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College of Midwives



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APRIL 1999

Feminism in Midwifery

Internet Surfing

Postnatal Support for First-time Mothers

Psychological Sequelae of Abortion

The Issue of Midwife Self Preservation

ISSUE 20



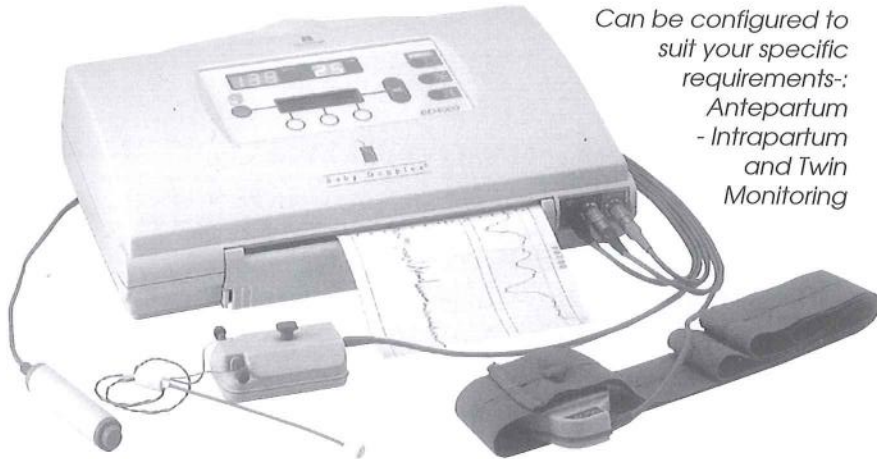
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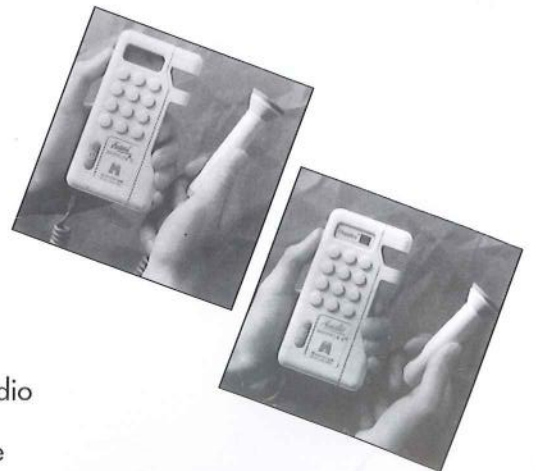
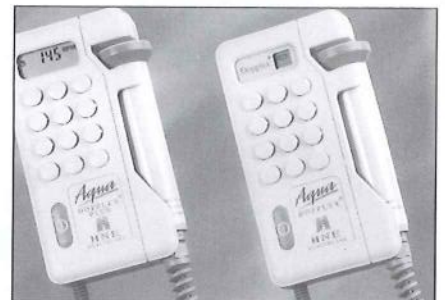
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- Promote women's health issues as they relate to childbearing women and their families.
- Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- Provoke discussion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

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Contents

- 4 Editorial ~ Helen Manoharan - Letter to Editor ~ Sandra Sinclair
- 5 Embracing the Past, Understanding the Present, Creating the Future: Feminism in Midwifery ~ Deborah Davies
~ Anne Kerslake Hendricks
- 12 Postnatal Support of First-Time Mothers: The Role of the Midwife
- 17 Open Letter to the National Health Committee ~ Joan Donley
- 19 Psychological Sequelae of Abortion (Spontaneous and Induced) and Subsequent Pregnancies ~ Cariad Milmine
- 23 Be Aware of Price-Fixing Risks ~ Jackie Pearse
- 24 Surfing in Gisborne ~ Sarah Stewart
- 25 The Issue of Midwife Self Preservation ~ Lilian Rolston
- 27 Book Reviews

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.

Helen Manoharan

As midwives it is imperative we are vigilant in updating our knowledge of the changing legislation pertaining to midwifery practice, so we can safely and effectively assist midwifery clients and legally protect ourselves. In this issue the College's legal advisor, Jackie Pearse, reminds us of the perils of price fixing, applying it to maternity services that are subcontracted out, that an agreement must be negotiated by the individual contractor and the individual subcontractor. Any collective agreement, formal or informal, by any Lead Maternity Carers about what they pay subcontractors is likely to breach the Act.

Deborah Davies explores the practices surrounding childbirth, the attitudes and values which accompany birth and childbirth knowledge and illustrates the ways in which the historical, cultural, political and social legacies of the past remain an active influence on the experiences of women and midwives today.

This journal provides a unique platform in which midwives can share their views on what really matters to the profession in the clinical setting, personal development and in the political sphere of health economics. Joan Skinner expresses her viewpoint regarding models used in midwifery practice, suggesting that models are developed which not only work, but that enhance our individual practice and protect and promote the health of the families midwives provide care for. A potpourri of perspectives is imperative for a balanced midwifery viewpoint for the future.

More and more frequently student midwives and midwives call to discuss their ideas for potential projects and articles. It's exhilarating to hear their ideas for innovative projects and techniques that are being created but even more importantly the zest with which their midwifery practice is described. But somehow, when some of the articles arrive, the message so clearly expressed previously has vanished. Why? Maybe it is the idea of being 'published' which takes over the article. So for all potential writers, try not to focus on the idea of 'going into print' and write to communicate. Use the language that best describes the practice situation to your colleagues. Don't be intimidated by the idea of being published and don't let your creativity, knowledge and experience be forgotten. Assistance is given with articles once they have been received, to help you make the most of the information you have provided. So don't become despondent, write. It is important that we gain strength and wisdom by being informed of the issues affecting the midwifery profession in New Zealand today allowing us to all share the challenges that face us together. Write and tell us. We may not have all the answers to all the issues in front of us currently, but we do have the collective power that can effect appropriate and acceptable change.

We need to hear from you and 'writing to communicate' would be great!

Letter to the Editor

Dear Editor,

The November issue of the Journal was a full of interesting and provocative articles as one would expect from a publication of the standard of the NZCOM Journal. However, the Notice of Publication regarding the Nursing Council findings on our colleague Jean O'Neil again leaves me reeling. A page long report has no doubt satisfied the requirements of the Nursing Council to have published the outcome of the proceedings but does little to enlighten the reader about that moment in time which has now passed. The report would present Ms O'Neil as a midwife whose practice has fallen short in standards of care. It fails to acknowledge the ever-present reality of human error (to which we are all subject), nor the high standard of both professional and pastoral care provided by Jean O'Neil for hundreds of women and their babies. This is not the women with whom I worked for many years. The midwife with whom I worked was conscientious,

thoughtful and reflective and at times placed the wellbeing of both mother and baby to the fore. The midwife whom I know would have gone out of her way to provide information about choices and options for care, and would always advocate for the woman and her baby. It is hard for me to believe that the Council's findings and explanations of their outcomes have given a full picture of what went on in those hours of labour during which the participants only recall what was said and done. This highly publicized case has made national headlines and engendered huge debate both in and out of the midwifery profession.

Yours truly,

Sandra Sinclair.

Upper Hutt

Embracing the Past, Understanding the Present, Creating the Future:

■ Deborah Davies
Midwifery Lecturer
Otago Polytechnic

Feminism and Midwifery

As we all know, birthing is something that has been with us since the beginning of time; how could it not. With birthing comes birth care practices and people who assist women in childbirth; midwives. While birthing is a natural phenomenon, the practices surrounding childbirth, the attitudes and values which accompany birth and childbirth knowledge are cultural, social and political phenomena. These cultural, social and political influences have evolved over time.

The lives of midwives and women have been shaped and continue to be shaped by dominant and pervasive ideologies that have evolved historically.

We are our histories. Street (1991) says of our historical legacy;

We are embedded in our personal histories and the specific histories relating to the contexts in which we work. We are also influenced by the histories which constitute medical domination, oppression by race, gender and economic means, and by the construction of nursing in the past.

There is no act that is not imbued with personal and professional history or embedded within a particular social, cultural and political context. Often we accept this reality without question and in so doing reify the status quo.

Both Critical Social Theory and Feminism are concerned with exposing the cultural, social and political structures which support, maintain and perpetuate the status quo. In so doing they make room for understanding how the man-made world could be different; for transformative action.

It is the purpose of this paper to explore some of the influences which have shaped and continue to impact on women and midwives with the hope that in bringing these to light we may begin not only to more fully understand why midwifery and childbirth is as it is, but also how it could be otherwise.

To illustrate some of the points made throughout this paper I have used the words of women (with permission) as described in their birth stories which were included in a recent assignment by midwifery students. The women's own words provide an immediacy and poignancy so vital if we are to appreciate fully the great impact that our practices, and embedded beliefs and attitudes have on the lives of women. I was privileged to read over forty birth stories occurring mostly in New Zealand from the 1940's to the present day. Quotations used throughout this paper from these birth stories have not been referenced so as to protect the privacy of the women involved.

Hegemony and Ideology

To appreciate critical social theory and feminism as a means to transformative (and liberating) change there are two key concepts that must first be understood. These are ideology and hegemony. Ideology is "...the body of doctrine, myth and symbols of a social movement, class or large group" (Delbridge, Bernard, Blair, Peters and Butler, 1991). Ideology embodies the knowledge, values, attitudes and assumptions of a particular group or culture. It is a group of ideas which is clearly distinguished from a body of scientific "fact" or "truth". Hegemony occurs when the ideology of a dominant group predominates to such a degree that the structures supporting this ideology appear "natural".

Grundy (1987, p. 107) comments;

It is the trick of ideology to make that which is cultural, and hence in principle susceptible to change, appear natural, and hence not open to change at all.

So, what is problematic about maintaining the status quo and hence the dominant ideology of our society? It is problematic because the dominant ideology of our society (western, industrialised, white, middle class, patriarchal) is unjust in that it favours some over others, it

embodies the advantaged and the disadvantaged.

We have come to accept that this is "natural"; it is natural that business should be organised to bring profit to those investing capital rather than those who invest their labour. It is "natural" that our social world should be stratified by levels of wealth and prestige; the low, middle and upper classes. It is "natural" that the developing world with over 75% of the world's population should utilise just 5% of the world's spending on health. It is "natural" that work at home raising children should be women's work and as a contribution to society, should be worthless in terms of monetary value.

In a short period of time it became "natural" to have babies in hospital and for doctors to have authority over the process. It seems to be fast becoming "natural" to have technological involvement in your pregnancy i.e., the ultrasound. Have you ever heard a pregnant woman being asked, "Have you had your scan yet?" not "Are you going to have a scan?" or better still, "Do you need a scan!" Since the available evidence does not support routine ultrasound for all women (Enkin, Keirse and Chalmers, 1991), why is it fast becoming an accepted norm for pregnancy care in the industrialised world?

In my reading of the birth stories provided by student midwives many of the women interviewed included comments such as "That's just the way it was....." Another woman discussing the birth of her child in 1944 comments, "All of my births were done with chloroform, I don't remember any of my friends not having it....". It had become "natural", everybody was doing it or having it and therefore it was seen as an accepted norm for childbirth and as such went without questioning. When women and midwives come together in childbirth we bring these dominant ideologies and the norms of society with us; every action and every word is imbued with this legacy.

This, of course, is the danger of ideology and hegemony. When a practice or situation is accepted as "natural" it is no longer held up for scrutiny and most often it is not even seen as being problematic.

Grundy (1987, p 109) comments on the hegemonic operation of ideology;

"For it is not simply through the development of a consensus over time that our understandings of the world are determined. Rather, it is the operation of a selection process which ensures that certain

meanings are given credence and not others."

For feminists it is patriarchy that parades as natural and the meanings which dominate and evolve over time are those which serve the interests of men to the detriment of women. The Critical perspective regards no aspect of our social world as natural and seeks to expose the systems of social relationships which constitute social reality (Cheek and Rudge, 1994). Reflexivity is an integral component of this process and has been described as;

...considering one's own place in the social world, not as an isolated asocial individual but as a consequence of one's experience in the membership of social groups (Willis, 1993).

