with National Section endorsement, forwarded a vote of no confidence in NZNA. Section Chairpersons demanded that referral be made to the Minister for action based on reliable data on midwifery manpower. While each midwife paid a NZNA subscription of \$72 plus a subscription to her Section, the Section midwives were required to fund this survey, although the nurses had such 'donkey' work done for them. Also, NZNA declined to fund the National Midwives Chairperson to the ICM Western Pacific Regional Conference. She had to go begging to various trusts for funds.

In 1985 in order to reverse the defeat of Section 17 at the 1984 Conference, NZNA put a further remit forward that the advanced specialised knowledge and skills of midwifery are built upon the concepts developed in the basic nursing programme. The rationale was that since midwifery cannot be regarded as a basic course, a separate course would be a retrogressive step. This was not only defeated, but a remit (33/85) calling for a separate midwifery course to be treated as urgent, was passed! "It is time the debate stopped and the action occurred." Also passed was that NZNA adopt the ICM definition of a midwife in all future policy statements. (14/85). NZNA pointed out that there were only 600 midwives and more than 20,000 nurses. Could such a small group of midwives expect to sway the opinions of the nursing profession? (Pat Carroll). A prophetic statement!

In September 1986 the first National Midwives Conference was held in Christchurch. Lorraine Sivyver, NZNA President wrote a 'secret report' for NZNA Executive. She reported that the topic of a separate organisation was raised which had evolved from the Massey Workshop (August 1986) where 'midwives were really looking at

'there is failure to agree to the most basic question - "Who is a Midwife?" The Association considers a midwife to be a nurse....

their resources and ability to represent themselves. Our anticipation of a breakaway did not occur in reality. They will look at the feasibility of setting themselves up as an organisation. They had the information as to the cost and the implications of this. I sensed the climate was timid at the moment and certainly the political awareness was not as astute as we might have believed.' Maureen Lawton also secretly reported that her "off-side lobbying' at every break was exhausting but helpful (to NZNA).

In 1987 the Evaluation of the ADN was published. It found that half the nurses who undertook the course, mainly to qualify as midwives, said it was 'unsatisfactory' or 'very unsatisfactory'. They were either 'dissatisfied' or 'very dissatisfied' with both the theoretical and clinical components of the course. The report also admitted that 'nurses who undertook the course leading to a midwifery registration have different requirements from most nurses seeking an advanced diploma'. Although the ADN course was to continue, a one-year separate pilot midwifery course was initiated in 1989 by the Midwives Section's successful lobby.

In August, 28 New Zealand midwives attended the ICM Congress in The Hague. Not only were the official delegates not expected at the Council meeting as NZNA had not communicated with The Hague, but they were further embarrassed to be told that of the 52 countries only two had not paid their capitation and New Zealand was one of these.

The prolonged and dystocic labour was almost over! The 1981 NZNA Policy Statement on Maternal Infant Nursing was rewritten (1987). Chaired by midwife Steph Breen it was published in April. It recommended:

- \* that the principles of the Treaty of Waitangi be observed in all areas of midwifery practice;
- \* that clients be provided with continuity of midwifery care throughout the whole child-bearing process and that NZNA investigate employment for midwives on a case load basis under area health boards and the State Services Commission;
- \* that the present legislation be amended to permit midwives to assume full responsibility for their clients' midwifery care; and
- \* that adequate numbers of midwives be employed in health agencies providing maternal and infant health services based on the standards of midwifery practice. Joy Bickley said the Policy Statement "reflects the essence of midwifery - wherever it is practised".

In 1988 after over a year of investigation the Cartwright Report was published. This stressed the importance of 'informed consent' and the need for consumers to be represented on professional bodies.

Finally, in a chaotic climate of market-led restructuring of the health services, the Auckland Midwives Section held the second Midwives Conference. Here, I challenged

midwives to form our own professional organisation as the first step in speaking for ourselves - to be midwives not moas (an extinct species).

Despite years of shabby and contemptuous treatment as a minority group, midwives had clung to NZNA because it was the 'only organisation recognised by the Government to negotiate for salaries and conditions of work for nurses employed in general and obstetric public hospitals and district nurses employed by hospital boards' (NZNA 1983). But the era of collective bargaining was on its way out as Roger Douglas precipitated New Zealand into the market-led 'economic miracle.'

The National Midwives Section (July 1988) discussed the options in relation to what midwives could do in relation to the 1987 Labour Relations Act (The 1987 Labour Relations Act recognised NZNA was happy to relinquish negotiating rights) and the 1988 State Sector Act (March) which terminated collective bargaining as of 31 March 1989. After that midwives could be up for grabs on the industrial front. At that time 81.5% of qualified 'nurses' were employed in hospitals, 16.2% in Community health (Department of Health Report).

The Section suggested midwives could remain with NZNA as 'nurses' obtaining industrial representation by default and/or form an association whose primary aim would be to promote midwifery in order to survive as a profession. They recognised that these options would be expensive. But, they responded enthusiastically to the formation of the New Zealand College of Midwives, which included consumers on both the National and Regional bodies. The provisional subscription was \$52. An Auckland-based working party was elected to draft a constitution for incorporation. Karen Guilliland, currently president of the Section, carried on as NZCOM president. A leading obstetrician claimed that the 'three greatest threats to obstetrics were feminism, consumerism and midwives'.

Having lobbied hard and long, firstly as the Midwives Section then as the New Zealand College of Midwives, the College was barely out of nappies when the 1990 Amendment to the Nurses Act was finally passed. Recognising midwives as autonomous practitioners it gave them pay parity with GPs and access to public hospital facilities. As the traditional gatekeepers to maternity services, GPs were not about to accept this threat to their power base. The College therefore was forced to concentrate its energies to maintain the survival of midwifery as a profession (which the Section had agreed was the aim of an independent association).

Having worked 'under the doctor' for so long, there was no great rush on the part of midwives to become independent practitioners. Even the so-called 'relatively independent' DMs only gradually discontinued to work with GPs. Hospital midwives also took up the challenge. Unfortunately, a few hospital midwives made

arrangements with obstetricians to do lucrative intrapartum care only.

Meanwhile the NZMA boycotted three meetings called by the Department of Health to negotiate the doctors' medical model Maternity Benefit to accommodate midwives. This allowed midwives to claim \$285 for delivery plus the 'prolonged attendance' fee of \$69.80 per half-hour after attendance of 1.5 hours. The doctors screamed that midwives were 'blowing out the budget' in this period of 'fiscal restraint' and used this to demand a Tribunal.

A five-member Tribunal was set up in November 1992. Sally Pairman NZCOM President was the midwifery representative. NZMA hired a QC for \$40,000. With a membership of approximately 1200, NZCOM had to rely on its own resources. Karen, then National Coordinator and Stephanie Breen (NZNU) acted as counsels. A team of four midwives and a consumer accountant contributed research and evidence. The outcome: The Department of Health noted the clear philosophical differences between the two parties, but confirmed that the fee is for a service of equal value and should be paid

**This struggle for survival of midwifery not only united the hospital and domiciliary midwives it also made midwives aware of the value of consumer support.**

accordingly. Another victory - not only for the survival of midwifery as a profession, but a profession with the same status and privileges as GPs in maternity care!

Hard on the heels of the Tribunal came the 1993 Health and Disabilities Services Act - to corporatise the public health system for eventual privatisation. This too was promoted by Roger Douglas and the Business Round Table and their Treasury clones who had been advised by US Dr Patricia Danzon. Health care was to become a commodity with 'health a privilege, not a right' (Maurice Williamson).

The Act replaced the Department of Health with a Ministry to advise, monitor and disburse Crown funds to four competitive RHA purchasing agencies. Public hospitals became 23 profit-oriented/competitive Crown Health Enterprises (CHEs) under business management. NZNO went from having to negotiate one award for nurses (and midwives) to negotiating in 23 separate workplaces. As a small section of the NZNO midwifery was even less of a priority. Section 51 of the Act created a negotiating committee to adapt the medical model doctors' Maternity Benefit 'to a new pay structure, based on fiscal neutrality, agreeable to both doctors and independent midwives'. The committee comprised combined RHA representation

(the funders) with members from NZMA and NZCOM.

Totally disregarding the terms of reference, NZMA came to the negotiating table with its own agenda, declaring 'the 1990 Nurses Amendment Act was the root of all evil in the maternity services' (Statement, first Committee Meeting: Nov.1993) and its aim was to:

- \* Put midwives back where they belonged ('Under the doctor' in the missionary position!)

- \* Maintain fee-for-service. It opposed the 'modular' payment system recommended by the Tribunal, and budget holding - 'a managed care' tool to shift financial risk with no opportunity to recoup losses from either the patient or a third party.

The College spent three bitter and frustrating years 'negotiating' Section 51. Well aware that different funding arrangements for CHE and independent midwives - doing the same job - would be both unfair and divisive. NZCOM lobbied to have a CHE midwife representative on the committee, but was able to get CHE managers to one meeting. NZMA managed to get NZGPA on board. Also, with the support of consumer groups, NZCOM managed to get one consumer - Joy Christison - onto the committee.

By 1995 there were 500 independent midwives, 35% of women were choosing midwife-only care and 60-80% of women knew the midwife who attended her in labour.

Throughout this period, NZCOM was also involved in issues to ensure midwifery survived as a profession.

- \* It established 'Standards of Practice' based on continuity of care (Revised NZNA Policy Statement 1987) and partnership with women;
- \* It began adaptation of the 1986 DMs Standards Review process to accommodate independent midwives who were now outside the hospital QA assessment;
- \* It struggled with negotiation of midwives' legal right to CHE access agreements which were obstructed by the Obstetrics Standards Review committees.
- \* It developed software for a National Midwifery Database for Lead Maternity Carer (LMC) birth outcomes;
- \* It assisted in the development of Direct Entry degree programmes; and postgraduate Masters and PhD programmes.
- \* It worked intensively with all educational institutions to promote a standard of quality and direction in midwifery education.
- \* It initiated a working party of CHE, HFA, MOH, polytechnics and universities to establish courses for midwives working in secondary care.
- \* It worked in partnership with Maori midwives to establish and liaise with Nga Maia o Aotearoa me te Waipounamu.

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that midwives were  
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In July 1996, Jenny Shipley, Minister of Health, fed up with the doctors' Section 51 antics, made a unilateral decision embedding the modular system under a capped budget and the LMC as the budget holder. GPs refused to accept Shipley's conditions - there was 'no fat left in the system'. Having to share their gatekeeper role with a midwife LMC, they saw as demeaning the role of the GP and displacing the 'team' (led by a doctor). So they withdrew from maternity care - but still screaming women's right to "choice" of 'shared care'. Independent midwives became the scapegoats.

In 1997 the final of section 51 highlighted the insultingly low value placed on CHE midwifery services. This opened a whole new minefield. NZCOM pointed out that for a CHE labour fee of \$360 the midwife would provide 95% of the care, while the GP would rush in for the birth to claim \$590. The Tribunal had stated, that although it had no authority concerning hospital midwives' salaries, it felt an unrealistic conduct of labour fee would increase disparity. It could also send signals to consumers and professionals that this work was not valued - thus negating the intent of the Nurses Amendment Act.

The College challenged RHA's failure to assess service costs with CHEs. How much were GPs paying for the formerly free midwifery workforce, and for postnatal midwifery care? How much 'primary' funding was being used to cross subsidise secondary care? NZCOM advised CHE midwives to become LMCs in order to establish their autonomy and protect the continuity of care Know Your Midwife (KYM) schemes. When it came to negotiating KYM 'team' variance clauses, regional NZCOM committees sent representatives to any CHE in which NZNO would 'allow' College involvement. Some NZNO organisers were less than happy about involving NZCOM even though it was of no cost to them. Despite an open and long-standing invitation no organiser has ever approached NZCOM for input. NZNO has also refused offers from CHE management to negotiate better midwifery contracts on the grounds that it discriminates against nurses! Auckland NZCOM coordinators have mediated local issues for nine midwives - for free - even though they were not NZCOM members.

Unfortunately, CHE midwives seemed to believe that resolution lay in 'going with the flow' or that they would lose all by taking an unpopular stance. Also NZNO had not been very effective. Following the Employment Contracts Act 1991, the then (1992) NZNA settled only two of 14 AHB collective contracts and these had not been satisfactory to all. Successive health 'deforms' fragmented industrial negotiation even further. According to one NZNO organiser, the CHE midwives at NWH 'only get what they do because they ride on the coat tails of nurses from APH and Starship'. In view of that attitude, it is doubtful if NZNO has ever really addressed the internal problems of CHE midwives which have been exacerbated by deliberate under-

funding resulting in staff shortages with attendant stress and in-fighting. Meantime, insurance companies, like vultures, wait in the wings to pick up private contracts. In the interest of profits these will hire a few core midwives and many nurses.

(Remember? Any nurse can carry out obstetrical nursing under medical supervision).

The College supported NZNO in providing the industrial needs of CHE midwives. In 1995 and again in 1996 NZCOM approached Brenda Wilson re dual NZNO/NZCOM membership for CHE midwives by allowing a subscription rate of 50% of the self-employed fee - similar to NZNO recognition of Nursing Tutors paying a reduced rate to belong to both organisations. Since December 1996, technologists have had this membership concession. The request was declined by the NZNO national executive.