Part of this reflexive process involves raising our consciousness concerning the assumptions and generalisations embedded in our practices. We need to ask ourselves whose interests are served, what assumptions, values, and attitudes (ideology) are perpetuated by them.

Both feminism and critical theory provide a framework for doing just that. Feminism by exploring "woman" as a socially and politically constructed category. One of the defining assumptions of feminism is the belief that by virtue of being women we share a set of common experiences (Stanley, 1990). Not the same experiences but common experiences. These common experiences derive not from the biological fact of being a woman (though there is shared experience there) but from the common experience of oppression. Critical theory seeks to understand, analyse and scrutinise the structures of society that maintain the status quo (Habermas, 1974). Both perspectives strive to do more than study society but aim to change it in ways that are liberating and just.

We Are Our History

In analysing and scrutinising the structures of society and the practices involved with childbirth we are required to look beyond the present moment and sometimes to trace threads of ideas backward in time. Its a little like a loose thread that has unravelled in a knitted fabric. To understand its place in the scheme of things it has to be woven back through the garment to the place where it began to unravel. And so it is when we seek to understand the place of midwifery and women in the scheme of things. By

journeying backward in time we begin to appreciate more clearly those forces which shape our world and our understanding. It is surprising to find that many ideas and attitudes of old (centuries old, very often) are alive and well and functioning today. The past is far from dead and buried. This is what I hope to illustrate in this paper; that embedded in our social and professional lives are attitudes and values (which have their inception in the distant past) that continue to impact on us but do not serve us well, as women and midwives. What is powerful about this process is that we begin to see these forces shaping our lives as "man made" rather than "natural". With this understanding comes the recognition that unlike the laws of nature (the tides or gravity for example), they can be changed.

To illustrate this concept I'd like to explore several themes; that of the invisibility of women and women's work and the devaluing of women's knowledge and power. I will trace their evolution through history and discuss how the attitudes and values inherent to these themes continue to pervade our society today and so continue to impact on us as women and midwives.

Women and History

When delving into history as it is necessary to do in order to understand the cultural, social and political evolution of society as we know it today, it is important to remember that our knowledge of history has been recorded by men. It was what men regarded as worthy of recording that was etched into the history books. This was more often something about the public world (in which men played a larger role) rather than the private domestic world and more often concerning great feats of individuals rather than the ordinary lives of men and women (Bourdillan, 1988). Duby and Perrot (1990) comment on woman and history;

The tenuous traces they have left did not originate with themselves but were filtered through the gaze of the men who held the reins of power, defined official memory, and controlled public archives.

This fact contributes greatly to the theme we are about to explore; the invisibility of women. As women were more often confined to domesticity their life worlds were concerned with home and family and often healing and caring, as we will explore further in the next pages. This is where women had a huge impact on society; on the day-to-day

lives or ordinary people. Yet through the ages little has been recorded about women's life world. It was something ordinary that was happening every day, a silent companion to the great feats of individuals, the great advancements of mankind. As such it was invisible.

Women's Knowledge and Caring

I'd like to continue with the exploration of the invisibility of women with some analysis of the concept of "care", as "care is at the very root of women's history" (Colliere, 1986) and the institutionalisation of care is at the very root of nursing and midwifery as we know it today.

It has been said that 'taking care of' have been vital aspects of survival throughout history. Due to the procreative nature of women, women's domain of caring involved women maintaining the continuity of life whilst the role of men involved taking care of territory and repelling the enemy. In maintaining the continuity of life women the world over developed care practices relating both to the body and the plant world. This encompassed nurturing and nourishing the young and because birth is inextricably linked with death, also care of the aged and dying. In the plant world women developed knowledge on the cultivation and use of plants for both food and medicinal purposes (to become the basis for development of pharmacology as a science). Women produced a body of empirical knowledge based on trial and error, observation and experience (Colliere, 1986).

It was with the advent of the written word and the development of education based on this that women's knowledge came to be considered as inferior. Initially, writing was exclusively used by male priests and for centuries following this time, women were barred access to writing and academic knowledge.

Through writing men confiscated women's knowledge and began to record, collect and develop an academic knowledge base which formed the beginnings of modern day medicine and science as we know it. "Science" as such, has since been contrasted with empirical knowledge, the later considered inferior to scientific knowledge. Those without this scientific knowledge were considered unlearned and ignorant. Since women were prohibited from gaining this academic knowledge it goes without saying that most women were ipso-facto, considered

unlearned and ignorant and therefore incapable of learning in this way even if it were available to them.

In the field of midwifery the confiscation of women's knowledge was evident in the ways in which barber surgeons and physicians gained knowledge of childbirth first through the observation of midwives practices, then confiscated this knowledge as their own. This knowledge and any development in knowledge was then jealously guarded and made inaccessible to women. The following anecdote is another interesting example of the ways in which the medical profession have jealously guarded information, and so ensuring their own elite place in the world.

The Ancient Greeks inherited a significant body of knowledge regarding anatomy from the Ancient Egyptians who gained this knowledge through the procedure of embalming. This knowledge was exclusive to men as women in Ancient Greece were also prohibited from attending institutions of education. In one famous incident occurring about 200 BC, a midwife in Athens (Agnodike) dressed as a male to attend classes in anatomy. She did this to become better educated as a midwife and to assist women rather than compromise women's modesty by exposing them to male physicians. The demand for her services was so great that it eventually impinged on the services of male physicians and she was consequently put on trial for practising under false pretences.

The guarding and protection of territory and knowledge has been a recurring theme throughout the history of medicine. New Zealand has been witness to this in extremis since 1990 when legislation allowed for midwives to practise autonomously and so encroach on what the medical profession considered to be their territory. We have recently seen this come to the fore again with the suggestion that nurses may be given prescribing rights; a bastion of medical authority.

Knowledge and what we consider to be true knowledge is in itself a social construction. Today's society continues to be greatly influenced by Descartes (1596 - 1650) who proposed that the mind and body were separate entities. Within this view personal experiences are not apprehended directly but are thought to be represented mentally and so subjective experience is seen as something different to objective reality. An individual's

apprehension of reality could be less than perfect therefore, objective reality is seen as superior and a closer representation of "truth" than subjective experience (Benner and Wrubel, 1989). This objective truth along with the rationalism of scientific ways of knowing form the positivist perspective which is a deeply embedded dominant world view.

The influence of the Church in the evolution of attitudes toward women and women's knowledge cannot be underestimated. The structures of the Christian Church are deeply patriarchal and encompass a pervasive underlying belief that women are evil.

When a woman thinks alone, she thinks evil (From Maleous Malficarum, 1486).

We need look no further than the story of Eve for the justification of the belief that women are the source of all sin in the world. "Eve, given to Adam to be his companion, worked the ruin of mankind" (Simone De Beauvoir cited in Ashley, 1980). These misogynous beliefs have been perpetuated throughout history and many influential writers (both religious and philosophical) have enthusiastically argued for the case of male superiority and rationalised these ideas with arguments such as the following;

'...woman is defective and misbegotten, for the active force in the male seed tends to the production of a perfect...masculine sex; while the production of woman comes from a defect in the active force or from some material indisposition'. (St. Thomas Aquinas cited in Ashley, 1980).

Christianity inherited from Greek philosophy the belief in the superiority of the spirit over the human body. With the advancement of the church and church teaching's care practices concerning the body were increasingly despised and condemned. They were seen as pagan and the body as a source of corruption (Colliere, 1986). Ill health and pain of childbirth were seen as God's will and suffering, God's punishment for sin. Care practices became more concerned with the redemption from evil and the salvation of the soul than the alleviation of suffering.

Those most suited to the salvation of the soul were the consecrated virgins (nuns) who lived the ideal of denial of the physical body (source of evil) for the good of the soul. The purity of the soul required that nuns rely on no other source of knowledge than the grace of God. Every other source of knowledge was

condemned excepting the Holy writings and nuns lived by the ethic "obey and serve". They were obedient, devout, worked unquestioningly, tirelessly and modestly in the name of God.

This self-immolating attitude, blind faith in God's will and denouncement of knowledge gained through any other source prevented questioning or the development of new knowledge during this period. Through condemnation of health care practices there was a loss of women's knowledge of healing, health maintenance and birth lore. The witch hunts are a stark reminder of the zealotry and ferocity with which these attitudes were enforced.

The ideal of these Christian traits soon extended from the realms of the nunnery to embrace all women and they underpinned a powerful cultural and social code of behaviour to which women were bound. We are all familiar with the way in which nursing grew out of the service of nuns and how as a charitable, virtuous act, caring became remained the domain of women. We don't have to look far to see the impact of this heritage on nursing and therefore midwifery.

The five pointed star which forms the Registered Nurse Medal reminds us of this legacy. In the centre of the medal is a five pointed star and enclosed in the star is a Red Cross, as an emblem of the blood and Cross of Christ. The white background stands for the purity expected in the life of a nurse; blue stands for honour and loyalty, and gold for charity.

There are several key points arising from the discussion thus far that I would like to reiterate before moving on to illustrate how these ideas still pervade society today and continue to impact on women's experiences of childbirth. Firstly, we have discussed how men having confiscated women's knowledge (in particular women's childbirth knowledge) made education inaccessible to women thereby created an elite territory for themselves and relegating women to the to the realms of the ignorant and unlearned. Secondly, with the dominance of the positivist scientific paradigm, a hierarchy of knowledge was created where expert, objective knowledge is seen as superior to that of subjective, personal knowing. Finally, the influence of the Church has to a large degree, determined what has been considered appropriate behaviour and ideal traits for women.

Expert Knowledge

The notion of expert and laity and the belief in the superiority of expert, objective knowledge remain pervasive attitudes in today's society. When women as consumers of maternity care aren't given the opportunity to share in this expert knowledge and allowed the opportunity to be true partners in healthcare decision making we see these age old attitudes in force. There remains a fairly pervasive belief that the public is too unlearned and ignorant to understand and participate in health care knowledge. These attitudes underpin the practice of withholding information from consumers and the resistance of some professions to consumer membership in their professional bodies, to cite two examples. An excerpt from a birth story of 1965 further illustrates this point.

They weighed the baby before and after feeding but wouldn't tell me what the weight was. I was told that mothers did not need to know this.

A more recent story describes a woman labouring with a baby in a posterior position. She describes how she could hear the staff discussing a caesarian section but wasn't privy to the information they were sharing amongst themselves. In another example a woman with a threatened miscarriage had an ultrasound scan to find out if her 14-week fetus was alive or dead. The radiographer would not share the information with the woman at the time of the ultrasound and she had to wait several anxious hours before the obstetrician could see her to tell her that her baby had indeed died. The information was seen as belonging to the experts rather than the woman.

Objective Truth

The birth stories recounted many examples of the belief in the superiority of objective truth over the subjective experience of the woman. Cheek and Rudge (1994) discuss the ways in which the refusal to acknowledge certain knowledge such as the personal and subjective is a means of preventing the validation of that knowledge. The refusal to acknowledge this knowledge renders women (as consumers and caregivers) powerless and maintains an authoritarian relationship over women. Authoritarian here is described as linked to "...the ability to exclude from, and control, that knowledge which is recognised as authoritative" (Cheek and Rudge 1994, p. 60).

One of the student's birth stories illustrates this point. She writes of the birth of her own child at home in 1977;

After a few more contractions I had another and my body felt like bearing down, so I did. Well the doctor heard me make this sort of groaning, bearing down noise and he said "*Susan, you have to breath, it's much too early to push*". When the next contraction came there was no stopping me. My body was doing it and as I was bearing down I groaned "*PUSHIIIIING*". The doctor came and lifted the blanket and said "*My God, there's the head!*"

The subjective personal knowledge and experience of Susan was initially dismissed in deference to the expert knowledge which decreed that the average primiparous labour was of 12 hours duration and based on this "*scientific truth*", Susan wasn't ready to push. When women's knowledge is dismissed in this way it reifies the attitude that it is not valuable knowledge.

Another student writes of the childbirth experience of her mother in 1954 (Italics my own). She endured the experience of an induced labour for postmaturity, which my mother suspected was incorrect. She felt that because the doctor must know better than herself, that she shouldn't argue. In the course of events, she delivered a rather pathetic little infant who was obviously preterm.

We see here hegemony in action. The idea that expert knowledge is superior to personal knowledge is accepted as fact. Few would argue with this assumption and so it dictates the way in which we allow ourselves to be cared for in these situations and how we value our own knowledge. Through this process women have lost the very rich and valuable childbirth lore that once formed a part of our culture.

The western industrialised world continues to strive for more objective and rational means of attaining "truth". What could be more objective than or rationale than a machine. And so it is, that the western world has embraced the use of technology as being the purveyors of some higher order of rational and objective truth. Often this has been to the detriment of the care given to women as the focus of care shifts from woman to machine. Another birth story illustrates this point eloquently;

it was early in the time of monitors and Robert was asked if they could try one out on me. We were eager to please and so I was

plugged in, or rather my baby was. I was on a table which was very elevated and extremely narrow. I could not lie on my back comfortably and my increasingly irrational self wondered that if I rolled off, would the wires running into me keep me dangling in the air?...Saturday ran into Sunday and I lost track of almost everything. This baby was coming through my back and the monitor reader said that I wasn't in "true labour"...It turned out that a physical exam proved what the ticker tape hadn't. I was in full-blown labour.

This small snippet of a story, whilst brief, says a great deal. Firstly, it very much illustrates the invisibility of women within the institution. This woman's husband was asked if they could try out the monitor on her not the woman. Secondly, the woman alludes to the role of the patient in the hospital setting, "we were eager to please" and this is a theme I will pick up on again later. Thirdly, the reliance on the "truth" as expounded by the machine rather than the experience of the woman and finally, the care giver had become "the monitor reader", someone who was there for the machine not for the woman.

The Changing Role of Women in Victorian England

Being a colony of Britain, New Zealand has been largely shaped by forces originating in Britain. During the 18th and 19th centuries in Britain there was a major shift in economic, religious and cultural life which changed the way women functioned in society and eventually, altered the cultural status of the middle-class woman from that of a participant in active life to that of a phlegmatic, helpless, consumptive invalid.

The economic rise of the middle class in Europe during the 18th and 19th centuries coinciding with the development of the mercantile-industrial society, created new patterns of social relationships and adjustments to the middle class's cultural and moral perspectives which. "...led to the establishment of a fundamentally new, massively institutionalised, ritual symbolic perception of the role of woman in society" (Dijkstra, 1986).

The traits of the nuns epitomised the ideal of Christian virtue and gradually extended far beyond the realms of monastic secular life to embrace middle-class women of the time. Several forces contributed to the discrepancy in what was considered virtuous conduct for men and women of the time.

As the economic development created a market society in Britain, businessmen needed to be able to display their credit worthiness to prospective loan merchants. In this time, which was prior to the days of credit checks, credit worthiness was gained through word of mouth and the ostensible show of wealth. Wives became evidence of credit worthiness and the greater the display of conspicuous leisure, the greater the credit worthiness of the husband. This need to display wealth and allude to leisure was reflected in the fashion of the times which set out to demonstrate that "the wearer does not and, as far as it may conveniently be shown, cannot engage in productive labour" (Dijkstra, 1986).

Businessmen of the early 18th century remained concerned with the ideal of Christian virtue yet found this difficult to reconcile with the world of business which was often a less than virtuous place. To be successful in business it was often necessary to behave in ways that were less than virtuous; thus the moral dilemma. This dilemma was resolved with the propagation of the belief that a married man and woman shared one soul. It was therefore possible that whilst the husband indulged in the "pleasures of predatory capitalist accumulation" the virtuous actions of the wife could safeguard his soul. So the wife by staying at home (a place unsullied by labour and sin), through her purity, devotion and charitable deeds could protect male virtue. She had become the housekeeper of the male soul (Dijkstra, 1986).

A woman's physical inaccessibility came to be seen as a guarantee of her moral purity and any public or private display of levity or physical energy was considered a sign of spiritual weakness. A woman's nature and mission was to provide vicarious virtue for their husbands. So we have the idea evolving that women's value lies in their usefulness to man and that virtue is their only value. These ideas resonate with Christian religious doctrine as evidenced by the teachings of St Paul, who declared that;

"A man...is the image of God and reflects God's glory; but woman is the reflection of man's glory...Man was not created for the sake of woman, but woman was created for the sake of man". (Corinthians 11:7-7).

The home was to be a refuge for the husband after his days sullied with the sin inherent in business, and the home and his wife were to provide him with an opportunity

to renew both body and spirit. Remnants of these attitudes remain today and were strongly evident in the following excerpt from a 1950's New Zealand High School Home Economic Textbook providing instruction on how to be a good wife;

Have dinner ready. This is a way of letting him know that you have been thinking about his needs.

Prepare yourself. Be a little gay and a little more interesting for him. His boring day may need a lift and one of your duties is to provide it.

Clear away the clutter....catering for his comfort will provide you with immense personal satisfaction.

Prepare the children. They are little treasures and he would like to see them playing the part. Greet him with a warm smile and show sincerity in your desire to please him.

Listen to him. Remember his topics of conversation are more important than yours.

Make the evenings his....try to understand his world of strain and pressure and his very real needs to be home and relax.

Your Goal. Try to make sure your home is a place of peace, order and tranquillity where your husband can renew himself in body and in spirit.

Some Don'ts. Don't complain if he is late home for dinner, or even if he stays out all night. Count this as minor compared with what he might have gone through that day.

Don't ask him about his actions or question his judgment or integrity. Remember, he is master of the house...

From the attitudes and values that began to find dominance through this period we see several ideas that continue to influence society today. The notion of the weaker sex (prone to fainting, hysteria), the inferior sex, the very prescribed and inhibited behaviours considered acceptable for women and the double standards evident when considering moral and acceptable behaviour for both men and women.

Women in childbirth have been greatly influenced by the prescribed behaviours considered appropriate for women and birth itself came to be seen as a very undignified and primitive process because it threatened to move women from a state of decorum and control. From the birth stories, a woman describes her childbirth experience in 1942.

You just wanted to get it over and done

with. It was almost like being an animal. You were so primitive and undignified that you wouldn't want people to see you like that.

Birth had become not a source of power to women but a source of shame. Women have also been acutely aware of the behaviour expected of them in childbirth. One woman writes;

"I was having increasing difficulty concentrating but was still on my best behaviour." There were powerful sets of expectations about how you should behave while labouring. Making very little noise was seen as a very important sign that you were in "control".

Another woman tells of her childbirth experience in 1965; a lady down the hall was screaming and one of the sisters left the room. I heard a slap on bare flesh and the woman told to stop being a big baby.

It is of course, no longer appropriate to physically abuse client's in this way but we continue nonetheless, to enforce a specific code of behaviour on women in childbirth. This might be through chemical means or through the hierarchical structures of relationships or institutions which place women as clients on the lowest rung. On this level women are infantilised. One woman writes of her birth in hospital in 1954;

[You] did feel that you had to stick to other rules or routines. If you did break them, you felt like you were being naughty, and you really did want to be a "good" girl.

It is clear from this comment that any autonomous action by the woman (breaking the rules) would would bring her into disfavour with the staff. Another woman describes the experience of feeling infantilised; I got up and started pacing to relieve the discomfort. When I was caught walking in the halls I was sent back to my room. Didn't I know that I would be disturbing others? I had the feeling of becoming more and more child like and dependent on the good will of others. I made a very poor dependent person but I was off my turf and so I tried to behave.

These comments also allude to vulnerable position of women in childbirth and the ways in which the "turf" or medical territory contributed to the powerlessness of women. It is this same set of expectations that have prevented women from asking too many questions or participating in their care decisions.

Conclusion

As noted earlier both feminist and critical perspectives aim not only to analyse our world but to change it. Through exposing the structures that bind us to the dominant ideology, and becoming aware of the attitudes and values that we perpetuate through our actions, words and practices we create an opportunity for recreating our social world in ways that are just for all members.

This paper has attempted to illustrate the ways in which the historical, cultural, political and social legacies of the past remain an active influence on the experiences of women and midwives today. If we are our history so too are we our future. For me, this is what is so exciting about midwifery in New Zealand in the present day. We have an opportunity to change the social norms surrounding childbirth; to create an ideology that serves women, that promotes and supports them rather than diminishes them. New Zealand has indeed experienced a decade of great change in childbirth and midwifery. We must acknowledge that just as our past impacts on us today, our present day actions will have far reaching implications for the future. Code (cited in Cheek and Rudge, 1994, p. 61) comments;

"As long as women's invisible behaviour conforms to social expectations, the assumption is that they have consented to occupy the places that silence and oppress rather than empower them."

Our task is to refuse to occupy the places that silence and oppress us, to expose them as such and make our impact on the future a positive one for women.

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Postnatal Support Needs of First-Time Mothers: The Role of the Midwife

■ Anne Kerslake Hendricks - The mother of two young sons and a social and educational researcher.

We spent the first few days wondering what the hell we were doing - who could possibly give us this baby to look after when we had no idea what we were doing? I mean, you can be around kids, and you can look after other people's kids, but

I don't think anything can compare with having one 24 hours a day. The antenatal class really only takes you to birth, there's nothing - and no-one - that prepares you for what it's really like afterwards. [Theresa]

Introduction

Great demands are placed on new parents following the birth of their first child, many for which they may be unprepared. In Aotearoa/New Zealand, most forms of antenatal preparation provide relatively little emphasis on the transition to parenthood and the resultant challenges likely to be faced. Consequently, first-time parents may have given only passing thought to the type of support they may need following the birth of their child, and how and where they will find this support.

Transition to motherhood is an event influenced by social and cultural norms. This research has been analysed within the Aotearoa/New Zealand context, taking into account changes in policy over recent years. Three changes in particular have had a noticeable impact on the support available to women during the postnatal period. Firstly, midwives now play a much greater role in women's postnatal care, following the Nurses Amendment Act of 1990. Secondly, the introduction of early discharge schemes in most maternity hospitals has meant that there are expectations that women will be discharged as soon as possible after giving birth. Thirdly, there have been substantial cutbacks in funding to services offered by the Royal New Zealand Plunket Society (known colloquially as Plunket) meaning that contact with a Plunket nurse during a child's first six months has now decreased. My goal in conducting the research (which formed the basis of a thesis for a Master of Arts (Applied) in Social Science Research) was to explore the formal and informal support made available to 12 first-time mothers.

Method

During face-to-face individual semi-structured interviews of approximately one hour duration each, women were led through a series of questions as they were asked to talk about their personal sources of:

- Practical support
- Social and emotional support
- Information and advice

during the first six months of their baby's life. To assist recall and provide a sharper focus to women's recollections, questions about support during the six-month period were directed at three distinct intervals: the early days at home with the new baby, the first month overall, and the time that the baby was aged between two and six months old. Amongst other topics, women were invited to comment on their perceptions of the most and least valuable support received, as well as to identify the support that had given them the most confidence as a new mother.

Ethics approval for the project was granted by the Ethics Committee of Victoria University of Wellington. A small scale pilot study was undertaken to trial and refine the questions to be used in the main study. All potential participants were given a written and verbal description of the aims and objectives of the research, and had opportunities to ask questions before agreeing to take part. The consent form clearly outlined women's rights as participants, and emphasised that they were free to withdraw from the research at any time. With participants' permission, the interviews were tape-recorded and I personally transcribed all interviews verbatim. (Women had their recordings returned to them when the final report had been completed.) The qualitative analysis focused on describing women's experiences, behaviours, attitudes and beliefs, based on data that emerged during the interviews.