The Health and Disability Services Act established the Health and Disability Commissioner (HDC). By 1995 she had developed the consumers 'Code of Rights'. Meanwhile, the adversarial Accident Rehabilitation and Compensation Act 1992, (introduced by Birch) effectively abolished the no-faults Accident Compensation Act which offered protection from most forms of medical malpractice litigation. Dr David Collins claimed this would promote 'defensive medicine' resulting in unnecessary tests and evaluation and over treating patients to avoid subsequent allegations. Treasury expressed concern that broad-based patients' rights could lead to fiscal blow-out. (*NZ Herald* 27.9.95, HDC Seminar paper 1995). By 1997 the legal profession was encouraging consumers to sue for civil/exemplary damages (although the 1998 Crimes Amendment Act lessened the chances for medical manslaughter by limiting negligence for action for exemplary damages).

NZNO claimed that the Code of Rights left practitioners 'Carrying the can for a flawed system'. It pointed out that 'health care service' was not defined, leaving health practitioners to bear a disproportionate share of the blame for problems resulting from a poorly resourced and fragmented system. Systems had to be well-funded and well-run to provide the open ended 'consumer' rights (Hugh Oliver/ Laura Cronin, Kai Tiaki).

The College claimed the HDC used a punitive instead of a mediation/resolution process. Also, in maternity care, a significant number of interventions are opinion-based rather than research-based and the Code does not support client/patient-centred or partnership model of care. The Code has

been used very effectively against midwives - aided by obstetricians and doctors encouraging parents to bring complaints against midwives. The media does its part, featuring sensational stories to question the 'safety' of midwifery care.

By 1998 legal expenses accounted for 53% of NZCOM running costs - many of the costs were for the defence of CHE midwives. Although we had Jackie Pearse, our lawyer/midwife on board, it has been very expensive to be forced by insurers to use one of their high-priced barristers for court actions. The NZCOM subscription for a self-employed midwife is \$630 per annum and the subscription for an employed midwife is 50% of the self-employed midwife ie \$315 compared to NZNA subscription of \$350 NZCOM provides indemnity insurance of \$500,000 with an aggregate of \$1 million. This indemnity insurance covers HDC, Nursing Council, ACC, coroner and civil courts. NZNO provides \$250,000 in indemnity cover. (In the United Kingdom self-employed midwives pay £11,000 per annum (\$NZ 34,000) for indemnity insurance). For NZCOM to negotiate industrially for CHE, all CHE midwives would need to be members in order to fund a wage for one person to provide an effective service.

Today, there are approx. 1900 practising midwives. Nearly 83% are NZCOM members. Both CHE and independent midwives have freely contributed time and energy to ensure the survival of midwifery as a profession. Until late 1994 Karen was the only (under) paid employee - at \$20,000 per annum at a time when many midwives were earning much more. Until 1991, our 'office' was under Karen's bed! Currently, five of the 11 Regional coordinators are CHE midwives. None of the national and regional midwives and consumers who struggle with the numerous problems complain that 'the College does nothing for me'. (CHE midwife coordinators -Wellington - Sally Greed; Nelson Marlborough - Jessica Mills; Waikato-Taranaki - Ruth Kowalewicz; Otago - Mary Whitam; Auckland - Nimisha Waller).

In 1983 the hospital and domiciliary midwives set aside their individual grievances and united to 'save the midwife'. Today we are confronted with the chaos created by the destruction of our health care system as it moves to privatisation. The more dissension there is between groups the easier it is to negotiate 'contracts' for lower wages and conditions. It's called 'divide and rule'. In the interest of survival of midwifery as a profession in its own right we need to sort out our own personal grievances and speak with one voice.

# Informed Consent - Issues For Midwives

■ Jackie Pearse

- Legal Advisor, NZCOM

Presentation to  
the 5th National Midwifery Conference

Kia Ora Koutou

When the organising committee started planning this conference, they were very aware that 1998 represents ten years from the release of Judge Cartwright's Report on the Cervical Cancer Inquiry (Committee of Inquiry into the Treatment of Cervical Cancer at National Women's Hospital and other related issues - the Cartwright Inquiry). In preparing this paper it seemed fitting to go back and read that Report once again.

Much of my time is spent defending midwives and I constantly see the grief, the guilt, the worry, the self-doubt and general feeling of devastation that consumer complaints cause to the midwife and her family. A number of the complaints seem unjustified and the motivation is not for understanding, reasonable recompense or a just outcome, but is to exact punishment or revenge. It is not uncommon for the complaints to go through multiple forums and take up the time and energy of years of the life of the woman, of her family and of her midwife and of her family as well. At the end of it all there is often no resolution, no peace and no sense of satisfaction for either side; indeed the nature of these conflicts seems to leave the parties indelibly changed. Women lose their trust in midwives and in their own ability to birth, midwives lose their trust in women and their joy in birth. The win/win situation is seldom achieved.

It would be an easy matter to fall into the trap of thinking that in today's climate complaints are far too easily set in motion, that too little thought is given to the consequences and that the pendulum of consumer rights has swung too far. Any stirring of that view within me was utterly quenched when I re-read the Cartwright Report. It was like touching an important lodestone for me personally. When Phillidda Bunkle and Sandra Coney were first interviewed on television about their Metro Article (Coney & Bunkle 1987), I watched in total disbelief as the authors talked about Dr Green's research and its effects on women to whom he had owed a duty of care. I, like so many other people around the country, had known nothing about what had been going on and after that interview followed closely the process of Inquiry. As a midwife I was acutely aware that I had never heard anyone speak out about what was going on at National Women's and it seemed that our profession had also become enmeshed in the web of silence and solidarity that protected Dr Green's research and 'treatment' from wider scrutiny. During the months of 1988, I recall on several occasions hearing women say 'where were the nurses?'

When the findings were released, Her Honour also recognised that other health professionals had failed to protect their clients. She wrote "*Nurses have been conditioned to protect patients by stealth. They cannot therefore be effective advocates who will act bravely and independently*". (The Report of the Cervical Cancer Inquiry 1988, 173. Only one registered General and Maternity Nurse (and the Principal Nurse) gave public evidence at the Inquiry. Four other nurses were personally interviewed but preferred this to be done in private). At the time midwifery and nursing were two professions who were starting to describe themselves as advocates of clients, and this finding was a serious blow to that assertion. We had very publicly been found sadly wanting.

Recently, a decade later and as I read again the original Report, I still cringed at those lines. For some reason what occurred seems more abhorrent now than it did ten years ago. The complete disregard of the personal circumstances, the wellbeing and the effects of the policy on the women and their families seemed far more sobering then I had remembered. Touching base with this again has helped reemphasise to me the vital importance of consumers having rights and having mechanisms whereby those rights are protected. Despite my many concerns about the fairness of some current complaint processes, we must never, ever undermine or take away the voice of consumers and the right for them to complain - for at the end of the day we and those we love, are all consumers of health services.

## Informed Consent

I would like to look now at the background of informed consent, one of the key matters discussed in the Cartwright Report, and how it has become enshrined in New Zealand law. It is a vast and complex subject and I know that many of you have at times have studied it in various forms, so I do not propose to give you a definitive definition or statement. What I do hope to do is to provide an overview of your personal responsibilities as midwives to your clients. I will then discuss some complaints that have surfaced with respect to alleged failures of informed consent and give you some strategies that may help you and your clients to enter a dialogue whereby informed consent and choice can be the result.

The Medical Council of New Zealand issued a position paper on informed consent in 1990. David Collins quotes this definition and it is a good working definition for our purposes.

Despite my many concerns about the fairness of some current complaint processes, we must never, ever undermine or take away the voice of consumers and the right for them to complain...

*"Medical consent means a voluntary, uncoerced decision made by a legally competent and autonomous person on the basis of adequate information and discussion. This contrasts with the rejection of a proposed course of action; in short, it is a choice."* (Collins, 1990).

### Background

The doctrine of informed consent first gained some prominence in America in the late 1950s. The District Court of Appeal held in the *Salgo v Leland* case, (Stanford University Board of Trustees. 317 P 2d (1957) 'that [the ordinary patient] was entitled to know the nature, consequences, harm, benefits, risks and alternatives [of any treatment] in order to make a reasonable decision regarding whether they would accept or reject a treatment option'. The underlying philosophical premise of this decision was that the Court believed people had the right to decide what happened to their own body; in other words autonomy or self-determination.

This was quite a departure from English and the wider Commonwealth decisions where clients had generally been expected to comply with medical advice. The medical profession had traditionally been seen as being in the optimum position to decide what was best for its clients. During the Cartwright Inquiry, a variation of this theme was forwarded in defence of Dr Green as he argued that therapeutic privilege (this is where a Doctor is seen to have a discretion to stop short of disclosure if he or she feels there is a clinical reason to justify this) was a justification for non-disclosure of many of the things he was doing.

Commentators such as Olbourne have postulated reasons for why the American law developed so alternatively to that of England. Possible influential American factors that have been mooted as significant reasons for this departure, include the American egalitarian class structure, the more open society, the recognition of individual autonomy as guaranteed in the Constitution, the personal and civil rights movements, the growth of ethical discourse and the rejection of all types of discrimination including medical paternalism (Olbourne, 1998).

Throughout the seventies and eighties, the struggle to reconceptualise the decision making process and to balance the competing moral imperatives continued (Kerridge & Mitchell, 1994). The issues of competence,

disclosure, voluntariness and understanding were sharpened, largely within the institutional clinical settings. It was in some ways surprising that with this level of understanding of individual autonomy, the maternal fetal debate of the 1980s raged most strongly in America. It had become clear that a woman had the right to make decisions about what happened to her body even if her choice resulted in personal harm such as haemorrhage through the refusal of blood transfusions. The addition of the baby into the picture was seen as adding a new dimension to the consent debate. A growing awareness of the issue of whether a fetus had rights, led to a justification for a woman's choice to be overridden. The baby was seen as having rights to be born and to be born healthy and these rights were frequently given more weight than the rights and informed choices of the mother. This was more likely to happen if the mother was poor, black, Hispanic or a patient in a teaching hospital. (Sneiderman et al., 1995).

As a result of these clashing philosophies there was a series of forced medication, forced redundancy, forced feeding, forced confinement and forced caesarean cases in the United States. Viability came to be equated with full personhood and all its contingent rights and this led to incongruent situations. In one case the Court extended its protection to an 18-week fetus which the mother by law could have chosen to abort (Annas, 1993).

Various women's and human rights groups were critical of this growing trend. Some judges began to rethink what was happening. There was a judicial recognition that no one would countenance forcing a parent to undergo bone marrow biopsy or kidney donation for a living child, yet there had been a climate arising where it was seen as reasonable for a parent to be forced to undergo caesarean section with its inherent dangers in the potential interests of the unborn child (Reed, 1996). The effect of this on the relationship between women and their caregivers, who were expected to forcibly carry out the orders if the Court, was causing concern. George J. Annas, who advocated human rights, wrote thus:

*"force fouls the doctor-patient relationship subverting it into an assailant-victim relationship"* (Annas, 1993).

In another article he wrote:

*"The law must honour the rare case of a woman's refusal [to have a caesarean]. This may seem callous to the rights of fetuses, since some fetuses that might be salvaged may die or be born severely handicapped. This will be tragic but it is likely to be rare. It is the price that society pays for protecting the rights of all competent adults and preventing forcible, physical violations of women by coercive obstetricians and judges. The choice between fetal health and maternal liberty is laced with moral and ethical dilemmas but the force of law and the intervention of the courts and police will not make them go away"* (p127) (1993).

### The Current New Zealand Position

In New Zealand the issue of fetal maternal rights has not been overly prominent. There was a recent Palmerston North case (V, in the matter of Judge Inglis FC Palmerston North [1997] NZFLR 718) where an emergency order was granted to enable the local hospital to perform a caesarean on a woman referred to as V. V had been found to be incompetent due to a mental disorder and counsel for the hospital argued that V's mental state might worsen or pose a serious risk to the baby if natural birth occurred. There was no discussion in the judgment of the possible dangers of caesarean to V or to her baby, and this option was seen by the Court as the least restrictive intervention possible in the circumstances. Judge Inglis granted the application and the caesarean went ahead.

From time to time we see local newspaper clippings of social service agencies wanting to confine nomadic, drug-dependent young women for the term of their pregnancy but such cases have not, to my knowledge, gone as far as the Courts. I suspect that the overall issue of women's choice and informed consent vis-a-vis fetal rights will gain increasing future prominence in some areas of our country. Certainly there are still pockets of antagonism to homebirth and homebirth midwives from some interest groups. Their argument is that the women's choice should always be subordinate to the wellbeing of the baby and that no women, with risk factors, should have the right to chose to birth at home if it means that her baby is placed at risk. One mechanism of gaining support for this view is for opponents of homebirth to initiate and publicise complaints against midwives.

The concern of opponents of this type of thinking, whereby a baby's interests are placed before the rights of its mother, undermines the role of mothers as advocate for their babies and suggests that babies must be saved by other people from irresponsible mothers. Such ideas also are seen as largely ignoring the role of the father and significant others in the decision-making processes surrounding pregnancy and birth.

What our society is seeing now is women challenging medical advice and midwives supporting women's choices. Recent English cases have been quite emphatic about a woman's right to refuse treatment. One such decision was *Re: MB (Re MB [Medical Treatment] 1992 FLR 426 CA 663)* where the Court of Appeal stressed that a competent woman has an absolute right to refuse a caesarean and that the interests of her unborn child were irrelevant. The Court expressed the view that it was a well established legal principle that the unborn child has neither rights nor interests in law, any rights were contingent on being born alive. The Court said that the issue of determining where the balance lay between a woman's right to refuse treatment and her responsibility to a viable fetus was an issue for society and parliament. This is to be compared with the view of writers such as

Draper (1996) who argue that parents [mothers] should act as good Samaritans towards their children and do anything necessary to minimise risk to their health, including consent to unwanted caesareans. (Draper holds the practically difficult position that whilst minimal decency obliges mothers to act to save their babies, others are not at liberty to proceed with operations without the women's consent).