The research was influenced by the principles of feminist methodology. Oakley (1981), a feminist researcher, encourages the development of a non-hierarchical relationship between

the researcher and the person whose thoughts and opinions are being sought. Oakley's (1979) qualitative study of women's experiences with pregnancy, childbirth, and the transition to parenthood provided valuable guidelines. I was also influenced by other feminist researchers such as Reinharz (1992), who outlines the benefits of listening with "care and caution" (p.24), enabling the participant to use their own words to express and develop their ideas within a trusting atmosphere; the researcher is encouraged to be a "learner and listener" (p.29). Appropriate self-disclosure is seen as good feminist practice, thus I answered any questions directed at me and (briefly) shared some of my own experiences as a recent first-time mother. All participants were given summaries of work in progress and invited to offer their comments. When the final report had been written, they received copies of the key findings and recommendations, a reading list, and booklets listing local parenting resources. They were also invited to contact me if they wanted to borrow a copy of the full report (thesis).

Opie (1992) notes that interviewing can foster empowerment for participants by allowing them to contribute to the description and analysis of a social issue. Similarly, Roberts (1981, in Gottlieb, 1987) states that, ideally, research findings can become a strategy for documenting the social conditions of women so that change can occur. All of the women I interviewed spoke candidly about their postnatal support experiences, with several emphasising their desire for their stories to be shared so that others could learn from their experiences.

The Research Sample

The women interviewed were all first-time mothers whose babies were aged between seven and eleven months at the time the interviews took place. I did not wish to interview women who had received treatment for severe postnatal depression, or women whose babies had been born prematurely and required special care, because such women would typically have required support from services that were beyond the focus of my research. Other than these limitations, I did not deliberately seek to include - or exclude - women whose experiences may have differed from the "norm" in some way (for example, mothers of children born with a disability or with particular medical needs, women who had Caesarean sections, women

who had experienced multiple births, adoptive or single mothers). Prior to the interview, I did not ask whether the mother had given birth at home or at the hospital. As it happened, all women in the final sample had given birth at the same local public Hospital, two by Caesarean section. All of the women interviewed had lived in the same city at least since the period immediately before giving birth, which meant that they would have had comparable access to the range of support services in the region.

Basic demographic data were requested. All of the women described themselves as European/Pakeha New Zealanders; several of the women had partners who had been raised either outside Aotearoa/New Zealand, or by parents of another culture. Observations of their homes and surroundings indicated that it would be fair to describe the women as middle-class. The women ranged in age from early twenties to late thirties; five had given birth to boys, and seven to girls. Other factors likely to influence women's experiences with support include household income, education, cultural beliefs, socioeconomic status, and the length and strength of their relationship with their partner prior to the baby's arrival. Although I did not specifically ask questions about such factors, information was sometimes volunteered spontaneously.

Pseudonyms have been used to protect the confidentiality of the participants, and potentially identifying characteristics have been altered.

Locating the Sample

To find women who were willing to be interviewed, I relied on two primary methods - friends and acquaintances arranging personal introductions to potential participants, and notices in two newsletters likely to be read by first-time mothers. Additionally, I placed notices in the local Plunket Rooms and the public library. Due to the self-selection process it is acknowledged that the women who were motivated to respond to my request for participants were probably better educated and more confident than those who did not.

I chose to interview women whose babies were aged at least six months old because I believe that many women find the first six months of parenthood to be a challenge, and that a request for an interview during this time may have been an unreasonable demand. By six months, many babies had settled into a routine, meaning that it was

easier for the women to specify a particular time of day or night that was most suitable for the interview. It is my assumption that beyond eleven months, recall about support systems is unlikely to be accurate. Also, as the need for support typically lessens as a child gets older, there may have been a tendency to under-report the extent of support needed during the early months.

Results

Analysing the women's experiences allowed me to identify, describe and discuss the roles of people and organisations within their formal and informal support networks, and the type of support they provided. The influence of the researchers Strauss and Corbin (1990; 1994) is acknowledged. They stress the importance of exploring conditions, actions, consequences, and subsequent changes. In analysing my data, I placed particular emphasis on identifying and describing changes affecting the new mothers. These included changing conditions (such as the growth or decline of their need for support), changes in their actions and attitudes, and changes in the amount and sources of support received.

Partners, grandparents, midwives and Plunket nurses emerged as being particularly important in the lives of most women. The support of friends, family/whanau, and neighbours was also valued. Others who were mentioned less frequently as support providers included doctors, pharmacists, colleagues and employers (the latter by creating supportive work environments for women who had returned to paid work). Women also appreciated the support given by organisations such as La Leche League and Parents Centre, and services such as Plunket Line. Other sources of advice and information mentioned included books, pamphlets and magazines. Television programmes about parenting issues were rarely watched, suggesting that television is not a very effective medium for providing support and information to new mothers.

Overall, support providers or services perceived as being most helpful had the potential to offer women social and emotional support, practical help, and information and advice. People who were often singled out as providing this all-encompassing support (to varying degrees) were partners, grandmothers, and midwives. Obviously, the extent to which women's partners and mothers (or mothers-in-law) were able to

provide such support depended in large part on the relationships that had been developed with them in the past, relationships which were expected to continue in the future. Relationships with midwives were by necessity more temporary, yet women placed considerable emphasis on the importance of selecting a midwife with whom rapport can be established, one whom a woman can trust, and who can provide continuity of care throughout her pregnancy, labour and transition to motherhood. Many women also wished to stress the multiple benefits to be gained from developing friendships with other new mothers; groups which facilitated such introductions (e.g. Parents Centre, Plunket) were praised. Support that was not perceived as beneficial included unsolicited advice given by grandparents who adhered strongly to their own (sometimes outdated) beliefs, and advice given by strangers not familiar with the family's situation. It was not always easy for women to ask for the help or support they needed to meet their own needs, which were often suppressed as support was primarily directed at their babies (see Kerslake Hendricks, 1998).

Among the women I interviewed, there was a reasonable level of awareness of the more formal support services that were available to new mothers. Women learned about these services through a variety of ways, including word-of-mouth recommendations from friends and family, and information passed on by professionals such as midwives and Plunket nurses. Not all women were aware of organisations such as New Mothers Support Groups, or La Leche League. There were indications that such groups need more publicity, particularly to counter misperceptions about the type of support they offer.

The thesis addresses these topics and other support-related issues in detail. In this article, I will describe women's perceptions of the role of the midwife in the provision of postnatal support.

The Role of the Midwife

In Aotearoa/New Zealand, the passing of the 1990 Amendment to the 1977 Nurses Act has allowed midwives to take total responsibility for the care of a woman throughout her pregnancy, labour and postnatal period, whether the birth takes place in a hospital or at home.

All women I interviewed reported receiving support from a midwife during

birth, as well as during the postnatal period. Midwives played an important role, providing reassurance and guidance. Most women I interviewed were fortunate in that the midwife who supported them during labour and delivery was someone that they had established a relationship with during their pregnancy, and therefore were comfortable with. There were exceptions, however: Bev had a last-minute substitute, as her chosen midwife had just finished assisting at a 30 hour labour and was too tired to continue. Theresa had elected to have a hospital midwife, whom she had not previously met. Simone had been handed over to the hospital team, as she was considered to be high-risk. She and her partner found this difficult, because there were three shift changes during the labour and delivery, requiring adjustments to each midwife's style:

"... every time you would feel like you were connecting with a midwife, they would go, and there would be someone else, and you'd be starting again, and they all worked slightly differently."

The importance of continuity of care for the woman-midwife relationship is addressed elsewhere in this article.

During the first week or so at home, midwives typically visited the women at least once daily, with one visiting three times a day. Most also encouraged the women to ring them at any time. Midwives assumed a significant role in the women's lives, with their influence extending beyond the period during which they had personal contact with the women they assisted. Some women singled out their midwives as providing the greatest support overall during the first six months; this is noteworthy given that the amount of time that the midwife spent with a woman was proportionately quite small in comparison to other support providers. The midwives had a big impact on the women's lives, as they helped the women (and their partners) during the transition to their new roles as parents.

Support Provided by Midwives

The support provided by midwives typically addressed the entire spectrum of the women's needs, including the provision of practical help, social and emotional support, and information and advice. Their support related not only to the care of the baby, but also to the care of the women themselves. Many women credited their midwives with helping them establish successful

breastfeeding. The one woman who had chosen to bottle feed her baby recalled with gratitude how her midwife was the only person who seemed to support her with that decision. Other support provided by midwives included showing women how to make up the bassinet, how to fold cloth nappies, how to bathe the baby, and advising how many layers of clothing the baby should wear. Midwives were also reported to have loaned books, and one provided care for a baby while its mother kept a medical appointment.

Many midwives emphasised to women that they were available day or night, being just a phone call away. Even if additional support was not required, the fact that it was there as a back-stop was immensely reassuring. For this reason, midwives who lived locally were especially appreciated, as women knew that their midwife could potentially arrive to help them within minutes.

It was common for women to describe their midwives as "brilliant", "excellent", or "wonderful". Clare described her (postnatal) midwife as "the next thing to a goddess ... an angel". Several women stressed how important it is for women to have a good relationship with their midwife, who should be someone that they can trust. Repeatedly, the women talked about the reassurance that their midwife had offered, and how much their midwife's encouragement had meant to them:

"I found that [my midwife] was there not only for the medical side of things but also the friend side as well, which I think is really important. You need to be able to talk to [your midwife] about anything - and she was great. She was a shoulder to cry on when I needed it, and she was also there to help out. I think she probably went beyond her call of duty." [Esther]

"[My midwife] was so encouraging . . . and just kept saying, 'You guys are doing well, ' . . . and that gave me a lot of confidence . . . I just found that there was an immediate rapport . . . she worked on basically building our confidence as a team for looking after [our daughter]." [Pam]

These and other comments reinforce the comments of Guilliland (quoted in McLoughlin, 1993, p. 56), who believes that the midwife should be "an adviser, a facilitator". Guilliland and Pairman (1995) identify the Aotearoa/New Zealand midwifery partnership as a relationship of "sharing"

between the woman and the midwife:

This is a relationship - involving trust, shared control and responsibility and hared meaning through mutual understanding.

(Guilliland and Pairman, 1995, p. 7)

Guilliland and Pairman emphasise that this partnership underpins the practice of midwifery. They also acknowledge that the nature of each new partnership will be different, in response to each woman's expectations and requirements, and will be influenced by the midwife's knowledge, scope of practice, and ability to recognise the need for referral when necessary.

Expectations of Midwives

Although, overall, the women expressed high levels of satisfaction with the rapport established with their midwives, a comment made by Sarah suggests that there may be potential difficulties for new mothers in knowing exactly what to expect from their midwives. Reflecting on the support received during the first week at home with her baby, Sarah felt that she would have liked more support from her midwife, although found it difficult to express exactly what had been missing:

... I really liked my midwife, but in some ways I felt that I actually needed more from her ... but really, I'm not sure what form of extra help I needed.'

Based on my own experiences, and informal discussions with other women, it appears that expectations of the relationship between a woman and her midwife are seldom clarified at the outset, tending to evolve as the relationship develops over time. Sarah's experiences appear to confirm this assumption. As a first-time user of midwifery services, she was left with the feeling that perhaps there was "something missing", although found it difficult to articulate what that might have been.

The College of Midwives in the region in which this fieldwork was carried out has set up a system of review and evaluation. Midwives are asked to present a report of their practice before a Midwifery Standards Review panel. The review process is complemented by evaluation forms completed by the women with whom each midwife has worked. Feedback from the forms is discussed with the midwife, to help to ensure that they will provide acceptable care. This form is sent out some time after the midwife has fulfilled her responsibilities, and offers women an opportunity to reflect on

the adequacy of support that was provided. Women are asked, for example, to rate their midwife's communication skills, their empathy, honesty, and reliability, as well as their professional competence. Perhaps completing this evaluation form would help women like Sarah to come to a greater understanding of some of the skills that they value most highly in a midwife, and help them to more clearly define what they would expect from a midwife during and after a future pregnancy. However, I would argue that it might be more useful for women to have guidelines for selecting a midwife during their first pregnancy, rather than simply remaining with whichever midwife is assigned to them, as often happens.

Cole (1996) outlines a series of questions that women may wish to ask of a prospective lead maternity carer (who may be a midwife, GP, or obstetrician). These include questions about qualifications, experiences, beliefs about birth, annual caseloads, intervention rates, and quality assurance measures. Bennet et al. (1993) also present issues for women to consider before choosing a birth attendant. They stress that women should consider whether the attendant's values and views on decision making during pregnancy and birth will match their own. Bennet et al. refer to a "therapeutic alliance" (p. 20): a process of mutual cooperation through which a birth plan is negotiated, "combin[ing] a woman's] informed decision making with the birth attendant's perception of a reasonable standard of care" (p. 20). Reference to guidelines such as those provided by Cole and Bennet et al. could help women to be more confident that they have chosen the midwife who will be right for them.

Very few of the women I interviewed discussed the role of their midwife during labour and delivery, probably because the focus of the interview schedule was on the postnatal period. The only woman who talked in detail about her midwife's presence during this time was Clare, who was critical of her midwife's attitude:

'[The labour] seemed to be going really well, and then the midwife said something which made me feel it wasn't. Instead of saying, 'Wow! You are nine centimetres dilated!' she said, 'Oh, you could have another couple of hours to go, ' [said in a pessimistic voice] and it made me feel really blah.'

The midwife's comment had a negative effect on Clare, causing her to elect an

epidural at this stage, as she felt disheartened with the lack of progress.

'[And then the contractions - which had been going really well up until then - stopped, and from then on, we were heading all the way down for forceps and stuff. I'm still not really sure whether me making that decision [to have an epidural] affected the outcome, or whether that was going to happen anyway.'

The Importance of Continuity of Care

A difficult delivery can have a significant effect on a woman's physical and emotional health. Galinsky (1987) suggests that part of the process of forming an attachment to the new baby is reconciling the actual birth with the imagined birth. Galinsky describes women's accounts of giving birth as "evaluative", although the difference between a positive and negative evaluation is not necessarily solely related to the length of the labour and the amount of pain experienced. She believes that at the core of the evaluation is the question: "Did this birth live up to or not live up to prior expectations?" (Galinsky, 1987, p. 52). Consequently, women who have difficult births sometimes feel cheated - that they have missed out on or been deprived of what might have been.

Many women I interviewed described their birth experiences in positive terms, however others were left with negative feelings. Echoing Galinsky's beliefs, Simone described feeling angry about the whole process, as there was such a great difference between her initial expectations (e.g. for a drug-free labour) and what had actually happened (her labour was induced, there was evidence of fetal distress, and a Caesarean section was performed.) She believed that she had not been adequately informed about the risks of her particular situation.

Continuity of midwifery care can be particularly important for women who are trying to come to terms with the circumstances surrounding their baby's birth, if it has not gone according to plan. Although most of the women I interviewed reported that the same midwife had provided support before and after their baby was born, for various reasons some women received their postnatal care from a midwife other than the one present during the delivery. Consider the contrasting experiences of Clare and Theresa, both of whom had births that differed from what they had anticipated.

Clare talked about her still unresolved issues with what had occurred during her labour. Her feelings were exacerbated by the fact that the midwife who supported her during the birth had been unable to provide follow-up care, and had never made contact to explain more about the circumstances surrounding the birth. Clare was left wondering whether her decision to accept an epidural had affected the outcome, or whether she would have had a difficult labour and delivery regardless. She wished that she had been given an opportunity to talk these issues over with someone (ideally, the midwife present at her daughter's birth) who could have helped her to understand why events had unfolded the way they did:

'There were some issues unresolved about the birth, which kind of remained unresolved. I'm not really sure what could have been done about that, but it might have helped if my midwife from the birth had ever seen me again . . . that might have helped, but she never even made contact.' [Clare was transferred to a different midwife for her postnatal care, for geographical reasons].

Theresa, on the other hand, was full of praise for her midwife's role in helping her to come to terms with her experiences:

'[My] midwife was marvellous. She . . . was there to talk about the whole events of the labour and the whole experience. She had the time to sit and listen, and because at the time of the labour there was so much intervention. . . it was all a bit vague in my mind and a bit clouded. She was there to go over it which was good.'

Guilliland and Pairman (1995) stress that continuity of caregiver is essential, as the woman and her midwife need time and opportunities to develop a trusting relationship. Where midwifery care is fragmented, the partnership is compromised:

Fragmentation of the woman's experience into discreet [sic] components of care means that the midwife is more likely to lose sight of the whole woman-person with whom the midwifery partnership is formed. (Guilliland and Pairman, 1995, p. 38)

Guilliland and Pairman also suggest that continuity of care has positive effects for the midwives themselves. Having access to a woman's complete maternity experience can increase a midwife's confidence and knowledge base, giving the midwife an opportunity to observe the outcomes of the decisions they have made.

Saying "Goodbye"

The support provided by midwives is unique, in that it is by necessity of short-term, limited duration. It differs from other forms of postnatal support (e.g. that provided by friends, family, and Plunket) in that it is withdrawn relatively soon after the birth, and there is usually no expectation that the relationship will continue to evolve over time with the provision of further support. Among the women I interviewed, contact with midwives was typically phased out after the first few weeks (although two women reported that their midwives had gone on to become good friends). There was sometimes a feeling of sadness when the midwife's visits ended, particularly if the woman and her midwife had developed a good relationship, as was often the case. Stephanie recalled her feelings at the time of the impending departure of the midwife from her life:

'Because [the midwife] played such a big part in the labour and the whole big event, I didn't want to make that break from her, which of course [had to] happen, and [I] felt quite sad about that when that took place.'

Summary

First-time mothers have access to postnatal support from a diverse range of sources. The enthusiasm with which this sample of first-time mothers praised their midwives emphasises the important role that midwives play in the provision of support. Continuity of care was important; fragmented care had detrimental effects. Most women benefited from the one-to-one contact and focused attention as their midwives listened and responded with sensitivity to their concerns. In particular, the midwife's skills in motivating the women and building the women's confidence in their ability to assume new responsibilities, their positive feedback, and their practical advice were credited with helping to make the transition to motherhood much easier than it might otherwise have been.

Acknowledgements

I would like to express my thanks and gratitude to the twelve women who so willingly shared their stories with me. The thesis was supervised by Dr Jenny Neale, Victoria University of Wellington, whose support and advice was greatly appreciated. A Sarah Anne Rhodes Research Fellowship and a Victoria University of Wellington Graduate Award contributed to the funding of the research.

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Open Letter to the National Health Committee

Maggie Barry
Chair, Committee to lead Review of Maternity Services
National Health Committee
PO Box 5013
WELLINGTON

Dear Maggie,

Re: Review of Maternity Services.

When the Minister of Health Bill English announced a review of the "fraught maternity services" to inquire into the inadequacies of the current system he made reference to the "debate between general practitioners and midwives". It is therefore important that you and your Committee understand the historical and political background to both the "debate" and the resultant "inadequacies".

The 1990 Amendment to the Nurses Act 1977 made midwives autonomous practitioners. They could "carry out obstetric nursing" without a medical practitioner, order relevant laboratory tests, have access to public hospital facilities on the same basis as general practitioners and claim on the doctors' Maternity Benefit. In other words they could legally challenge the general practitioners' turf.

The Department of Health had long considered that doctors over-utilised and abused the fee-for service Maternity Benefit. The midwives as represented by the New Zealand College of Midwives (NZCOM) now provided the lever - and the heaven sent scapegoat - to restructure the maternity payment system. The doctors, represented by the New Zealand Medical Association (NZMA) boycotted three attempts by the Department of Health to discuss restructuring to accommodate midwives. NZMA demanded a Tribunal.

A five-member Tribunal was set up in November 1992. There it was argued that the Public Finances Act focuses on outcomes, therefore, if outcomes (normal birth) were substantially similar, the work was of equal value and should be paid accordingly. Noting the "clear philosophical differences" between the two parties, the demand of the NZMA to establish two scales of payment was rejected as "an untenable argument".

Section 51 of the 1993 Health and Disabilities Services Act established a committee of NZMA, NZCOM and representation from the four newly established RHAs to negotiate "a new pay structure, based on fiscal neutrality, agreeable to doctors and midwives". Section 51 replaced Section 106 of the Social Security Act 1964 which guaranteed a fully subsidised maternity service with every woman having the right to select her practitioner(s).

Ministry Policy Guidelines charged the RHAs to use the inequities of the uncapped maternity benefit to bring all demand-driven expenditure under control to pave the way for budget holding/integrated/managed care. The maternity budget was capped at \$96 million for primary care. The birth rate was approximately 57,000pa. The 1993 Maternity Benefit per birth was \$1398.

The NZMA came to the first negotiating committee meeting, November 1993, claiming that "the Nurses Amendment Act was the root of all evil in the maternity services". They were determined to maintain fee-for-service. Fee-for-service was seen as the basis of both the doctor-patient relationship and clinical freedom.

A General Practitioners Action group (GPA) formed a national Section 51 body to fight for fee-for service with niche contracting. Although only the 15% of general practitioners with a Diploma of Obstetrics (Dip Obs) were affected, all general practitioners took up arms claiming, "Today maternity care, tomorrow general practice".

The NZCOM insisted the system should be woman-centred encouraging continuity of care, equity, choice, quality and accessibility. It must be adequately funded to discourage under servicing. NZCOM also pointed out that midwives as primary care givers are the only health professionals able to provide a total service and continuity of care.

The Lead Maternity Carer (LMC) - primary provider of care and budget holder - was basic to the maternity service reforms. At the Tribunal Professors Hutton and Mantell had argued the case for only one labour and delivery fee to be paid to the person having the ultimate clinical responsibility and the skills to effect a safe outcome - eg the doctor. This would eliminate duplication of services and costs.

By July 1995 there were 500 independent midwives and 20% of women were choosing midwife only care. The RHAs arbitrarily attached fees to the modules that had been developed by the committee. There was one fee for labour and delivery. Aside from the indignity of a

general practitioner having to negotiate with a midwife LMC for his "share" of the labour/delivery fee, general practitioners claimed that with fees "screwed to base level and no fat left", the one fee for labour and delivery would drive them out of the market.

Also sharing control with a midwife LMC "gatekeeper" was seen as demeaning the role of the general practitioner and displacing the "team" approach (with the doctor as head of the team). However, "shared care" with the general practitioner as LMC was actively promoted by doctors as "women's choice". This despite the fact that at the Tribunal, the professors had claimed that "shared care results in poor outcomes".

Despite medical opposition, in May 1996 the RHAs announced that the RHA determined Maternity Benefit Schedule (MBS) would become effective as of July 1, 1996 - budget capped at \$323 million.

NZCOM considered the document formalised autonomous midwifery practice as it existed, but that postnatal and rural funding were inadequate. It agreed to provisionally work with the RHAs to improve these areas. (Eventually \$1.4 million was made available for these services.)

NZMA totally rejected the notice. Threatening boycott they advised women not to get pregnant until things were "settled" Minister of Health Jenny Shipley offered the doctors \$1.5 million to enable women to consult a general practitioner who was not their LMC. This was refused as inadequate for "women's choice" of "shared care". NZMA then used the RHA failure to give the required six months notice re the MBS to demand further negotiation to address their "greatest concerns".

Consumers who, other than the one consumer brought by NZCOM, had had no official voice in the negotiations expressed concern that the focus on funding constraints rather than women's needs could deprive women at risk from obtaining primary care - the business model having separated the previous integration of secondary and primary care. The RHAs came up with "referral criteria" to secondary care. Both NZCOM and NZMA opposed the inappropriate linking of protocols to payment. NZCOM felt "risk lists" would emphasise birth as pathological and distort clinical judgment. The obstetricians refused to act as "obstetric police".