This poses a dilemma for midwives as there is a growing expectation in some quarters that a reasonable midwife will simply say no and walk away from a client who has risk factors, or who makes decisions against advice. For some midwives that will be a completely understandable decision and they will do this, but there will always be midwives who will chose to stay with the woman and her baby. The latter argue that walking away will only result in births occurring in situations where neither mother nor baby has any professional support at all. This is more likely to occur with the most vulnerable clients those who live an alternative lifestyle or those who feel marginalised or alienated from health professionals and the health system by their prior experiences. It is important for the midwifery profession to debate and consider the responsibilities owed to both the mother and the baby in light of a woman's legal right to chose the place of birth and the type of caregiver she wants. Such a debate would give guidance to practitioners who are caught between their concern that a mother not birth unattended and yet who recognise that they are legally vulnerable should they support a 'risky' homebirth if an adverse happening occurs.

### Aspects of Informed Consent.

In New Zealand the doctrine has not legally developed at the same rate as other countries, substantially because of the effect of the ACC legislation. The earlier focus of informed consent was however laid down in *Smith v Auckland Hospital Board* (Smith v Auckland Hospital Board [1965] NZLR 191 (CA)). This case was about a client who went to have an aortic angiogram. He had asked about risks and was reassured that it was a straight forward and low risk procedure. During the angiogram the blood flow to his right leg was occluded and the ultimate result was that it needed to be amputated. The Court of Appeal judgment confined the doctor's obligation with respect to the issue of informed consent, to providing information and carefully answering any questions the patient might have. Mr Smith was successful on appeal because he had asked specifically about risks and he relied on what he was told to agree to go ahead with the procedure. The doctor's answers

The baby was seen as having rights to be born and to be born healthy and these rights were frequently given more weight than the rights and informed choices of the mother.

to the questions posed were held to be inadequate. In this decision the onus was on the patient to ask the questions and the practitioner then was required to adequately answer them. This was obviously unsatisfactory as it relied on a patient who was sufficiently well-informed to know which questions to ask. In the Cartwright Report, it was the view of the Honourable Judge that this was not good enough and that the real test should be centred on the patient. Her Honour considered that the patient should be given the information that a reasonable patient would expect to have on which s/he could the base a decision (Cartwright Report p137).

Judge Cartwright then looked to the American decision of *Canterbury v Spence* (Canterbury v Spence, 464 F 2d 772 (DC 1972) which was rejected in England. In that case the 19-year-old plaintiff was admitted for back surgery for a suspected ruptured disc. There were complications of that surgery, namely partial paralysis, ataxia and incontinence. These 'material' risks had not been disclosed prior to the operation and it was clear to the Court that the plaintiff would not have consented to surgery if they had of been. This was a seminal decision in changing the focus of informed consent from the test

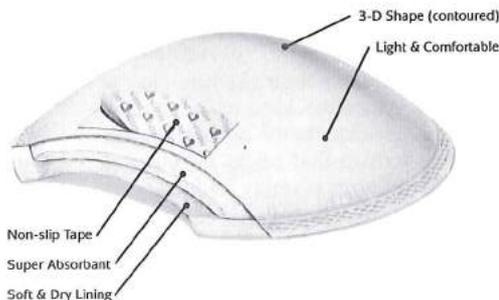
of the 'reasonable doctor' to that of a reasonable patient. The Judge held that the practitioner had a duty to supply the patient with all the information that she might reasonably need to assist her in making a decision about consenting to a proposed treatment.

In the Australian case *Rogers v Whittaker* (Rogers v Whittaker-1992 175 CLR 479) the plaintiff was blind in her right eye and was to undergo surgery on this eye to prevent glaucoma. Her ophthalmologist did not tell her that there was a risk of her developing sympathetic ophthalmia and becoming fully blind. Sadly this occurred and the plaintiff sued for damages. The Court ruled that the patient should have been told of all information that was material in the circumstances including: the nature of the treatment and the general surrounding circumstances. The giving of information was to be driven from the health, temperament and information needs of that particular person. That was the key to the judgment as it advocated a subjective test focused in the person undergoing the procedure. The client gave evidence that if she had been warned of the possible adverse effect of blindness, she would have never consented to the surgery.

It had been recognised that it is virtually impossible to discuss every potential risk. In this case a new test of informed consent was proposed to determine whether the risk was material and thus should be disclosed:

*"A risk is material if, in the circumstances of the particular case, a reasonable person, if warned of the risk would be likely to attach significance to it or if the doctor is or should reasonably be aware that the particular patient, if warned of the risk would be likely to attach significance to it"* (ibid).

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These few decisions have ramifications for New Zealand midwives. If you are discussing options of care and places of birth, then you must consider whether the woman has any material risks which could be significant to her, in her circumstances, in her making of a decision. Let us look at an hypothetical example. A woman has diabetes and is carrying a very large baby. It is not engaged at 41 weeks. She has declined a scan or pelvimetry and opts to birth at home. She has had two caesarean sections in the past for severe cephalo-pelvic disproportion. The midwife must warn the woman of the material risks of homebirth to both her and her baby and she must carefully document the content and outcome of these discussions. If the midwife does not then she will be in a precarious legal situation if anything goes wrong. This position will be far worsened if the woman later says that she would never have had a homebirth if she had been told of the possible adverse consequences. In *Rogers v Whittaker* this type of retrospective statement from the claimant was received as evidence against the practitioner and was seen to be persuasive by the Court.

The problem with these type of decisions is that they fail to practically define the characteristics of autonomous decision making; for example, just how much information is required for the true exercise of autonomy and an informed choice to be made? A further difficulty is that the decisions do not identify the responsibilities of the consumer in the interaction. This has given rise to the criticism that there is a climate of all consumer rights but no consumer responsibilities, but this fails to take account of the socialisation of women whereby women have not always been held accountable or seen as able to make informed

...The choice between fetal health and maternal liberty is laced with moral and ethical dilemmas but the force of law and the intervention of the courts and police will not make them go away

decisions about themselves or their babies.

It is still a particular concern when there is always the possibility for a woman to make an apparently informed decision but then at a later date to deny or go back on that decision should an adverse outcome happen to her or her baby. It is always open for the woman to say, regardless of the amount of information that she received, that she did not fully understand the risks or their possible consequences. She can then argue that the midwife was negligent because informed choice did not actually occur.

**Informed Consent as a Process**

The Rogers and Whittaker decision is also important for its emphasis on disclosure and informed consent as being a process rather than a single event or action akin to signing a consent form to surgery. This theme was discussed further in a useful medical law article by Kerridge and Mitchell (1994). They wrote:

"What is required is a shift in focus from disclosure to understanding and from unilateral information transfer to the integrated process of shared and informed decision making" (p.242).

Kerridge and Mitchell consider that the

term informed consent is misleading as the courts are increasingly interpreting it as a 'duty of disclosure'. The writers argue that the issue is not so much legal liability (or avoiding it) or even the adequacy of the disclosure, so much as the degree of the understanding of the client. They emphasise the quality of the clinical interaction and the process by which the decision making is involved - as opposed to just meeting the institutional, (Section 51), or legal standards. The process must focus on the parties participating in a shared dialogue which is responsive to the needs, wishes, capacities and expressed concerns of that particular patient (p.242). One of the encouraging things in Aotearoa New Zealand is how hard our consumer partners work to provide women with information about options of care. Many of these groups are selfless in terms of sharing their time and their own experiences to help others make choices that are good for them. The midwifery profession also places a real emphasis on dialogue in information provision and sharing. Generally women are given a wide array of information and have considerable time to think about and come to make their choices and I congratulate all of you who facilitate that.

**The Statutory Offspring of Cartwright**

The current office of the Health and Disability Commissioner and the Code of Health and Disability Services Consumers' Rights have much to owe for their inception to Justice Cartwright. The Report observed:

"In the absence of a Bill of Rights and in a jurisdiction where the financial accountability of the medical profession has been distorted by no-fault Accident Compensation legislation, there needs to be a procedure which patients or their relations can follow if they want more information about their health problems; if they need someone to negotiate on their behalf; or if they want some form of sanction to be considered" (Cartwright Report p172).

The Health and Disability Commissioner's process has been enacted and its mandate is to provide such a service to consumers.

There has recently been an upsurge in complaints, right across health professional groups, alleging negligence as a result of a failure of informed consent. It is therefore imperative that practitioners are aware of their statutory and professional responsibilities in this area.

**Accident Rehabilitation and Compensation Insurance Act 1992**

Informed Consent is not defined in this Act but a failure to obtain informed consent in

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all but a few cases, may lead to a finding of negligence through the medical error provisions. Such a finding will then often result in professional disciplinary proceedings. Section 5(6) states:

"A failure to obtain informed consent to treatment from the person on whom the treatment is performed or that person's parent, legal guardian, or welfare guardian, as the case may be, is medical misadventure only if the registered health professional acted negligently in failing to obtain informed consent."

### The Health and Disability Commissioner Act 1994

This Act established the Code of Health and Disability Consumers' Rights ("the Code"). Rights 5, 6, and 7 of the Code interact to form the nucleus of the doctrine of informed consent and require all health and disability service providers to uphold these rights. Failure to give effect to the rights may result in a finding that the midwife has breached the Code and disciplinary action could result. I am certain that you are all familiar with the Code but it is important, particularly in the current political climate, that you be constantly reminded of your responsibilities under that document. The rights are as follows:

Right 5: Communication - *You have the right to be listened to, understood and receive information in whatever way you need. When it is necessary and practicable an interpreter should be available.*

(Taken from 'Your Rights when receiving a Health and Disability Service'. Brochure published by the Office of Health and Disability Commissioner).

This right requires that consumers be given sufficient information in a form, language and manner that they can understand. It has the contingent effect that the environment of communication should be conducive to free, private and open discussion.

Right 6: Information - *You have the right to have your condition explained and be told what your choices are. This includes how long you may wait, an estimate of any costs and likely benefits and side effects. You can ask any questions to help you are fully informed.*

This right lists of some of the matters to be considered in the information giving process is included in this Right. It is important for practitioners to remember that it talks about 'choice rather than consent' and the Commissioner has indicated that this is because 'the Code envisages consumers taking an active part in decision making' (Stent, 1998). The Commissioner also has interpreted this right as requiring an additional component that 'providers should explain which option they recommend and why, but must accept that the consumer also has a right to seek a second opinion' (Stent 1998). (This is a more recent gloss on the Code. A practitioner has a great deal of influence over client decision making and any recommendations should be made with care so that actual freedom of choice is

maintained. Ultimately the final choice should be that of the client.)

Right 7: *Its your decision - Its up to you to decide. You can say no or change your mind at any time.*

The ability of a woman to make decisions in labour may be affected by pain, medication, mental disturbance, emergency situations, extreme illness and many other factors. While competence is assumed in this right, the practitioner must be aware of situations when it would not be appropriate to expect the woman to be able to consent. Fortunately this type of scenario will be uncommon. It must be differentiated from the common transition situation whereby a woman appears to change her mind regarding the place of birth. You will all be aware of women who are at home who ask to go to hospital, women in hospital who ask to go home and women who ask to come back next year. The birth plan and presence of support people who know the woman well will enable a decision to be made as to whether the woman is in fact changing her mind. Ultimately, any actions where the competence of the woman is in question, must be made in the best interests of the client and the decision should be consistent with her views.

### The New Zealand Bill of Rights Act 1990

This is another statute foreshadowed in the Cartwright Report and that guarantees the right to personal autonomy. Section 11 states:

*"Right to Refuse to Undergo Medical Treatment- Everyone has the right to refuse to undergo medical treatment."*

This right might be modified by the application of other legislation such as the Mental Health provisions if a woman is 'mentally very unwell, the Health Act if a notifiable disease is an issue, Criminal Justice Act and various other statutes. For most competent clients the right stands.

### Examples of Alleged Breaches of the Code

Our most common type of complaint at present is with respect to the Code and so I have limited discussion examples to that inquiry process. When an allegation of breach is made the Commissioner makes a decision whether she will investigate or refer the complaint for advocacy or mediation. If the former option is taken then following investigation the Commissioner will base her ultimate decision of whether there has been a breach, on the standards contained within the NZCOM Code of Ethics and Standards for Midwifery Practice. Sometimes an expert midwifery opinion will be sought and occasionally the Commissioner will look to overseas standards or she may make a decision based on her own opinion as to whether the practitioner's actions or omissions have been reasonable (Stent, 1998 p36). If a breach is found to have occurred then the Commissioner will recommend that the midwife undertake various actions to remedy this.

It may help if I give you some idea of the type of breaches of the Code related to informed consent that have been alleged. It is always beneficial to avoid pitfalls by watching where others stumble. In the words of MacIntyre and Popper quoted by Justice Cartwright,

*"To learn from one's own mistakes would be a slow and painful process and unnecessarily costly to one's patients. Experiences must be pooled so that doctors may also learn from the errors of others. This requires a willingness to admit that one had erred and to discuss the factors that may have been responsible. It calls for a critical attitude to one's own work and to that of others."* (MacIntyre and Popper, p130) (The writers continue "doctors rarely observe the work of their colleagues at firsthand; they rely on their own approach and on their own ability, so their work tends to be self validating and self confirming." This can also be a problem for midwives and is an important reason why peer review should be sought.)