In an attempt to retain the general practitioner workforce, and since general practitioners cannot provide a maternity service without midwives, the RHA separated

the single labour and birth fee, introducing a cheap midwifery "support" option for doctors only - a return to pre-1990 fragmented care.

Since the RHAs had not negotiated with the competitive debt-ridden CHEs re service costs, it was not possible to determine how much of a CHE's primary funding could be used to pay doctors, or how this would distort funds available to cross-subsidise secondary services. Doctor LMCs opted for this service

	n	NVD	Forceps/ ventouse	C/section	PNMR
Midwife only	1094	88%	5.7%	6.2%	3.8/1000
Midwife/general practitioner	605	82%	9.3%	8.8%	11.1/1000
Midwife/O&G	134	60.4%	18.7%	20.9%	14.9/1000

which was cheaper than paying an independent midwife. In fact, they discouraged (even illegally forbade) "their" women from engaging an independent midwife. This eventually resulted in CHE staff shortages and disrupted KYM schemes which increased CHE funding. It also created tensions between CHE and independent midwives and contravened the Commerce Act.

NZCOM considered the \$360 midwifery fee to be "insulting" to hospital midwives. Midwives would provide 95% of the care while the doctor would rush in for the birth or shortly after and claim an average \$590. The Tribunal had stated that although it had no authority with regard to hospital midwives' salaries, it felt that an unrealistic conduct of labour fee would increase disparity. This could send signals to consumers and professionals that this work is not valued - negating the intent of the Nurses Amendment Act.

The GPA, lobbying for "women's choice", demanded that any general practitioner should be able to provide antenatal care to 28 weeks. Finally, persuaded by the doctors that "shared care" was the safer option, during October 1996 the RHAs assisted NZMA to develop a "financially transparent" capped fee-for-service proposal that completely destroyed three years of negotiation.

The LMC as "provider" was changed to "managing provision of care". Antenatal care was divided into three "fee-for-service" modules opening the door to subcontracting. Women could now "choose" a non-Dip Obs general practitioner for two-thirds of their pregnancy. As medical students, doctors get

only four weeks obstetric 'attachment' in years IV & V, and a six-week "allocation as apprentice" on an obstetric team in the sixth trainee intern year.

Karen Guilliland (1998) surveyed 2212 births of self-employed/independent midwives (December 1995 to March 1996) for her MA thesis, in relation to Maternity Care Provider and Outcomes.

The RHA having made NZMA's structure functional, the "Proposed Amendments" introducing 39 different funding streams compared to MBS' 16 streams was received by NZCOM on Christmas eve 1996 - with "despair".

However, the Royal New Zealand College of General Practitioners rejected the NZMA negotiated "Proposed Amendments" because they failed to meet seven NZMA specified conditions! This left NZMA in limbo with no credibility or fallback position. By May 1997 the RHAs reverted to the MBS. At this time self-employed midwives made up 42% of the midwifery workforce; and 30% of women were choosing midwife-only care.

Dissatisfied with the March 1998 Section 51 Amendments that deducted hospital midwifery costs directly from their MBS, doctors were leaving maternity care - "in droves". By September 1998 HBL showed that only 451 doctors had registered as LMCs compared to 845 in 1997. Some of those who continued were illegally charging women. One group with specialist affiliations charges women \$900 entitling her to two specialist consultations - but a normal pregnancy/birth seldom needs specialist consultation. Individual general practitioners collect \$10 to \$20 "donation" per visit. Another group of seven rostered general practitioners charge \$100 "administration" fee. When the HFA ordered general practitioners to stop these illegal charges and in some cases to refund the money to women, the issue of the "pitiful" funding again erupted - resulting in the Minister's "Review".

I trust you will find this "evidence based" background helpful.

Sincerely
Joan Donley

The Psychological Sequelae of Abortion (Spontaneous and Induced) and Subsequent Pregnancies

■ Cariad Milmine
- Independent Midwife

I ask the questions. She responds with her answers. I dutifully write them down, filling in the spaces on the antenatal booking sheet. I move quickly and smoothly from one category to another. I ask "Is this your first pregnancy?" "Tell me about your previous pregnancies?" I prompt her to tell me about the dates, places of birth and periods of gestation. I do some simple additions and write 3/0

or 7/2, fractions that never look complete, and then turning the page I move on. But what memories have I ruffled or stirred? What dead pain have I reawakened only to ignore it and to move onto issues more tangible, more pressing, never to revisit the past because I have not given her permission, nor the space, nor a listening heart to share something of her grief or trauma with me.

"Miscarriage is the commonest complication of pregnancy. Of all conceptions 25% end so early that pregnancy is not recognised. A further 15% end in clinically recognised miscarriage" (Farquhar and Jamieson, 1994). Because of its common occurrence the resulting psychological trauma has largely been ignored. When family size was larger, the loss of a pregnancy was deemed less important by society, but as family size has declined, the loss of an desired child by spontaneous miscarriage has acquired much more significance.

Conversely, society allows abortion on demand in the first trimester. Last year in New Zealand 15,208 pregnancies were terminated. (Statistics New Zealand, 1997) These combined statistics represent much psychological suffering among women. This paper explores the emotional problems some of these women experience.

My journey has taken me through literature, led me to talk with women who have personal experience of early pregnancy loss as well as to discussions with professionals working in this field. Frost and Condon in a critical review of miscarriage literature comment, "The interpretation of miscarriage literature is limited by methodical flaws. Anecdotal accounts abound. While illuminating our understanding of the subjective experience of miscarriage, these accounts are often personal, or are derived from self selected populations; this inevitably limits the extent to which they can be generalised" (Frost and Condon, 1994).

A critique of available literature on the psychological sequelae of induced abortion is conflicting. The World Health Organisation view is, "There is now a substantial body of data reported from many countries after careful and objective follow up suggesting frequent psychological benefits and a low incidence of adverse sequelae, moreover when post-abortion depression does occur, it is apparently due to stresses other than the abortion" (Farquhar and Jamieson, 1994). This is substantiated by some but refuted by others. The real issue is not exactly how many women suffer, but that they do suffer.

The advent of pregnancy, particularly a first pregnancy, is a catalyst for fundamental psychological change. When this change is interrupted by abortion, either spontaneous or induced, psychological sequelae results. Even though the circumstances may be very different for women who seek induced abortions as opposed to those who spontaneously abort, there are many similarities with the psychological symptoms experienced after the event.

Grief

Literature is unanimous that symptoms of grief after miscarriage are common, occurring in up to 90% (Peppers and Knapp, 1980) and 88.6% (Madden, 1994) of women. "Studies on the grieving process tend to present a unidimensional view of responses to miscarriage. Peppers and Knapp (1980) report that grief after miscarriage was as intense as after stillbirth. In the course of developing their Perinatal Grief Scale, Toedter, Lasker and Alhadeff (1988) report... that the majority of respondents do not exhibit severe grief reactions and that similar patterns were present for miscarriage, ectopic pregnancy, fetal death, and neonatal death (Madden, 1994). Unresolved grief reactions include: vivid, clear memories of events surrounding the loss, frequent intrusive thoughts of events or specific scenes of the day of the loss, persistent anniversary effects (such as intense mourning on the date of the abortion or the calculated birth date),

persistence of dysphoria (sadness or anger) when talking about the loss persisting for years and a disproportionate emotional response to a subsequent crisis (Peppers & Knapp cited by Frost, Condon, 1996; Stack, 1984).

Grief has a multi-facet dimension. It may not be clear to the woman what she is grieving. It could be the loss of the baby, or it may also be distress at the thought of subsequent childlessness. It may be associated with an unpleasant medical experience or a feeling that family members have not supported her as she would have liked causing her to lose faith in those closest to her, or a realisation that life is unfair.

Popular literature on miscarriage devotes a large proportion to grief and mourning with many testimonies from women included. These women speak of feeling numb, washed out, disorientated, uncontrollable crying, and feeling devastated. Grief is a process. It needs to be acknowledge, confronted and worked through. It needs to take its course.

Judith Cameron, Pregnancy Loss Counsellor, National Women's Hospital, in her paper, "Miscarriage: The Dilemmas of Unacknowledged Loss" (1997) provides some useful insights into unresolved grief. She reports that when young Maori parents are supported by their Whanau unresolved grief is rarely an issue. Increasingly they are requesting the return of their fetus and pregnancy tissue and when the demise of the unborn child is acknowledged in the same way as any family member, with the loss openly shared without restraint or denial, grief is effectively resolved.

The extent of each women's grief is varied depending on the depth of her desire to have a baby, her attachment to that baby and the pregnancy length. Those who do not perceive their abortion as a loss do not grieve at all, they may in fact feel relief. Kay, at 18 years of age, induced her own abortion and repressed her emotions for 13 years. She told me she was unable to grieve the loss of her baby believing that it was hypocritical to mourn the death which she had procured. Mei shared with me that she cried for weeks after her induced abortion. Dr Christine Forster, chairwoman of the Abortion Supervisory Committee said, "Every woman I have seen who has had a termination has a difficult time subsequently. They have a grief process and sorting out time to go through. It certainly doesn't leave them unmarked and I have never met a woman who has had one who would want to go through it again of her own free will."

A comparison of the symptoms of grief as reported by Frost and Condon for spontaneous abortion and Reisser and Reisser for induced abortion shows many similarities. This includes: grief, depression, guilt, anxiety, inability to sleep, loss of appetite, sexual dysfunction, poor concentration, reduced motivation, feelings of failure, anger and irritability, repetitive dreams, preoccupation with the baby or becoming pregnant again, avoidance of reminders of the pregnancy, doubting one's femininity and competence as a woman, somatic disorders, and disruption in interpersonal relationships.

Depression

Guilt and self-reproach after abortion is very significant and is often accompanied by a sense of loss of identity as a mother with substantial impact upon self esteem. It is therefore difficult to differentiate between grief and depression.

Following spontaneous abortion women have more mental health complaints than women who gave birth to a living baby (Janssen et al, 1996) and the use of psychotropic medication was three times higher than in the general population of women the same age. (Garel et al, 1994) A Finish study to determine rates of suicide associated with pregnancy found the suicide rate associated with birth was (5.9), miscarriage (18.1) and induced abortion (34.7). They concluded, "Increased risk for a suicide after induced abortion can, besides indicating common risk factors for both, result from a negative effect of induced abortion on mental wellbeing" (Gissler et al, 1996).

Guilt

Guilt arises when a woman believes that she is responsible for the death of her unborn child. Women who spontaneously abort describe feelings of guilt believing they are to blame. Ambivalence towards the pregnancy exacerbates these emotions, the mother believing she has "wished" her child dead. Judith wrote, "I feel guilty, as originally I had regretted falling pregnant accidentally. I felt as though my feelings had caused the miscarriage to occur" (Cuthbert and Van Eden Long, 1987). "In an increasingly secular society, "making sense" of tragic events creates profound personal dilemmas of increasing complexity. Following unexpected bereavement, the search for "meaning" can become synonymous with the search for "cause". Most pregnant women are intensely aware of the total dependence of the fetus

upon them for its well-being, enhanced by medical entreaties to adopt a healthy lifestyle. If the fetus is lost, this sense of responsibility may rapidly turn to profound guilt and self-recrimination, regardless of whether these feelings have any grounding in reality" (Frost and Condon, 1996). Jenny expressed, "I felt I had murdered my baby. After all no one else had anything to do with it dying, it was me. I still don't know what I did wrong" (Moulder, 1990).

For some who choose abortion the burden of guilt may be relentless. They feel they have violated their own moral code and have consented to the killing of their unborn child. A Swedish study assessing abortion ethics amongst recently aborted women reports that, "38% spontaneously voiced disapproval of the intentional extinction of life, although the interview did not include any questions on this topic....All interviewees expressed views to indicate that they regarded the fetus as a separate individual, not as part of their own bodies or as something a woman has every right to get rid of because it is an intruder in her body. This view however, was not sufficient to solve their moral dilemma. The women were not able to consider the fetus without its network of close interpersonal relationships" (Holmgren and Uddenberg, 1994).

For women who choose abortion, the inner voice of self-condemnation can play a repeating accusing tape. She may blame herself for any unhappy event which occurs after the abortion. Mei described her first pregnancy and birth as trouble-free. In her pregnancy following her induced abortion she suffered severe morning sickness, was hospitalised at 38 weeks with high blood pressure, necessitating an induction of labour which took 36 hours of contractions. Post delivery she required anti-hypertensive medication and an 8-day hospital stay. She also experienced significant breast feeding difficulties and at 5 weeks was still attending the Plunket Family Centre. She told me she attributes these problems to her induced abortion and not convalescing in the appropriate Chinese manner. She thought she was being punished and in her mind probably felt she deserved it.

Impact upon Identity

There are many different influences on the way women feel about themselves after abortion. The hopes and expectations the pregnancy held will be reflected in her emotions. A first pregnancy marks the transition into motherhood and for a woman

who feels her biological clock ticking by an abortion may represent a sense of utter failure in all that she perceives to be feminine. "It is as if the pregnancy which failed has become a test of womanhood that she never passed and a personal indictment of her ability to properly nurture and sustain the precious cargo she is carrying within her body" (Stumpf, 1994). Linda expressed herself thus, "About a month after losing my baby, I hit rock bottom as far as being a woman was concerned. I wanted to tear the womanly flesh off my bones and swap my body for a man's. I felt it had brought me so much heartache and pain" (Cuthbert and Van Eden Long, 1987). She distrusted her body and its dysfunction, felt less feminine, resulting in a lowered self-image. For the woman who chooses to abort these feelings of unworthiness may be profound as she sees herself as a lost cause. She does not believe she can help herself nor can anyone else help her.

Societal Attitudes

Literature and women agree that society does not generally accept spontaneous abortion as a significant loss. Over the past 20 years there has been increasing understanding of the impact of late pregnancy loss accompanied by a more sympathetic attitude to bereaved parents and the support by professionals of rituals surrounding the dead baby. The grief of abortion appears to be less understood and is often unacknowledged by health professionals and the woman's family. It is pleasing that some hospitals offer counselling following a spontaneous abortion and women are offered the return of their pregnancy tissue with a brief explanation of the value of farewell rituals. "To bury this tissue is surely the most symbolic meaning of farewell to the baby, the lost hopes and dreams of the future" (Cameron, 1997). If women who spontaneously abort find themselves hampered to grieve openly, in spite of it being socially acceptable for them to take time out to do so, and they are able to draw support from a wide range of people, from their nearest and dearest to acquaintances and work colleagues; then women who choose abortion experience much more difficulty. They have already been through a life crisis of the diagnosis of an unwanted pregnancy, with its associated dilemma, causing tremendous stress and anxiety and they are often unable to process the fear, anger, sadness and guilt surrounding their experience. They are probably reluctant to

take time off work and are unable to draw support from any except very close friends and professional counsellors.

Long-term negative psychological effects are more likely in cases where: there is a history of depression; the woman is very young or unsupported; there is marked ambivalence or feelings of coercion; the pregnancy was desired; or terminating a pregnancy is against her personal philosophy or religion. "The more difficult the circumstances prompting abortion, the more likely it is that a woman will suffer severe post-abortion sequelae" (Reardon, 1987).

Defense Mechanisms

In order to cope women who experience induced abortion may employ common defense mechanisms such as rationalisation, repression and compensation. Any painful experience can cause a person to deliberately avoid future situations that may lead to reawakening of memories. A variety of experiences such as seeing pictures of prenatal development, other pregnant women, babies, subsequent pregnancies, gynaecological examinations, or even the whine of the dentist's drill can trigger repressed memories. Some post-abortion women work hard to keep their emotions under check. They are afraid to experience either highs or lows. Tessa said, "I appeared calm and talked about normal things, but I was really very far away. As I was unable to immediately verbalize my feelings - they were too basic and hadn't surfaced as words - people took me at face value... The thing was I dared not let myself go beyond the tears that I couldn't help because I was frightened of the pain I would have to acknowledge. It took time to do that" (Oakley et al, 1984).

Mei, a Chinese immigrant, found she was pregnant at the same time she had applied to study for a MBA at university. Married with an 8-year-old and working full time, she rationalised that she would not be able to continue with her pregnancy if accepted to do the university course so decided to terminate her pregnancy. However, she was unable to repress the painful emotions and after 4 months of guilt, grief and depression she compensated by deliberately conceiving an "atonement baby" as a replacement for the one she had aborted. Compensation can also be demonstrated by women making a supreme effort to make up for the abortion by "doing good things", being a "super-mum" or investing heavily in making a success of the career they have sacrificed for. As effective as these defense mechanisms might

be in keeping emotions suppressed, they consume a lot of mental energy. Eventually, if her life becomes too stressful she lacks the ability to cope and psychological symptoms occur. The term "post abortion syndrome" is used to describe long-term emotional disturbances in a women's life following induced abortion.

Anxiety and Subsequent Pregnancy

Many women find the trauma of spontaneous abortion does not begin to heal until their next child is born. The legacy of miscarriage haunts the next pregnancy with the possibility of it all going wrong again. In a subsequent pregnancy most find the corresponding weeks leading up to their previous miscarriage especially difficult, but once they are past the first trimester they feel increasingly optimistic and less anxious. For others, anxiety is carried beyond. In their article, "The effects of miscarriage and other "unsuccessful" pregnancies on feelings early in a subsequent pregnancy", Statham and Green found that women who had experienced an unsuccessful pregnancy were more anxious about the possibility of miscarriage or of something being wrong with the baby than other pregnant women. Factors that influenced anxiety levels were; the number of pregnancy losses experienced, whether or not there were living children, the timing of the miscarriage, and whether or not there had been an induced abortion (Statham and Green, 1994).

As giving birth and entering into motherhood is a threshold in a women's life, so too is the experiencing of pregnancy loss. It is a threshold where the crossing is hidden, but it may likewise make a profound difference to the way a woman lives her life in the future. What kind of difference is for each woman to discover. One woman described it like this: "For me it seems that miscarriage is something that makes a difference to how one is. It was something that changed me, quite fundamentally. A part of me died. It was a brush that I had with death. I find I can no longer take life for granted. This feeling was very intense in the early stages after miscarrying and it has subsided, but it is still there. Nor will pregnancy ever be the same experience again. I've lost my nonchalance there. Previously birth had been a simple notion. Now it holds the possibility of death. Before, I was able to take the way my body functioned for granted. Now I am horrifyingly aware that it will not always do what I want it to do. Life

has become even more precious than it was before" (Hey et al, 1989).

Midwife's Response to Abortion

Midwives need empathetic understanding when caring for women who have experienced any pregnancy loss, whether it be spontaneous or induced, early or late. We need to take time to help the woman feel relaxed and confident, providing her with a safe and supportive relationship in which she feels accepted and free to share her pain. During history taking we need to give her the opportunity to express her feelings about her previous loss. Asking "How have things been since your miscarriage/termination?", or "Have you been able to grieve?", can give us an insight into how she is coping emotionally with the past event. We also need to be alert to situations when a woman's reaction or response to the immediate event is out of character. For example vaginal examinations, lithotomy position, turning on a suction apparatus may trigger unpleasant memories. At such times we need to be extremely sensitive and loving. If signs of unresolved grief are evident the offer of referral to appropriate counselling services should be made. Our ongoing relationship should be

non-judgmental, based on trust and one which empowers women to take steps to address past events which have left them feeling fearful, angry, guilty or sad. For these women life goes on, and with them goes the memories, acknowledged or repressed, of the child who never came to be.

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Be Aware of Price-Fixing Risks

■ Jackie Pearse
- Legal Advisor NZCOM

Midwives are increasingly aware of their legal responsibilities and risks under the diverse legislation that governs practice. It is no longer enough for a midwife just to maintain a reasonable standard of clinical practice. She must also comply with the law in areas of marketing, small business management and competition. These areas are quite new to midwives but ignorance of the law has never been an excuse for failing to obey its requirements.

One example of the less considered laws is the Commerce Act 1986 (the Act). The Act prohibits anti-competitive behaviour and the following article looks at one aspect of this, namely price fixing. The only action it may take to breach this legislation is that two midwives get together and discuss, for example, how much they will pay for a non LMC general practitioner visit and both decide that they will charge the same amount. That simple informal discussion might constitute price fixing and be a breach of the Act.

It is not a breach of the Act for an individual midwife to negotiate with an individual sub contractor to pay a set amount such as the \$25.00 set down in the Section 51 Notice. In practice it may turn out that many individual midwives will contract to pay that fee and that individual general practitioners will work on those terms and that will be acceptable. If, however, midwives or any group of health providers get together and talk about what they will charge or agree to charge the same fee or a range of fees for services provided then this is price fixing and illegal. This is a problem that IPAs and smaller practice groups are straying into and the New Zealand College of Midwives is anxious to prevent midwives, as a profession, from making this mistake.

Adam Parker of the Commerce Commission has written the following article

to give midwives guidance in this area and I would urge you all to read it closely. The staff of the Commission is actively involved in education and willing to be contacted if you have any concerns about arrangements you may be considering. The Commission and NZCOM advise that the best protection is that if anyone starts talking fees within your hearing - stop the conversation or walk away.

The Commerce Commission enforces competition law in New Zealand through the Commerce Act 1986 (the Act). The Act aims to enhance the welfare of New Zealanders with the promotion of competition, through:

- more efficient businesses;
- a wider choice of goods and services;
- higher quality goods and services;
- and competitive prices.

The Commission has continued a proactive study into the health sector into the 1998/99 year. The aim of this study is to educate and assist those in the sector to comply with the law. This article focuses on the price-fixing provisions of the Act.

Price fixing is prohibited under Part II of the Act. The prohibition is sweeping and will catch most arrangements between competing health providers that affect the price of goods or services in a market. The prohibition covers arrangements that affect not just price but also any credit, rebate, discount or allowance for goods or services. To discuss or agree on any pricing issues with your competitors can put you at risk under the Act.

Your competitors are those persons that you are vying with to provide or purchase goods or services in a market. For example your competitors might be the other midwives in your town or area, or any general practitioners in your area, if they too provide maternity services.

It is emphasised that all providers of the same service within a geographic market are considered to be in competition with each other. Traditionally the health sector has not regarded members of the same college, association, IPA or ICO as being in competition with each other. For the purposes of the Act they may well be competitors.

The kind of situations that might

constitute price fixing arrangements include arrangements which:

- fix a price;
- create a price range;
- create a price or discount formula;
- create maximum or minimum prices;
- set discount levels; or
- otherwise control costs which contribute to price.

An example might be where competing specialists collectively agree on what they will charge for their services. Another example might be where an IPA negotiates with a service purchaser the contract rates or subsidies payable to the members of the IPA.

A situation that recently arose in the North Island was where it was alleged that a group of midwives had got together and decided that the price in the maternity payment schedule in the SS 1 Notice on Maternity Services was the price they would pay when they subcontracted services to another provider, usually general practitioners. It appears to be a common misunderstanding that the prices in the maternity payment schedule are the prices to be paid when subcontracting. In fact, the prices in the maternity schedule are the prices that apply between the purchaser, the HFA and the contractor. If any services are subcontracted out, an agreement must be negotiated by the individual contractor and the individual subcontractor. Any collective agreement, formal or informal, by any Lead Maternity Carers about what they pay subcontractors is likely to breach the Act.

A brochure dealing exclusively with the health sector is available free of charge from the Commission. A copy of the brochure or further information about the application of the Act to the health sector is available by contacting the Commerce Act Division's Enquiries Officer:

Telephone (04) 498 0942

Facsimile (04) 471 0771

E-mail michelle.kitney@comcom.govt.nz
Mail PO Box 2351, Wellington.