### (1) Failure to Inform Women of Significant Risks

This is a common theme in complaints. An example is where a woman birthed at home in a pool, some light meconium staining in the liquor had been seen earlier in the labour and transfer was discussed. The woman did not want to go to hospital. The fetal heart rate was good, there were no decelerations and no further meconium presented. The baby was suctioned vigorously at birth but was initially 'flat' and an ambulance was called. He improved rapidly and by ten minutes, his apgar was 9/10. The complaint was made by a paediatrician, the women remained supportive of the midwife and stood by her decision to remain at home. The concern of the Commissioner was that in view of the meconium stained liquor, the lack of a laryngoscope compromised the level of resuscitation and posed a significant risk to the baby of which the woman was not advised. A concern with regard to this finding was that neither NZCOM nor the interdisciplinary Fetal and Newborn Advisory Committee advise practitioners to carry a laryngoscope. The opinion of the Commissioner went against recommended practice and could be interpreted as an attempt to force a change of practice without appropriate professional or research based evidence to justify this. Some midwives do carry laryngoscopes for the use of medical or emergency personnel should it be required, a further minority of midwives carry a laryngoscope and are sufficiently skilled and presumably regularly update so that they are competent to attempt intubation should it be necessary. The vast majority of midwives do not and it would appear in the view of the College and most paediatricians should not carry equipment that they are not skilled in using. Right 6(1) was found to have been breached. The Commissioner recommended that the midwife keep more substantial records of the advice she gives to women and their decisions particularly when complications arise. She also recommended

that the midwife carry a laryngoscope and update on its use.

### (2) Failure to Inform Woman of Results

This is type of allegation can be wide ranging and has included failure to inform about scan results, swab results, blood tests eg: elevated uric acid levels, fetal heart decelerations, CTGs. The latter is particularly concerning as some midwives still have the view that they should not worry or upset the woman and her family and so say little about their concerns. It is a difficult call if the woman is particularly anxious and the CTG is borderline, the midwife feels it is probably okay but she wants to watch it closely. Recent decisions of the Commissioner and increasingly the Nursing Council, indicate that the woman and her family have the right to know if there is even the potential of something abnormal occurring. These forums consider that the family should be involved in the decision making about ongoing care. It is no longer considered acceptable to 'sit on things' without identifying your concerns and gaining the consent of the client. Failure to inform is closely linked with allegations of failure to promptly follow up any abnormality or concern.

### (3) Failure to Inform Woman of Options

We have had one complaint where a woman alleged that she was not told of the option of shared care with a general practitioner and another where a midwife allegedly told a woman that she did not need the care of a doctor. The involvement of other practitioners seldom becomes an issue for women unless things go wrong. Tragically the process of grief also includes the woman going through the very normal stage of blaming herself and others, for instance, for the stillbirth of her baby. It is very common for other practitioners, paediatricians, general practitioners and neonatal nurses in particular, in such scenarios to critique the midwifery care. It is suggested, often without justification, that the baby would have been saved if a doctor had been involved, if the baby had been born in a hospital, or if the labour had been induced. The very vulnerable parents are often influenced by these opinions and so additional to losing their baby, lose faith in and the support of their midwives. The parents then have to live with the tragic but usually inaccurate belief that the outcome could have been different. The reality is that regardless of how carefully midwives practise and how conscientiously women protect their own health, babies sometimes die and are sometimes born irretrievably damaged and it is seldom the fault of anyone.

### Conclusion

As Judge Cartwright predicted in 1988, a new type of consumer has arisen. She wrote: "I predict the rise of a more assertive patient who will ask and expect to receive information..." (Cartwright Report p174)

Such a development should be welcomed as beneficial to us all. Passivity in the face of

To learn from one's own mistakes would be a slow and painful process and unnecessarily costly to one's patients.

Experiences must be pooled so that doctors may also learn from the errors of others.

paternalism (malleability in the face of maternalism is as dangerous) should not be the experience of women or men. This change owes a considerable debt to the legacy of, largely, the Cartwright Inquiry. Consumers now have legislative rights, rights of autonomy, rights of decision making and rights of complaint. I have written a great deal about midwifery responsibilities and liabilities with respect to informed consent but midwives are only part of the equation. Consumers also have responsibilities. They have responsibilities to ask for more information or a second opinion if they are unsure, responsibilities to reject advice that they are not happy with it, responsibilities to consider and balance the information they are given and responsibilities to stand by the informed decisions that they make. Consumers have, in effect, the same responsibilities of communication with and fair treatment of the midwives as midwives have to the women and her family. It is called partnership and it is not enshrined in legislation and it cannot be enforced at law but it is the foundation of the relationship of mutual respect between women and midwives.

The profession of midwifery has taken a massive media bashing over the last six to eight months and I know that everyone of you has been affected by that. Confidence has wavered, practice numbers have declined and many wonderful experienced midwives have walked away because they can no longer practise without fear. Sadly practising well no longer immunises a midwife against a complaint and its effects and for some midwives it has become all too hard. Some women have also become frightened by the media distortions and hype and have opted for second choices options with respect to their place of birth or caregiver. The most tragic effect that I have noted has been the loss of trust. Women have lost their faith in the ability of midwives to provide competent midwifery care and midwives have lost their trust in women to stand by them, and by the women's own choices when things went wrong. The spirit of partnership has been sorely tested and yet despite all that has occurred women continue to chose midwifery only care in increasing numbers.

It has been a rapid learning curve for all of us as we have adjusted to the expectations of autonomous practice, as we have battled the attacks of our competitors, as we have fought for the right to birth how and where we want to and as we have struggled to counter the hegemony of medicine in determining what is reasonable practice. As Nelson Mandela so aptly put it when asked

how it could have endured without bitterness, his long imprisonment, he replied "the cause is just". The cause of women's right to an informed choice of where they birth, how they birth and who supports them and their baby is an honourable one. I am confident that you will rise to the challenges ahead. I salute you all for your resilience and your commitment. You are here because women need midwives and midwives need women, we must never forget that.

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## The Artist and the Canvas My personal definition of midwifery

■ Anne Hardie

Student Midwife, A.I.T. 1997  
currently - Midwife National  
Womens Auckland.

The midwife is the artist, the woman represents the canvas. Initially the canvas is blank but slowly a picture emerges of the womans' life, her hopes, aspirations, emotions and relationships.

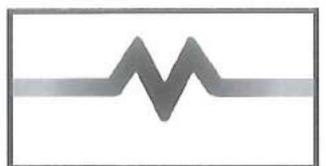
As the months of pregnancy progresses, the canvas reveals another picture as the midwife records and observes the growth and development of a new life. The midwife is watchful that the emerging picture is as it should be that is calm, peaceful and in perfect symmetry.

The painting is nearly complete before the theme is revealed. At this time the skill of the artist and her implicit trust in the quality of the canvas will ensure a masterpiece.

Finally the new life and a Mother ready to embark on a new journey completes the painting.

If the artist is satisfied with her work, she leaves the completely painted canvas and goes on to paint another. There are many different artistic styles employed by the artist, no two canvas or paintings alike.

This is the excitement and challenge to be had when practising the art of Midwifery.



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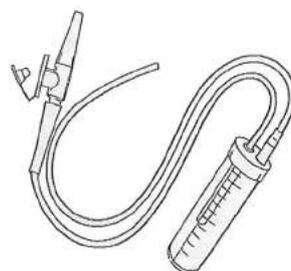
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# Informed Choice in Maternity Care

■ Anne Viccars  
- Midwifery Manager at MIDIRS

The term may have been around for some time, but the question is, do we just pay lip service to it or do we give it the credence it deserves? This article sets out to briefly explore what is meant by informed choice. It will explain how the Informed Choice Initiative is working in the UK and how we can evaluate whether we are offering women informed choice about the care they receive during pregnancy and childbirth.

Although developments in New Zealand have overtaken those in the UK regarding the woman's choice of professional since the 1990 Midwives Act (Donley, 1995), many of the issues facing midwives have strong similarities. Concerns over how much information is given, in what way and at what stage of pregnancy, labour or the postnatal period has been highlighted by greater consumer awareness. The New Zealand College of Midwives has encouraged the involvement of consumers within its membership since inception, which has helped the voice of women to be heard within the maternity services.

What does Informed Choice mean? Developments such as the media awareness of changes in midwifery practice and how it affects women, midwives, GPs and obstetricians have contributed to the debate about Informed Choice. What do we mean by Informed Choice? The Oxford English Dictionary (1995 p 698) gives the meaning of Informed as:

1. With knowledge of the facts (take an informed decision)
2. Educated, knowledgeable (informed readers)."

Therefore, giving women an informed choice means that as midwives, we are arming them with the facts about the processes of pregnancy, labour and childbirth. Empowered with that knowledge women are able to make decisions, which are appropriate for them and their family.

The Antipodeans were already ahead when the House of Commons Select Committee Report, more widely known as the Winterton Report in 1992, was published in the U.K. This stated that

"Many women ... feel that they are denied access to information in the antenatal period which would enable them to make truly informed choices about their care, their carer and their place of birth" (paragraph 73. pxix.)

## Midwives should be the lead professional

Clearly, women were not being involved as partners in care with their health professional. Women considered that midwives were best placed to care for them during normal childbirth, in the most appropriate place, not necessarily hospital. These recommendations were substantiated by the Changing Childbirth Report of 1993, Department of Health, which stressed that women should have Choice, Continuity and Control in childbirth. The key to the findings of this report was that women had been involved in the discussions about their needs and their concerns regarding place of birth, choice of carer and other important facets of the maternity service. At a time when funding was being restricted within the National Health Service, savings were being made closing some of the smaller maternity units which were GP or midwife led. The publication of these reports led to a review of this process.

So what do Choice, Control and Continuity mean? The report identified that "Women should be fully involved when decisions are to be made about their care" (Department of Health 1993, p.13).

This quote sums up the report. Significant changes in practice for all involved with pregnant women were recommended. Midwives were to be the lead professional for women in normal pregnancy and childbirth; GPs should work with midwives and obstetricians should be caring for women with complications of childbirth.

Furthermore, practice should be based on the best available evidence and research so that an optimum standard of care is given.

## The Informed Choice Initiative

As a result of these recommendations, Midwives Information and Resource Service (MIDIRS) and the NHS Centre for Reviews and Dissemination (CRD) developed the Informed Choice Initiative. CRD was established in 1994 at the University of York in England. Their mission is to conduct and to commission systematic reviews of research evidence required by the NHS and disseminates summaries of significant, reliable and published reviews to practitioners (Sheldon, 1996). MIDIRS is an educational charity with the aim of disseminating information to midwives. A quarterly journal is produced after scanning over 500 key international journals; this Digest of research and original material provides midwives with up-to-date information to help them provide a high standard of care for the clients. A database of over 60,000 articles and pieces of research on midwifery-related topics is also accessible.

In January 1996 MIDIRS and CRD launched a series of leaflets. The topics were chosen by a series of focus groups of women throughout the U.K to find out which areas of pregnancy and childbirth were most important in terms of their information needs. The first five titles were:

- \* Alcohol in pregnancy
- \* Ultrasound in early pregnancy
- \* Support in labour
- \* Positions in labour
- \* Monitoring the baby's heartbeat in labour

## Leaflet production

For each topic, two leaflets were produced: one for women, and a fully referenced version for professionals. This initiative aimed to provide women with unbiased information about pregnancy and childbirth.

Each leaflet was written by an expert in the topic area and an extensive peer review process was followed whereby six further experts (including midwives, obstetricians, GPs, researchers, consumer representatives) made comments which were incorporated into the final version. Following the development of the professional leaflet, the woman's version was written in a more journalistic style. This was to ensure that the leaflet was interesting to read, and appealing to women. The final versions were awarded the Crystal Mark for clarity by the Plain English Campaign which aims to ensure that a document is easy to read and understand by removing ambiguous terms or words which are difficult to interpret.

The professional leaflets were written using the hierarchy of evidence available. Principally this included the Cochrane Library (1998) overviews of randomised controlled trials, and individual randomised controlled trials, and data from the remaining literature including prospective and retrospective research. A pilot study was conducted by the Social Science Research Unit at the University of London (Oliver et al, 1996), which allayed some of the anxieties felt by professionals as to how women would view the information. In general terms women were pleased to receive the information and wanted to know in which areas there is clear evidence or uncertain evidence and which aspects of care we have no research on which to base our practice. Women who wanted more information were offered the professional leaflet in addition.

The aim of the project was to ensure that all women could access the information free of charge from their midwife. It was hoped that all hospitals and community trusts would purchase the leaflets for both health professionals and women. To ensure an equitable service, plans to translate the information into other languages were prepared although this has not gone ahead due to a lack of funding.

The following year a further five leaflets were published; these covered the following topics:

- \* Epidural anaesthesia in labour
- \* Breast and bottle feeding
- \* Place of birth: home or hospital
- \* Breech delivery: the options
- \* Antenatal screening tests for congenital abnormality

The hospitals in the UK have been encouraged to purchase the leaflets for their staff and the women they care for. To date, however, the uptake has been less than was anticipated at the outset of the project. Approximately one third of Trusts have purchased either the first or the second series or both. There have been many barriers to the distribution of this information throughout the service providers in the U.K.

**The aim of the project was to ensure that all women could access the information free of charge from their midwife.**

There are many reasons for this including a lack of funds for the purchase of information leaflets. This does acknowledge that the leaflets are giving midwives up to-date, research-based information (which they may not have the time to gather themselves).

Once the leaflets have been purchased by a hospital the midwives are offered training in their use. The aim of providing informed choice training is to ensure that the leaflets are given out at specific times during the pregnancy when the topics are being discussed. This can be on an individual basis or during a given period of the pregnancy e.g. the breech leaflet would usually be offered at 35-36 weeks prior to referral to an obstetrician for external cephalic version if appropriate. Primarily, the leaflet should be shown to the woman and the issue discussed; an opportunity is then given for the woman to go away and read the leaflet and return at the next appointment for further discussion. Midwives are discouraged from putting leaflets into racks in clinics or surgeries because this may detract from the discussion.

In the medium to long term, the leaflets may help hospitals to save money. This may include a reduction in the use of cardiocotograph machines as more intermittent monitoring is carried out; a reduction in pharmacological methods of pain relief as women adopt more upright positions in labour and a reduction in the hospital costs of admitting sick newborns if more infants are breast fed. How can managers and providers of health care be encouraged to incorporate evidence into practice?

The evidence within the leaflets may conflict with current hospital policy or simply with the views of some of the health professionals involved (midwives, obstetricians, GPs, radiographers, anaesthetists). Where hospital policy differs, some units have rewritten their policies and procedures to ensure that they provide evidence-based care. Conversely, some hospitals have not purchased the leaflets because of the conflict of views.

Some of these concerns may be alleviated following the evaluation of the use of the informed choice leaflets in maternity care and the many issues for women and health professionals associated with offering and receiving information. A project has now been in progress for almost a year and will be completed at the end of 1999. Led by Professor Mavis Kirkham, it includes a randomised-controlled trial covering three sites in Wales and an ethnographic study of three sites in England. The findings will be two-fold: firstly they will give the much-needed information about the use of the informed choice leaflets in practice and, secondly, give health professionals an understanding of the concept of IC in maternity care.

In conclusion this article has explored some of the issues surrounding informed choice and particularly how the Informed Choice Initiative has been developed to improve maternity care. The barriers to giving women the information they require have briefly been discussed. The evaluation project exploring the wealth of issues within informed choice should give midwives a valuable insight into the needs of women and all of those who work with them. The road to providing women and their families with evidence-based care is a long one, but in both countries we are now well on the way to understanding the importance of it and ways in which it can be implemented. Midwives can make a difference to the type of care offered and the way it is provided. Informed Choice is the way forward.

NB: The Informed Choice leaflets are available to purchase from MIDIRS, 9 Elmdale Road, Clifton, Bristol, England BS8 1 SL, telephone 0117 9251791, fax 0117 925 1792, email: midirs(-dial.pipex.com). Leaflets can be ordered in bulk, but information packs (including one of each of the 10 titles) for individual midwives can be obtained for £9.35 each.

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## Key Points

### The Informed Choice Initiative

- Enables women to make informed choices about their care in pregnancy and childbirth once they have received evidence based information about which practices are proven to be safe and effective and which are not.
- Provides midwives with succinct, evidence based information on which to base their practice.
- Encourages hospitals and providers of health care to provide women with well researched literature cost effectively.

# Commonwealth Nursing and Midwifery

## Action Plan: New Zealand Progress Report, 1998

The following report is an outline of the midwifery profession's progress on meeting the International Commonwealth goals for strengthening midwifery in New Zealand. The goals were set out as an Action Plan by the Commonwealth Nurses Federation in Vancouver during 1997. They also recommended ongoing feedback, monitoring and evaluation of these goals. The Chief Nurse Advisor, Frances Hughes, is to present this report to the 11th Commonwealth Ministers of Health meeting in November 1998. In addition it provides a useful synopsis for midwives who have not been involved in the evolution and achievements of the NZCOM and the midwifery profession.

### Introduction

Due to the broad health care reforms in New Zealand in the 1990s, the way in which we have approached the Commonwealth Nursing and Midwifery Action Plan may differ from that of other countries.

The New Zealand Government does not have operational oversight over workforce and practice issues affecting professional groups such as nurses and midwives. The Government encourages the various organisational and professional groups to collaborate on developing a national plan of action, and the Ministry of Health would have a leadership and facilitation role, but the central Government would have no further influence over the implementation or outcome of such a plan.

This report is structured into separate reports on nursing and midwifery as these professions are represented by different non-governmental organisations.

### Recommendation 1

Ensure that nurses and midwives are the focus of a needs led service which includes community participation, and to develop structures which fully involve nursing and midwives leaders in health policy development and planning.

The concept of the Lead Maternity Caregiver has been developed and implemented, and midwives have been given statutory recognition as Lead Maternity Caregivers. All obstetric or secondary maternity hospitals offer midwife continuity to some degree, and most have an increasing number of their midwives in Lead Maternity Caregiver roles. The Health Funding Authority has initiated a Lead Maternity Caregiver database. The profession has also established a midwifery database.

\* Other initiatives include:

- \* Development of midwifery competencies
- \* Formation, by Maori midwives in partnership with the New Zealand

College of Midwives (NZCOM) of *Nga Maia o Aotearoa me te Waipounamu* - a professional organisation for Maori midwives and their whanau (families). This is the world's first professional organisation for indigenous midwives.

- \* Increase in midwife Lead Maternity Caregiver to 53% of all women
- \* Increase in women having a named midwife to 70-80%
- \* Increased primary maternity service delivery in the community.

### Recommendation 2

Ensure and strengthen leadership development for nursing/midwifery leaders to operate in the corporate environment of changing health systems.

- \* NZCOM education series on leadership
- \* NZCOM appointments to corporate working parties
- \* NZCOM mentoring policies
- \* Development of postgraduate Masters and PhD programmes for midwives.

### Recommendation 3

Increase active provision of support to nursing/midwifery leaders to deliver programmes which emphasise health promotion practices in addition to core nursing/midwifery skills. In addressing the health care needs of each country these programmes would make use of relevant technology advances.

- \* Introduction of direct-entry midwifery degree programmes
- \* Multilevel involvement of stakeholders in the monitoring of midwifery undergraduate programmes, eg. New Zealand Qualifications Authority, NZCOM, Nursing Council of New Zealand, the Ministry of Health, the Ministry of Education, Maori and consumers
- \* Funding contracts which recognise the primary nature of maternity care
- \* NZCOM Midwifery Standards Review process and statistical analysis of outcomes
- \* Implementation of Midwifery Competencies by the Nursing Council of New Zealand and NZCOM
- \* Introduction of midwifery continuity of care teams in obstetric units

- \* Funding of antenatal education by the Health Funding Authority
- \* Effective liaison between polytechnics, universities, practitioners and the NZCOM in development of education programmes
- \* Locally defined clinical education programmes by NZCOM regions
- \* NZCOM initiation in partnership with public hospitals on education programmes for secondary care (obstetric hospital) midwives which focus on women and continuity of care
- \* Proposals for the funding of education programmes to Ministry of Education and the Clinical Training Agency.

#### Recommendation 4

Facilitate nursing/midwifery leaders across all sectors including government nurses and midwives to share, within regions and across the Commonwealth, experiences of assessment planning, managing, teaching, practising, and evaluating nursing/midwifery in order to maintain standards of health in a changing and resource scarce environment.

- \* Implementation of the Health Funding Authority Referral Guidelines in Maternity Care: a consensus view of all professional disciplines
- \* NZCOM development of software for a National Midwifery Database for birth outcomes of midwife Lead Maternity Caregiver
- \* NZCOM members of the New Zealand Qualifications Authority moderation panels for midwifery degree programmes
- \* External moderation for midwifery degree programmes throughout New Zealand
- \* NZCOM organised an international midwifery symposium which included visitors from the UK, Canada, Sweden and Australia - a consensus was reached on a midwifery database to enable international comparisons
- \* NZCOM national survey of 190 self employed midwives and the birth outcomes of their clients
- \* NZCOM membership in the International Confederation of Midwives (ICM), and NZCOM representation on several other international agencies, including the UN
- \* Establishment of a midwifery website.

### Recommendations to Nursing and Midwifery Leaders Progress Report-Midwifery

#### Recommendation 1

Develop a national action plan for nursing/midwifery within the national health policy which includes the nursing/midwifery contribution to health policy, quality care, cost effectiveness and education and training.

The New Zealand College of Midwives (NZCOM) has always worked in cooperation with government agencies in policy and planning to ensure that a national plan include midwifery services. The midwifery contribution to this has included -

#### Health Policy

- \* Negotiating member of the Joint Maternity Project which restructured the maternity service to a lead maternity caregiver concept
- \* Consumer groups affiliated to the College of Midwives have also contributed to the development of women centred maternity services
- \* National networks and liaison with all health policy makers, consulted and provided submissions on a range of health policy issues, eg nutrition, parental leave and legislative changes.

#### Quality and Cost-Effective Care

- \* Establishment of a national midwifery database
- \* Provision of consumer evaluation mechanisms at individual and policy level
- \* Provision of Midwifery Standards Review processes for all midwives acting as Lead Maternity Carers
- \* Establishment of a Midwifery Provider Organisations (MPO) to contract for a standards based service contract. Successful contracting by the MPO for a total regional midwifery service which includes resource allocation and funding decisions based on outcomes
- \* Establishment of regionally located Midwifery Resource Centres for the public and health professionals.

#### Education and Training

- \* Establishment of a national framework for undergraduate and postgraduate midwifery education
- \* Establishment of Masters and PhD programmes
- \* Establishment of a mentoring system for midwives new or returning to the workforce
- \* Research on midwifery care.

#### Recommendation 2

Take responsibility for developing strategies for monitoring the utilisation and effectiveness of the nursing/midwifery workforce in promoting better health and take a leading role in planning, implementing and evaluating programmes using relevant technological advances. See comments on recommendations to Government.

In addition, strategies to improve maternal health and increase the options for women choosing midwifery have included:

- \* Setting up a number of midwife owned and operated birthing units and midwifery led birthing units
- \* Establishing midwife Lead Maternity Carer provider contracts
- \* Successful midwifery owned group practice contract operating since 1991.
- \* Accessible community education
- \* Establishment of a New Zealand

Breastfeeding Authority to implement a Breastfeeding Hospital Initiative in New Zealand.

#### Recommendation 3

Ensure that all nurses and midwives take an active part in collating, analysing and interpreting health information to contribute

to the development of health policy, programme delivery and clinical practice.

See comments on recommendations to Government.

In addition, NZCOM has committed considerable resources toward encouraging midwives to evaluate their care. Initiatives include:

- \* The development of a national midwifery data collection mechanism through the Midwifery Provider Organisation
- \* The NZCOM Midwifery Standards Review Committees. Twentyfive such committees review outcomes of the Lead Maternity Carer initiative on an annual basis.

#### Recommendation 4

Take responsibility for networking in order to access and share the knowledge and experience of their peers in the region and across the Commonwealth.

See comments on recommendations to Government. In addition, the networking by the NZCOM includes a wide variety of media use, including: numerous publications, participation in television documentaries, presentations to international conferences, and the establishment of an NZCOM website.

#### Recommendation 5

Consider initiating a review of the legislation and regulatory processes within their countries to ensure that competency at all levels remains within nursing/midwifery in order to meet the changes being introduced through health care reform and to make recommendations to government.

To contribute to this, NZCOM has developed an NZCOM Handbook for Practice; National Standards of Midwifery; and National Competencies for Registered Midwives. Actions ongoing include the development of National Ongoing Competencies and NZCOM involvement in developing National Guidelines for Maternity Care.

The following organisations were consulted on nursing issues:

- Nursing Council of New Zealand
  - College of Nurses Aotearoa New Zealand
  - ANZ College of Mental Health Nurses
  - Nurse Executives of New Zealand
  - Nurse Educators in the Tertiary Sector
  - New Zealand Centre for Evidence Based Nursing
  - The New Zealand Nurses Organisation
- Comment was sought from the following organisations:
- New Zealand Guidelines Group
  - Health Research Council of New Zealand
  - Save the Children Fund New Zealand
  - Red Cross New Zealand
  - Volunteer Service Abroad
  - World Vision New Zealand
  - The New Zealand College of Midwives (NZCOM) contributed to the sections on midwifery.

# Surfing in Gisborne



■ Sarah Stewart  
- Self-employed Midwife

Well, here I am again with another list of suggestions for people who have nothing better to do than sit for hours at their computer - no, that's not me, honestly! I must admit though that I spent a very long time looking through the links provided by the web site owned by Pat Sonnenstuhl:

<http://www.halcyon.com/cnmpat/>

Pat is a Midwifery and Women's Health Consultant in Washington, USA, whose website provides information ranging from childbirth to general health issues such as Group Strep. B, migraines, polycystic ovaries, menopause and many more. It is an attractive site and easy to peruse. She includes a link to the College of Midwives new web site and describes it as "an excellent example of unity ... Very well done and a joy to visit." Pat, I would like to return the compliment!

Pat also provides links to Ina May Gaskin and The Farm; the Association of Radical Midwives; Karil Daniel's waterbirth site; Australian midwives, and finally the White House. This site provides information on specific women's health issues and American government documents, and you can leave a message for the President.

<http://www.whitehouse.gov/wh/welcome.html>

The Farm's site, it includes a breakdown of their statistics which confirms the safety of home birth, with an interview with Ina May Gaskin, in which she comments on the state of maternity care in the USA compared with other countries such as the UK, Netherlands and Denmark. It also has a very detailed article about shoulder dystocia which I mean to download and keep, as it is my personal nightmare!

<http://www.thefarm.org/charities/mid.html>

Another great site is Karil Daniel's waterbirth site. It is the original website about waterbirth and is very attractive and easy to follow. It has information about waterbirth and its benefits; preparation; and waterbirth stories. It also has a fantastic photograph gallery, which almost persuades me to have another baby (but not quite) and a Resource List, where you can place your details if you provide waterbirth.

<http://www.path.net/user/Karil/>

Another one of Pat's links is to a midwifery project in the Wangaratta District, Victoria, Australia. This project was set up to provide continuity of midwifery care to women in the Wangaratta District. The results of the evaluation after a year confirms what we already know, that one-to-one midwifery care reduces the rates of Caesarian section; reduces the use of analgesic drugs in labour, and increases consumer satisfaction and safety. This website has links to international websites of interest for midwives, which I was unable to access at the time, but hopefully will be available on a future visit.

<http://home.netc.net.au/~midwife/aboutus/>

The Association of Radical Midwives (ARM) is an organisation made up of midwives, student midwives, and others committed to the improvement of the maternity services in the UK. It came about in 1976 when two dissatisfied student midwives got together and discussed their concerns about the growing medicalisation of childbirth. Its purpose is to research into midwifery issues and raise awareness of choices in maternity care for women in the UK. The web site is plain but supplies clear information.

<http://www.radmid.demon.co.uk/>

I always find it fascinating visiting sites owned by midwives, and finding out how midwives practise around the world. It is especially valuable if one is researching midwifery in other countries or looking for a job elsewhere. There are a lot of committed midwives in Ontario, which is one of several Canadian States that recognises midwifery in Canada. So if you want more information about midwifery and midwifery education in Ontario, visit Kathi Wilson and her two colleagues. They provide links to other midwifery practices and education faculties in Ontario, breastfeeding sites, and also an obstetric calculator that will tell you exactly how pregnant you are.

<http://members.home.net/tvmidwives/>

There is a huge website run by American physicians for health professionals and women, providing all sorts of clinical information about obstetrical and gynecological questions. It has a large number of links to subjects such as preeclampsia, caesarian section, lupus, and so on. I didn't consider it as a fun site to spend ages cruising around, but do regard it as valuable resource for when one seeks clarification about obstetric complications.

<http://obgyn.net/home.htm>

Another site that is not a fun site is the UK National Health Service Centre for Reviews and Dissemination. It is very informative if you are interested in health care research that is based in the UK. The only midwifery related review I found were the prevention and treatment of teenage pregnancies but then I didn't look for very long. It does have valuable links to various databases, the UK Department of Health, and other organisations in the UK that have been set up to help practitioners look at the effectiveness of the service they offer, read the *Nursing Times*, May 6, volume 94, number 18, 1998, page 29.

<http://www.york.ac.uk/inst/crd>

I quickly became sidetracked to the internet resources in medicine and healthcare. One example is the Nursing and Health Care Resources web site, which has a multitude of links to just about every health care topic you can think of, including to midwifery sites that I hadn't come across before. I shall definitely revisit this site.

<http://www.shef.ac.uk/~nhcon/>

A further site I will revisit is run by Miranda Castro and Betty Idarius on homeopathy for women's and children's health. Amongst others, there are articles about caulophyllum, arnica, calendula, and what to use for emotional recovery after childbirth and postnatal depression. There is lots of information that will be valuable to download.

<http://www.zapcom.net/~bidarius/homeo/>

I would also suggest that you check out the quarterly MIDIRS Digest as they have started producing information about web sites. In this year's March edition, page 30, there were several breastfeeding sites reviewed. I continue to appreciate any details about websites of interest, especially those relating to New Zealand. The midwifery mailing list is up and running, so would welcome anyone who want like to join.

Finally, I would like to congratulate the College of Midwives for their new website. I think it is very informative and attractive. I am not sure how much it will be used by women seeking midwives, and I suspect it may be more of a resource for midwives outside the country. I have entered my details and photo, and when last I heard, have had 50 hits. Mind you, I have told everyone I can think of about it. So get a move on everyone, get your details on the database too and don't forget the photo. It is great to put a face to a name.

<http://www.midwives.org.nz>

I leave you with:

## HOW TO TELL IF YOU'RE AN E-MAIL JUNKIE

1. You wake up at 3 am to go to the bathroom and stop to check your e-mail on the way back to bed.
2. You turn off your modem and get this awful empty feeling, as if you just pulled the plug on a loved one.
3. You spend half of the plane trip with your laptop on your lap...and your child in the overhead compartment.
4. You decide to stay in college for an additional year or two, just for the free Internet access.
5. You refer to going to the bathroom as downloading.
6. You can't call your mother...she doesn't have a modem.
7. You check your mail. It says "no new messages." So you check it again.
8. You don't know what gender three of your closest friends are, because they have neutral screennames and you never bothered to ask.
9. You move into a new house and decide to Netscape before you landscape.
10. You tell the cab driver you live at <http://www.edison/~garden/house/brick.html>
11. After reading this message, you immediately E-mail it to a friend.

# Notice of Publication

NURSING COUNCIL OF NEW ZEALAND

## Mary Jean O'Neil

Registered General and Obstetric Nurse and Midwife

On 11 February 1997, the Nursing Council of New Zealand ("the Council") referred a complaint concerning Ms Mary Jean O'Neil to the Health and Disability Commissioner as required by law. Subsequently, on 25 August 1997, the Council received an opinion from the Health and Disability Commissioner that Ms O'Neil had breached the Health and Disability Services Code of Consumers Rights and a Notice of Charge was referred by the Director of Proceedings to the Council on 30 October 1997 and a disciplinary hearing convened by the Council in January and March 1998. The Council's findings in respect of professional misconduct and penalty were confirmed in writing on 24 March 1998 and 21 May 1998 respectively.

In particular, the Director of Proceedings alleged in the Notice of Charge that Ms O'Neil's conduct in relation to the management of pregnancy and labour of her client during the period April 1996 to 30 November 1996 amounted to professional misconduct. The Council found Ms O'Neil guilty of five of the ten particulars as follows.

- (i) *that Ms O'Neil failed to arrange a foetal heart trace for twenty minutes on the mother's arrival in hospital or for such other satisfactory length of time which would allow an appropriate interpretation of the trace.*

Council was satisfied that these facts were proved as alleged. On admission Ms O'Neil decided to perform a CTG. For a variety of reasons this CTG was difficult to obtain. The CTG tracing showed an admission trace intermittently for 4 1/2 minutes at 1850 hours. In the Council's opinion, this CTG trace was inadequate to determine foetal wellbeing and Ms O'Neil herself admitted she had been concerned about the initial CTG. However, she did nothing to pursue these concerns and satisfy herself as to the foetal wellbeing. Instead she allowed the mother to spend up to an hour in the bath without any further foetal monitoring. Ms O'Neil stated she did not feel she could intrude on the mother during this time. All expert witnesses agreed that a more concentrated effort to obtain an interpretable CTG tracing was essential.

In Council's view the conduct amounted to professional misconduct on the grounds of negligence. Ms O'Neil had established herself as an independent practitioner able to provide appropriate care and advice to pregnant women, which she failed to do in this instance. Ms O'Neil did not pursue her own identified concerns about the foetal wellbeing and further, she demonstrated her

lack of understanding of her professional role in the management of labour when she allowed her feeling of not wishing to intrude on the mother in the bath, to override her intention to act in order to satisfy herself as to the foetal wellbeing.

- (ii) *Ms O'Neil failed to promptly act upon the abnormal foetal heart rate tracing;*
- (iii) *Ms O'Neil unacceptably delayed obtaining a specialist opinion on the trace and/or progress of labour;*
- (iv) *Ms O'Neil unacceptably delayed in arranging or attempting to perform an artificial rupture of the mother's membranes.*

Council was satisfied that the facts as alleged were proven in that by 2100 hours Ms O'Neil had at least fifteen minutes of CTG tracing which, by her own evidence, was still not reassuring her. Despite being concerned that the baby was under stress, Ms O'Neil attributed the lack of variability on the tracing to the effect of Pethidine. In the Council's view, supported by the evidence of Ms O'Neil's own expert witnesses, another opinion either midwifery or obstetric, should have been obtained by Ms O'Neil at this time. While Ms O'Neil may have not recognised the decelerations showing on the tracing she should have responded to the lack of variability. Council was also satisfied that although Ms O'Neil stated that she wished to check the liquor and that her plan from the beginning was to artificially rupture the membranes, this ought to have been done by 2100 hours, despite being concerned that she would accelerate the labour and add to the mother's distress.

The Council was overall satisfied that Ms O'Neil's conduct as alleged, cumulatively amounted to professional misconduct in that by 2100 hours, at the very least, Ms O'Neil should have acted on the CTG tracing she had obtained. The Council held that this action should have been both consultation with a specialist and ARM to determine the state of the liquor and that Ms O'Neil's failure to do this demonstrated a lack of awareness of the warnings of the CTG tracing and a lack of anticipation of the potential effects on the baby. In the Council's view, Ms O'Neil's failings or omissions were negligent.

- (v) *Ms O'Neil failed to adequately inform the mother of the risks to the foetus and possible consequences to the foetus and/or mother of the information shown on the trace.*

In finding this particular proven also, the Council held there was no evidence of any ongoing discussion between Ms O'Neil and the mother about any change of birth plan or labour management in relation to the identified clinical signs. Nor was there any evidence that Ms O'Neil provided the mother with any information about the need for a longer CTG tracing or the need for ARM. By her own admission, Ms O'Neil made decisions

around management which she did not share with the mother. Ms O'Neil was, in her mind, attempting to reduce the woman's anxiety, however in doing so Ms O'Neil denied the mother the right to make informed choices and retain control over her birth experience. This was both a breach of the Nursing Council of New Zealand standards and negligent practice. The Council was therefore of the opinion that Ms O'Neil's conduct amounted to professional misconduct on the grounds of negligence.

In relation to the remaining charges the following decisions were made by the Council: two particulars were not proven to the standard of proof required, in another the Council was of the view that the alleged contractual matters were not the appropriate domain of the Council, one particular was withdrawn by the prosecution and the other was a particular framed in the alternative which it did not consider necessary to turn to having made findings of professional misconduct.

In considering penalty, Council was concerned by Ms O'Neil's lack of insight and her lack of acceptance of responsibility for her conduct. Council believed Ms O'Neil's care of the mother was negligent in a number of respects and fell short of the standard of a reasonably competent midwife in similar circumstance.

In addition, Council believed that there is sufficient commonality between Ms O'Neil's registration as a midwife and general and obstetric nurse particularly in the areas of communication and patient rights, to warrant placing conditions on Ms O'Neil's practice as a registered obstetric nurse.

The Council therefore ordered that:

- Ms O'Neil's name be removed from the register of midwives. It declined to fix a time after which she may apply to have her name restored to the register of midwives;
- Ms O'Neil have conditions placed on her practice as a registered general and obstetric nurse for a period of twelve months and that she only work under supervision in a workplace approved by the Council;
- Ms O'Neil pay the sum of \$21,592.60 towards the total costs and expenses of and incidental to the Council inquiry and investigation and prosecution by the Health and Disability Commissioner's Office;
- A notice stating the effect of the orders above be published in the New Zealand Gazette, Kai Tiaki: Nursing New Zealand, New Zealand College of Midwives Journal and the Dominion; and
- Ms O'Neil deliver to the Registrar within 14 days her midwifery registration certificate and badge issued to her under the Nurses Act 1977.

# New Zealand College of Midwives National Conference, Auckland, 1998 Reflections on a Decade of Change

**A** paper presented by Maralyn Rowley, Professor of Midwifery and Women's Health, Victoria University of Wellington and Capital Coast Health.

Midwifery, in New Zealand has now had nearly a decade of rapid growth and development so it is time to reflect on what has happened, what shape we are in today and where we might be in another decade. Recalling the state of midwifery prior to 1990 and the passionate and hard won battle to achieve midwifery autonomy, is something we all need to reflect on from time to time.

It is important because it provides an opportunity to appreciate the pioneering midwives and women who had the political acumen to realise a dream.

I would like to explore two issues with you in this paper. The first is to describe my view of the state of midwifery in New Zealand today. The second will explore a vision for the future as the profession continues to develop and mature.

As someone who was not involved in the revolution of 1990, I can look back to the dispassionate eye of the historian to determine the events which have shaped the present and which continue to influence it. I can also use the historian's ability to use the past to construct a view of what the future might have in store.

So what is the state of midwifery in New Zealand today. There are around 2000 practising midwives participating in the care of over 57,000 women and babies each year. Simple arithmetic might lead us to conclude a woman to midwife ratio therefore of 1 midwife to every 28 women, but this is not the reality. Many midwives have caseloads of around 50-60 women per annum and others have caseloads as high as 100 or more. However, our ability to get a more accurate picture is severely hampered by the total lack of government initiated workforce planning in relation to maternity care. What has been revealed by research such as that carried out by Karen Guillard (1998), is that New Zealand has always relied on the majority of its midwife workforce being imported from the UK and Australia. Today that figure is 58% of the midwifery workforce. This is a crucial issue for the future of midwifery in New Zealand. In a recent visit to the UK, USA and Australia, it was apparent in interviews with key midwives in those countries that there is a worldwide shortage of midwives which will continue into the foreseeable future. Where will New Zealand's midwives come from? Will we be able to educate sufficient numbers of midwives to meet our future needs? How has this shortage impacted on the present?

I want to digress slightly because the impact of the shortage of midwives in this country has rapidly come to my attention through my role as the first clinical professor in midwifery and women's health in New Zealand. This position is a joint appointment between a university and a crown health enterprise with the majority of time spent in the clinical setting. The position is unique since the professor must be both an academic with

a responsibility for teaching and research, and a practising midwife, which is unusual for a university. It is also unusual for a crown health enterprise to appoint an academic to be a clinical leader in midwifery and women's health. So both organisations have a slight nervousness about what the position entails while at the same time expecting great things.

A clinical professor is required to have as a focus, the professional development of midwives, together with the establishment and monitoring of standards of practice which are evidence based. This requires the fostering of a research culture which includes the production and consumption of research; the provision and support of education and making a contribution to the further development of midwifery practice and midwifery knowledge at a local, national and international level.

At Capital Coast Health this all has to be done within a physical setting of decay in a poorly designed facility which provides a place of birth for over 3000 women and babies annually. Wellington maternity services are unique in New Zealand in that a large independent provider organisation (Matpro) has a contract with the Health Funding Agency to provide most of the primary maternity care in the city. This, together with a review of the CHE service provided after a year of consultation has resulted in the hospital withdrawing from primary care altogether. It has also required a re-orientation of staff from a commitment to one ward to a commitment to rotate throughout the Women's Health Service, including roles in caesarean theatre and recovery. The focus has become concentrated on establishing a centre of excellence in secondary and tertiary care. Exploring ways in which this can happen has revealed major clinical and professional dilemmas.

While many midwives within the CHE are experienced and expert clinicians, there are also numbers whose skills and knowledge development have been neglected. Change is also threatening to us all, and the requirement to now function fully as a midwife, capable of working in all areas of midwifery practice has created much anxiety as well as a commitment to provide support and education.

This is compounded by the finding that there is a severe shortage of midwives willing to work full time within the CHE or even applying to work within the CHE at all. Since there are no more midwives to employ, the burden on currently employed midwives increases as does the reluctance to commit to full time work. One result of the shortage has been the continued employment of nurses to provide postnatal care. When a similar situation arose in an Australian maternity unit many years ago, I can vividly recall loudly declaring to my colleagues, "nurses providing postnatal care totally inappropriate unprofessional. We cannot allow it to happen!" Yet here I am responsible for the standards of practice in a unit which could not function without them. Is this happening elsewhere in New Zealand I wonder. What are the consequences for women and

babies? Do we provide education and support for nurses to become experts in postnatal care? What are the consequences for the profession of midwifery? Who is responsible?

The loss of primary, maternity care for CHE based midwives has other important consequences. It has been suggested that midwives limited to secondary and tertiary care will lose their fundamental midwifery skills since the midwife is the expert in the normal - only. This is a proposal which needs serious consideration. In the UK, it has been suggested by key midwives such as Paul Lewis and others, that the future would be better served by developing two kinds of midwives. Those who are experts in the normal and those who specialise in the abnormal. Is this what we want for New Zealand? In the USA I visited a midwife-led unit which is actually staffed by obstetric nurses with the midwife supervising care in the same way that doctors do here. Is this what we want for New Zealand? I met midwives who worked in a maternity unit which had no core staff at all, where all care was provided by midwives working in teams or group practices independently contracted to the hospital. Is this what we want?

## What do women want?

It is also apparent from research in Australia and the UK that the provision of continuity of care or possibly, continuity of carer, is extremely wearing for the midwife. This model of care is not sustainable in the long term unless certain criteria are met. This includes a reasonable caseload of around 50 women per annum; compatible colleagues to share the load with so that time out and days off occur; institutional and management support; collegial support and regular meetings to debrief and learn from each other. Is this the professional support that midwives working in independent provider organisations currently receive? Are independent midwives becoming tired and worn out? What will happen if and when they retire from practice and there is no-one else to take their place?

These are just a few of the clinical and professional dilemmas with which we need to grapple and I hope find as I do that these issues are challenging and stimulating and a rich source of ideas for research and practice development.

The revolution of 1990 paved the way for the rebirth of midwifery, in New Zealand. The profession rapidly embraced the concepts of autonomous practice and partnership with women and overnight moved from hospital based practice under the supervision of doctors to independent practice. There was no gradual evolutionary process where midwives took time to learn what independent practice might mean. Some have clearly been shocked to find that autonomy, and accountability and total responsibility, are frightening and continue to work in shared care arrangements with general practitioners. Is this what the changes to the nurses act intended? What are the consequences of these arrangements? For women? For midwives?

What of the future? Midwifery in New Zealand will continue to evolve and mature. It will continue to provide role models for the rest of the world to examine. However it cannot rest on the laurels of past achievements. Midwives now have to embrace the spirit and intent of Standard Ten of the Midwives Code of Practice which requires that we begin to undertake our own research to find answers to these clinical and professional dilemmas.

# Community Birth Services

## Great Home Births in the Manawatu

Helen Griffin and  
Wheturangi Walsh-Tapiata

### INTRODUCTION

The early 1990's saw rapid health reforms in Aotearoa/New Zealand. In the Manawatu the Manawatu Home Birth Association (MHBA) was both active and well supported by consumers and midwives. Concern regarding the impact of these health reforms on home birth resulted in a decision to proactively pursue a contract with the Central Regional Health Authority (CRHA) to ensure that home birth remained a viable, safe and appropriate option for all concerned.

This article will look at the development of Community Birth Services Trust (CBS), an umbrella organisation for the delivery of home birth services. This will be followed by an outline of the current operation and provision of CBS services, highlighting some of the critical factors to the success of this service to date. This success is best measured by those who use the service and therefore the last words are comments from both consumers and midwives.

### HOW IT ALL BEGAN

Community Birth Services (CBS) is a consumer initiative that practices partnership between clients, contracted health professionals and the CBS Trust Board. It aims to provide a high quality and appropriate service to all clients and to provide a supportive environment for midwives to work in.

The uncertainty of the health reforms in the early 1990's prompted members of the MHBA to set up a working party of consumers and midwives to produce a draft contract aimed at safeguarding home birth services in the community. The contracting initiative eventually taken to the CRHA was based on the principle of partnership between consumers and midwives. Contract negotiations took over two years and in addition included input from the Maori caucus of the NMBA and home birth doctors.

A three year contract was signed in December 1995 and the CBS Trust started providing services in January 1996. The Trust received \$30,000 in transitional funding from the CRHA providing it with finances to establish itself as a business. This included the rental of a house and the purchase of office equipment. The house had the capacity to cater for the needs of the organisation, offering a large meeting room, office, midwives consulting room and kitchen and bathroom facilities. The meeting room is regularly used for home birth activities and also by community groups such as Le Leche League. In addition a spare room was rented out to a group of "domino" midwives.

To provide a suitable structure to administer the contract CBS Charitable Trust was established. The current Trust Board membership consists of two general consumers representatives, one Maori consumer representative, a home birth midwife representative and a home birth doctor representative. Another consumer has also been co-opted onto the Board. The Trust Deed clearly indicated the importance for consumers to retain ultimate control of the Board. Hence, the balance of consumers to health professionals on the Trust and the stipulation that the Chair of the Trust must be a consumer.

### THE OPERATION AND PROVISION OF THE SERVICE

Critical to the operation of CBS has been the employment of an administrator with both excellent skills and a home birth philosophy. Her administration and management experience ensure the smooth running of the organisation. This is enhanced by her commitment to and passion for home birth. Our administrator works 30 hours a week and in addition has recently taken over the teaching of the ante-natal classes. A person with these qualities is vital to the success of this service.

Midwives contract their services to CBS and are paid by them which claims directly from Health Benefits Limited. CBS claims on a modular system based around trimesters with administrative and other costs built into the service price for each module. A full and comprehensive range of maternity services are provided starting from pregnancy testing through to the completion of postnatal care at 4-6 weeks. Midwives are also reviewed annually. Our midwife numbers have continued to grow with the midwives stating that CBS has assisted their professional development and offered them considerable support.

CBS is now a well known community resource and an easy point of referral. It participates in community networking and is a focus for postnatal social support. Consumers are often surprised and delighted at the range of services offered by CBS. Some of these were established in the contract, with further innovations being added as the service developed. These include:

- CBS house as a meeting place/drop in centre.
- Free antenatal classes.
- Free antenatal hui for Maori clients about traditional Maori birthing practices.
- Access to birthing pools where clients pay for a disposable liner and any CNG costs.
- Free linen and sterile birth equipment.
- Free home help and nappy services postnatally.
- Free access to the NMA library and resources.

- A free 'gift pack' for clients consisting of a zip bag with promotional pamphlets, bumper sticker, bib, magnet, meal voucher and list of support services. This is available in either Maori or English.

In addition the Trust has supported a number of initiatives promoting home birth. A series of television advertisements have run in the first half of 1998, there has been regular advertisements in the local newspaper, and media coverage has been sought for home birth events. Further initiatives for Maori whanau are currently being developed. These include T-shirts in Maori, an audio tape of Maori traditional music and the purchase of Maori posters with a home birth theme. An increasing number of Maori whanau see home birth as a viable option, such that a small group have started meeting on a regular basis, and are taking a much more active role in supporting, particularly the Maori midwife, as well as the other midwives, and becoming more involved in the organisation of CBS.

The Trust is confident that clients receive an excellent service and midwives are well supported in their work. They are in the early stages of re-negotiating a further contract with the Health Funding Authority.

## RESPONSES TO THE SERVICE

For me as a new graduate, working with CBS has been wonderful. I have had great mentor midwives. It is a great deal for the women too and really gives home birth a centre in the Manawatu. Both women and midwives are really well supported.

Home birth midwife. Trust Board member.

Community Birth Services is the culmination of many years of work, working in partnership with the women of the Manawatu. It offers a safe and nurturing place to work as a midwife and it offers support and guidance for the families who use our services. It is the ultimate partnership model where the consumers support the professionals with a good and fair remuneration package and the professionals support the consumers.

One of the best outcomes for me has been the prominent physical presence the CBS "blue house" has within our community. About sixteen midwives operate their practices from the CBS house and they are both home and domino midwives. It means that the community sees midwifery in a totally practical and complementary way and that these midwives work together in a complementary way. CBS has enabled us to be more professional and public. It has enabled us to advertise our services regularly, raising the public image of midwifery generally.

Home birth midwife.

Some 150 years after Te Tiriti o Waitangi was signed, CBS provides the means in today's world whereby tangata whenua may continue to "safely" and "legally" practice the traditional and ancient ways of our tupuna concerning the honouring of new life, the creation of whanau - Te Whanauhanga. Hei

whaingā tino rangatiratanga tenei - te whakawhanau mai ki te kainga. Hei whakamana te tapu o te wharetangata, te mana aroha o nga matua, te taonga nui ko te mokopuna. Ka haere tonu te ira tangata, e kore rawa e ngaro - he kakano i ruia mai i Rangiatea.

Maori home birth midwife.

At the beginning of the CBS journey it was awe inspiring to be involved with a group of such skilled hardworking and visionary women. I feel very proud and confident of what CBS has to offer when I present it to the families I attend because it is a maternity service created by and for the women it serves.

Home birth midwife.

I was excited to be pregnant once again and met my midwife at the CBS house for confirmation two days after being overdue with my period - great another baby on the way! What fantastic services we received, the care, support and birthing at home in a pool, it was all luxurious! After care included home help and nappy service and by the time our six week check came up it was tears as our midwife said her big goodbyes. Thanks to Community Birth Services.

Consumer. Trust Board member.

I've found CBS a very supportive and informative group of people, they have an excellent range of resources and I've found them willing to offer any sort of help throughout my pregnancy, and afterwards as well.

We choose homebirth as our first choice for my second pregnancy to get a more informative and supportive pregnancy and birth of our child. I wanted a more relaxed and unstreamed delivery for our child. The support and continuity we received was outstanding and I would strongly recommend homebirth for this reason.

Consumer.

I have had the same homebirth midwife for all three of my babies and it's like she has become a member of our family. She has always kept me abreast with all the literature around birthing and was really accepting of the different cultural nuances that my whanau felt were an important part of birth. She would come as often as I needed after my births until I was comfortable and at ease.

During my last home birth I was also privileged to have a Maori midwife. I remember in the middle of my contractions she joined with a family member to say karakia and to sing waiata. These were incredibly soothing to focus on and helped me through my labour. Because she could also speak Maori, and my children only speak Maori, it was wonderful to have her there to explain what was happening to my two children and their cousins who were present.

Since becoming a Maori representative on the CBS Trust Board I have been a part of an organisation who are committed to partnership and who regularly challenge themselves to ensure that they are answering the needs of their Maori clients. They have a

Maori midwife, a Maori administrator, a Maori Trust Board member', and this is reflected in the 25% of their clients are Maori whanau.

Maori consumer. Trust Board member.

A homebirth for us was not an option we knew a lot about until we met our midwife and listened to a few stories at home birth meetings. After meeting our midwife a few times (including other family members) we became more confident with the decision we had made to have baby at home. My labour was long, but something I felt in control of. I went for walks, baked a cake, played cards and spent time with my family. I felt safe at home and liked the freedom of walking around, hopping in the bath, playing music, and being in a familiar environment. The exhilaration of giving birth is beyond words, but to be at home made it more special. To have loved ones with us made Waikohu's entry into this world really important.

Consumer.

The most overwhelming notion that sits with me when I think about CBS is the sense that to give birth is a wonderful and uplifting experience. This all pervasive notion seeps from the literature, that walls, the midwives and people who are associated with the service. I felt wonderfully supported by people who were able to provide many resources and by midwives who were flexible, who cared about me and my family and who bring with them many gifts over and above their 'training'.

It is absolutely vital that as Maori women we are able to celebrate birth in the manner Maori, and for me my midwife supported me in this way. Her extensive knowledge of karakia and tikanga around birthing allowed me to relax and feel comfortable about handing that responsibility to her allowing me the space to concentrate on bring Katene into the world. We need to support more Maori into midwifery and particularly the transmission of knowledge to them regarding the tikanga of birthing. I look forward to supporting the birthing experiences of my sisters and my own daughters and trust that the work done at CBS will gather momentum and be replicated around the country. I trust that in the next Millennium a hospital birth will be strange and that women will once again learn to know and trust their own bodies and understand their strength in this process.

Maori consumer.

The vision that began with the members of the MHBA has truly blossomed into reality. CBS is now a viable, exciting birthing option in the greater Manawatu.

Wheturangi Walsh-Tapiata is a mother of three children - two having been born at home. She is the Maori representative on the Community Birth Services Trust Board as well as being a lecturer and Policy Studies and Social Work at Massey University. Helen Griffin is the mother of five children and is Chair of CBS Trust Board. Her MA thesis topic was women's expectations and experiences of home birth.

# BOOK REVIEWS

**Authors** Black. R.F., Jarman, L. & Simpson. J.B.  
**Book Title** The Process of Breastfeeding  
**Publishers** Blackwell Science Pty. Ltd.  
**Year Published** 1998  
**Country Published** USA  
**ISBN No.** 0-7637-0195-5.  
**Recommended Retail Price** \$72.00  
**Reviewed by** Sally McNeill  
 Midwifery Lecturer  
 Otago Polytechnic.

This is the second volume in the series and follows the original format designed for students preparing for lactation consultants examinations or for practitioners wishing to review or update practise.

This volume deals with issues that practising midwives face regularly while supporting women breastfeeding. The pre- and post-test questions allow the reader to identify knowledge deficits and monitor learning.

The text is clearly written and well supported by useful pen and ink diagrams. There is a selection of assessment tools offered which practitioners may find helpful.

When discussing weight gains/losses imperial measures are used and this tends to be confusing for those who consistently use metric measurements.

I have found this volume useful for Midwifery Students developing the knowledge and skills to support women breastfeeding.

**Author:** Banks. M.  
**Book Title:** Breech Birth Woman-Wise  
**Publishers:** Birthspirit Books, 15 Te Awa Road, R.D.3, Hamilton, N.Z.  
**Year Published:** 1998  
**Country Published:** New Zealand  
**Recommended Retail Price:** \$39.00 (+ \$2.00 P & P per copy)  
**Reviewed by** Rachel Taylor. Midwife - Good Health Wanganui.

This book has the potential to become the approved text for any maternity practitioner attending vaginal breech births or wishing to upskill. Contained within the pages of Breech Birth is a wealth of knowledge and experience. The chapters are clearly and concisely laid out with good accompanying diagrams. The photographs of actual births exemplify how and why vaginal breech birth from an upright maternal positions works so well. The chapters are referenced enabling practitioners to take an evidence based approach when arguing for breech birth.

I agree with the author that birth is a political act. It is very easy to compliment the parts of the text referring to breech birth, however there was a personal feeling of sadness regarding the other issues raised in the book. Some of the statements made regarding Health Waikato seemed to be tinged with personal concerns that are not within the scope of this guide. The authors great depth of knowledge is tainted by some pedantic comments regarding the course of normal labour, ie. page 71 'the Midwife should never rupture membranes in the normal course of labour'.

The wonderfully clear photographs contained within this guide will be of particular aid to core Midwives interested in upskilling. Whilst not having the advantage of developing a rapport during the long establishment of the partnership with women, core Midwives still wish for women to have as holistic a birth experience as they can offer. I believe it should be our aim to provide women with a choice beyond those identified by the author. There has most definitely been a de-skilling of all practitioners regarding vaginal breech birth. This does not mean that women should be seen to only have the two options perceived within this text ie normal vaginal breech birth at home or medicalised, highly interventional birth within the hospital environment. It is only through the re-education of our obstetric colleagues that the choice of normal vaginal breech birth in hospital for those women who desire it will be achieved.

It is interesting to note a small article on page 213 of the current issue of MIDIRS (June 1998). Whilst the terminology may not necessarily be our choice the sentiment behind it is clear. The photograph is in an American hospital setting and the research supports vaginal breech birth.

**Author:** Mander. R.  
**Book Title:** Pain in Childbearing and its Control  
**Publisher:** Blackwell Science  
**Year Published:** 1998  
**Country Published:** Great Britain  
**ISBN No.** 0-632-04097 - 1  
**Recommended Retail Price** \$A46.00  
**Reviewed by** Helen Manoharan. Midwife.

Pain is invariably regarded as a pathological phenomenon. Pain in Childbearing and Its Control examines the extent to which this orientation is relevant to pain associated with childbearing.

Focusing on the mother's experience of pain and her contribution to its control, this research-based text covers the background to historical and scientific understanding of pain and considers methods of researching and measuring pain. Pregnancy, labour and puerperal pain are covered in detail, along with fetal and

**Editor of:** Yeo. H.  
**Book Title:** Nursing the Neonate  
**Publishers:** Blackwell Science Pty. Ltd.  
**Year Published:** 1998  
**Country Published:** United Kingdom.  
**ISBN No.** 0-632-05049-7.  
**Recommended Retail Price** \$A66.00  
**Reviewed by** Helen Manoharan. Midwife.

Nursing the Neonate is written with neonatal, children's nursing and midwifery students in mind as well as practising neonatal nurses. Clear and accessible, with a host of illustrations, the book begins with a discussion of the history of neonatal nursing and specialist units. It then goes on to look at the specific nursing problems and issues which face neonatal nurses, and places them within a wider social, familial and cultural context.

This comprehensive text covers all aspects of neonatal nursing. It addresses issues such as discharge planning, stress in the neonatal unit, transcultural nursing and ethics as well as discussing the clinical care of the newborn and their various conditions which may require treatment. Research-based, Nursing the Neonate includes references to the most up-to-date research and practice.

**Key Features:**  
 \* Nursing Care Orientation  
 \* Written by a team of specialist contributors  
 \* Easy to read and accessible  
 \* Well illustrated  
 Would make an excellent resource book for health professionals within this speciality.

neonatal pain. As well as approaching the topic in considerable depth, the word 'pain' is interpreted broadly. Throughout the text, research-based theoretical approaches to pain and control are presented within the context of care.

In the course of the book the political implications of childbearing pain emerge. A prominent theme is the meaning of such pain to the childbearing woman. The role of health professionals and carers in facilitating the woman to cope with pain is featured, as is the possibility of iatrogenesis or the aggravation of pain through the provision of care. Key Features are:

- \* Written by a researcher who is an experienced and practising midwife.
- \* Emphasises the woman as being in control over her childbearing experience.
- \* Based on current research evidence which is analysed critically.
- \* Adopts an accessible and easily readable style. Pain in Childbearing and its Control will be invaluable to midwives and a wide range of care providers who seek to assist the woman in coping with her experience of childbearing and any associated pain.

## VIDEO REVIEWS

Eve Rush - Midwife and Lactation Consultant  
Margaret Whiteley - Midwife, Childbirth Educator and Lactation Consultant

### Breastfeeding - Coping with the First Week

Produced by Mark-It in association with the Royal Collage of Midwives.

Running Time - 30 minutes.

This is a truly excellent video featuring world leaders in Midwifery and Infant feeding - Chloe Fisher, Sally Inch and Caroline Flint. The programme is aimed at women themselves and it takes them through the first and often quite difficult week of breastfeeding.

Although this programme is aimed at women there are some points where clarification from a professional may be required.

The programme is very clear and carefully demonstrates the main points that will help get breastfeeding off to a good start in the first week. The reality of situations where several attempts are needed to get a baby correctly latched has not been overlooked. It demonstrates the patience and persistence that is often required. It also highlights some of the common pitfalls with getting started and the enormous emotional aspects that mothers are coping with.

Main points featured in the video :

- \* The babies' first feed
- \* Putting the baby to the breast
- \* How the baby gets milk from the breast
- \* Feeding in public
- \* Knowing if the baby is on the breast properly
- \* Getting help with breastfeeding

It also answers such questions as:

- \* What is colostrum and what is it for?
- \* How long should a breastfeed last?
- \* Should the baby have one breast or two?

A very easy video to follow as the programme sets things out in a logical sequence. A must for all concerned with breastfeeding. Ideal for mothers, midwives, Lactation Consultants, Plunket Nurses, Childbirth Educators and it also deserves a place in every public library.

### Breastfeeding - Dealing with the problems

Produced by Mark-It Television 1997

Cat. No. MITV 0034

Running Time 24 minutes

This is a very informative video for health professionals. Chloe Fisher & Sally Inch give step by step practical advice for such problems as failing to thrive, prolonged feeding with unsatisfied baby, colic, nipple damage and breast inflammation.

Although we see actually latching a baby to the breast for a mother as a technique of last resort the programme does demonstrate how this can be done correctly in a supportive, non-invasive manner.

Basically all the problems demonstrated in the programme relate to an incorrect attachment. Correct attachment is repeatedly demonstrated with excellent explanations relating to each problem.

Main points featured in the video :

- \* Failure to thrive
- \* Difficult attachment
- \* Sore damaged nipples
- \* Colic

A really worthwhile resource for every health professional.

### Breastfeeding - A Guide to Successful Positioning

Produced by Mark-It Television 1997

Cat. No. MITV 0036

Running Time - 12 minutes.

This programme is brilliant! It is very concise and superbly illustrated. A very clear demonstration of the basic steps to successful positioning for breastfeeding. It emphasises the importance of the mother having her own body posture correct in order to present the baby with the best opportunity for a perfect latch. The viewer is taken through correct attachment techniques in very easy to follow steps.

This video, we feel, is a must for all health professionals concerned with breastfeeding support and education. The terminology and dialogue is directed at health professionals which is perhaps a slight pity but never the less it is a very clear and excellent guide that mothers could use themselves with follow up support from their health professional.

An outstanding breastfeeding resource.

Overall the three videos are superb. The programmes are easy to follow with excellent advice and beautiful illustrations. We would highly recommend them as an addition to every breastfeeding resource library.

Videos produced by Mark-It Television, 34, Gadshill Drive, Stoke Gifford, Bristol. BS12 6UX . England.

Telephone (0117) 9405321 Fax (0117) 9761368

Email: robertcopeland@btinternet.com

Website: <http://bristol.park.co.uk/markit>



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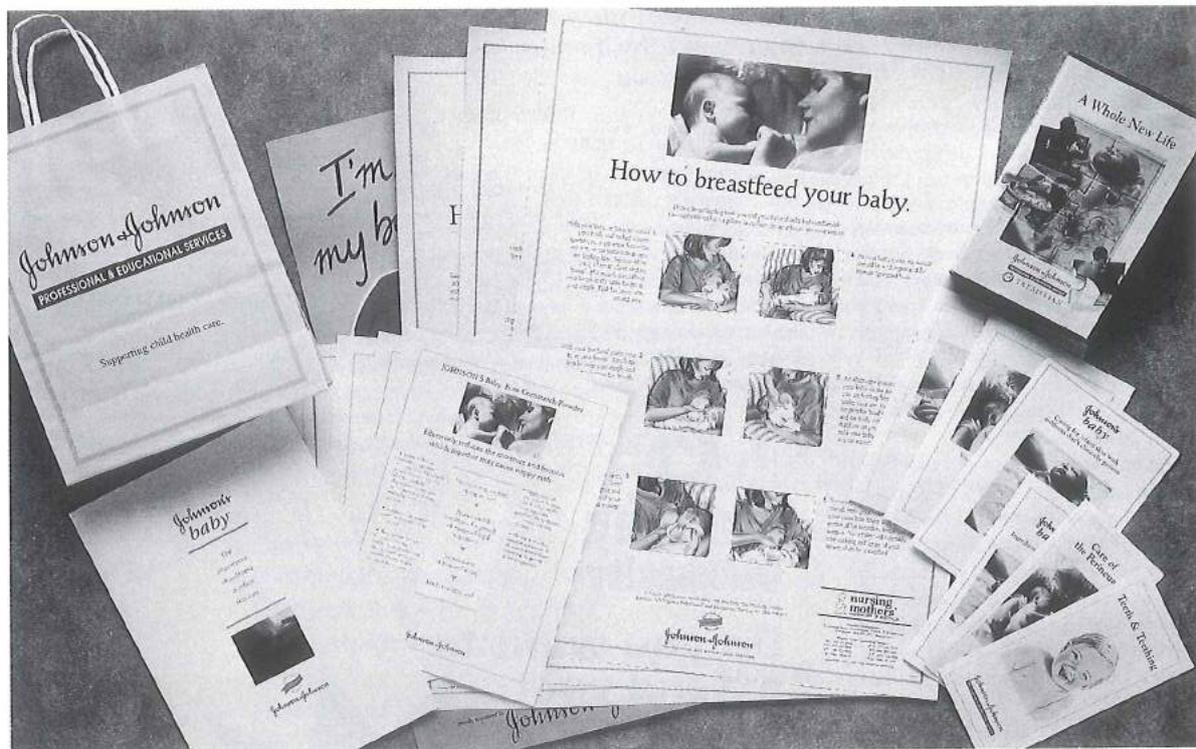
**Dr Gill White**  
Midwife  
Albany Programme Co-ordinator

**Associate Professor Cheryl Benn**  
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(Midwifery)

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# Good advice.



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