.....or you can visit the website at <http://www.comcom.govt.nz> for media releases, the public register, a publications list, and Commerce Act brochures. You can also download speeches, numbered decisions, the Commission's newsletters Fair's Fair and Compliance, and Commission submissions. The information on the site is updated frequently.



Surfing in Gisborne

Sarah Stewart - Midwife

The summer is drawing to a close here in Gisborne, so I have headed back to my computer after some lovely, hot days on the beach. Here are some websites for you to check out.

www.natfamplan.co.nz/

The Association of Natural Family Planning provides an attractive and consumer-friendly website. It has information on fertility awareness, breastfeeding and planning a family. There's a lovely picture of a breastfeeding mum. Its email address is:

nationalcoord.natfamplan.co.nz

The UK equivalent with much the same information can be found at:

www.fertilityUK.org

www.herpess.org.nz

The Herpes Foundation website supplies invaluable information about genital herpes for both consumers and midwives. It presents the facts about herpes - diagnosis, treatment, and consequences for partners. The pages for health professionals includes guidelines for treatment during pregnancy, and neonatal infection. This website is definitely worth bookmarking. Their email address is:

info@herpess.org.nz

www.midrivers.com/~jkuro

This website is run by Jude Kurokawa, an American midwife, and is just wonderful.

www.childbirth.org

You can reach this website from Jude's home page. It is another invaluable source of information about childbirth for both

consumers and midwives, with pages on birth plans, epidural, ultrasound scanning and episiotomy.

www.vh.org/

This Virtual Hospital website is a lot less exciting but I mention it because it has some interesting obstetric guidelines. They are provided by the University of Iowa. Whilst some of them made me grind my teeth, they are worth checking out especially if you are involved with writing guidelines.

www.vh.org/providers/clinref/fphandbook/08.html

Another site with clinical guidelines is:
<http://itsa.ucsf.edu/~petsam/>

www.medforum.nl/abservice

This website will email, on a monthly basis, abstracts on obstetric and gynaecological topics. Whilst the topics are mostly gynaecological, there are subjects that will interest midwives, such as infertility, ectopic pregnancy, gestational diabetes, ultrasound and prenatal diagnosis. You can also search and download past topics.

www.womens-health.org/

This is an American site with a huge number of links to women's health issues such as violence towards women, STD, HIV/AIDS. It also has links to American journals such as the Journal of Women's Health, advocacy groups and research centers.

www.widesmiles.org/

Widesmiles is an organisation that provides support to families with children affected by cleft lip/palate. I highly recommend this website to both consumers and midwives. It has invaluable information and facilities, such as a picture gallery, chat line, kid's story and club, as well as indepth material about cleft lip/palate. Definitely a web site to store away for future use.

At last I have the mailing list sorted out so if you want to join, please mail me on mazza@clear.net.nz or nzmidwives-subscribe@egroups.com

Student midwives are very welcome. Don't forget to let me know of any interesting web sites that you discover, especially if they are based in New Zealand.

Finally, for those of you who have daughters who are fans of Leonardo DiCaprio (or are closet fans, like me), his official homepage is

www.leonardodicaprio.com

Enjoy!!

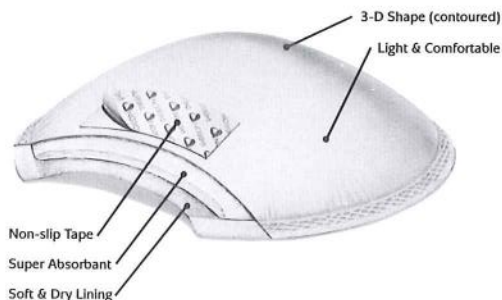
NZCOM Website News

In November 1998 there were:

Visits to Site	1609
Visits to College front page	377
Midwifery information page	322
Education page	209
Policy page	134
News	69
Order forms for College books	47

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PIGEON



The Issue of Midwife Self Preservation

A few years ago Joan Donley wrote a book regarding the status of midwives in New Zealand. 'Save the Midwife' championed a return to autonomy of practice for midwives.

When autonomy finally became a reality in 1990 following an amendment to the Nurses Act 1977, midwives increasingly

began offering continuity of care to pregnant women. A model of midwifery partnership has slowly been developed (Guilliland and Pairman 1995). The changes to NZ midwifery in the last eight years have been enormous and the independent midwife has been left to grapple with the challenge of balancing professional responsibility and personal needs (Kerins, 1997). The situation has changed from Save the Midwife - from extinction- to Preserve the Midwife - from exhaustion!

This article will explore burnout and the steps taken by five independent midwives in the greater Auckland region to cope with this syndrome, which is also known as compassion fatigue (Figley, 1995).

■ Lilian Rolston - Midwife
- Middlemore Hospital

Burnout

The burnout syndrome was first described by Herbert Freudenberger in 1974 (Bakker et al 1996). They also state that it has been defined as 'a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations'. Burnout is a process rather than a fixed condition (Figley, 1995), which begins gradually and becomes progressively worse. And it is a serious problem (Bakker, et al 1996) and outcomes range from reduced quality of care to suicide.

Behaviours which are commonly manifest include: overeating, binges, abuses, self criticism, numbing of emotions, immersion in work, negative description of self and others and a disruption of boundaries with others (Figley, 1995).

Midwifery is a challenging profession, as highlighted by Davis (1992), "Midwifery is more time and thought consuming than you might imagine, it is a way of life both grueling and transformative, it works a woman on all levels either disintegrating her or bringing her to essence." This is certainly true in independent practice. Flint (1986) points out that when midwives are on call in the continuity of care situation, they consider themselves on duty all the time. Often this never-ending availability to women places huge stressors on the midwife and her personal relationships. Tupling (1993) states, "Many dedicated midwives become exhausted and burnt out by the self imposed challenge of independent practice; some leave the field rather than continue to feel the way they do." Sandall (1997) in her study of midwife's burnout in continuity of care, encountered comments such as:

Oh work...I can't be bothered with it really, and that's sad. You see, as a midwife, at a birth where you think 'Oh just get on with it and have the baby. I want to go home, I've had enough'. I'm getting to the point where I think I can't be bothered."

And:

I felt I'd had a lot to offer to these women, it's robbed me of the absolute joy I had in that job beforehand. I don't think I'll ever go back to clinical work. I don't miss it one bit and that's made me very bitter, that it's done that to me."

On the other hand, there are those midwives who have found an appropriate balance and can say like Burgess (1997),

"Midwifery has been good to me...the life style is great." Or A. Priday, (personal communication October, 1998), "I love the lifestyle. I think I will do it forever."

Self Preservation

Flint (1986) recognised the need for midwives to preserve themselves and recommended the setting up of support net works. For some this will come from a supportive partner and family, but for others it will need to be cultivated; consciously set in place. Nichols (1992) describes how to spot the danger signals of unrelieved stress and how to set up a support scheme. Cures for burnout include: time - out, relaxational reading, change of scenery, hobbies, exercise and a proper diet (LaLeike, 1990).

Independent midwives in New Zealand appear to be recognising the need to 'preserve themselves', to maintain a reasonable standard of personal life and are taking steps to implement this.

Of the four midwives contacted, C. Hedgeman, (personal communication, September, 1998) said she had experienced burnout, both R. Kerins and A. Priday (personal communication, September, 1998) said they had come very close to it while A. White, (personal communication, September, 1998) stated that although she didn't consider she had reached clinical burnout, she had experienced times of extreme tiredness. For A. Priday the experience was manifested by an inability to unwind and sleep, eating badly and snapping at her own children.

Each has identified the need to have good strategies in place for coping and stress management. For some, like W. Smith (personal communication October 1998), working in a team situation with the use of telepaging and rostered routines is the answer. This team offers continuity of care not carer. Another style, preferred by A. White (personal communication September, 1998), is the combination of teams and case loading which allows a measure of flexibility to work safely and offer some continuity of care.

Yet again are those midwives who are committed to continuity of care, who constantly work on maintaining a balance to family/personal and professional like. Some work alone while others work in partnership or a group practice. A Friday, (personal communication October, 1998), one of the midwives who pursues the latter style, pointed out that the group to which she belongs has made family and personal health its highest priority and their women come second. Young, in her lecture at AIT (1998), mentioned the need to work so there is minimal wear and tear on the family and the need to constantly revamp her practice, weeding out the factors which don't work.

When asked how maintaining partnership and continuity of carer conflicts with long term independent practice, two felt it didn't conflict at all. For these two, case loading was preferable and although there were occasions when an element of guilt became evident, for example when a woman went overdue, each recognised the need to retain time for themselves and their family.

Tensions

The introduction of changes to Section 51 of the Health and Disabilities Act 1996 has increased the workload of midwives, but mostly in the form of paperwork. For some this has been alleviated by the introduction of computer software and employing a part-time secretary while others try to be super organised to keep the documentation current. The 28 day postnatal check was an element that some midwives already included in their care, for others it is performed in their rooms where the antenatal visits take place and consequently does not add a huge time commitment. R Kerins (personal communication September, 1998) finds that she needs to book more women than is sensible to cover for miscarriage, families leaving town, working for no pay attending emergency caesarean sections to

maintain continuity of care and doing perhaps 12 postnatal visits to ensure the woman is well and the baby feeding consistently. Section 51 has increased the element of accountability with an increased possibility of auditing to prove the claims are correct.

When questioned about the pay scale, most felt there are sufficient swings and roundabouts to consider the recompense adequate. R. Kerins (personal communication September, 1998) felt that sometimes a million dollars wouldn't be enough while occasionally it was money for jam. Some would question the validity of reducing the pay-out with late claims and others felt the postnatal module was under valued.

The tensions faced varied from the volume of paper work, the low levels of supplies in the hospital to the personality clashes within the team. One stated the need to foster tolerance but appreciated the liberty to 'bitch and whinge within the team' while presenting a united front to the world. One midwife who thoroughly enjoys the fact that her job allows her to offer a service to needy women, feels she must sometimes justify to her colleagues her 'extra activities' such as providing a taxi service to specialist consultation and gathering spare baby clothes for these women.

Legal Issues

The changing legal situation and the impact on a practitioner's level of self care is forcing midwives to do more than is legally required. R. Kerins (personal communication September, 1998) stated that it engendered paranoia, created constant unease and caused an obsessive attention to detail. A. Friday, (personal communication September, 1998) felt that getting an appropriate second opinion plays a big part in decreasing her stress levels. A recent study reported by Guilliland (1998) shows a high percentage of specialist consultations which reflect the medico-legal pressures for the maternity practitioner. All

those consulted noted that documentation must be excellent. For A White, (personal communication September 1998) personal courtroom experience in a previous role motivates her to document everything accurately and to practise defensively. Pearse (1996) states, "Notes should be accurate, factual, objective and detailed enough to decrease any possibility of misinterpretation. Sloppy notes, inaccurate spelling, lack of clarity and objectivity, inadequate and ambiguous statements all lead to an inference that the midwife is incompetent." She goes on to say that in an investigation the midwife's notes can be her greatest defence or her worst accuser.

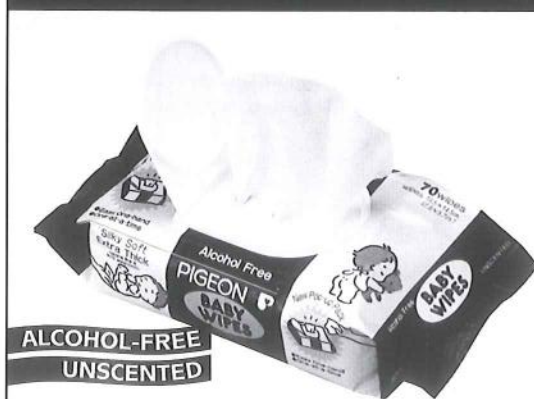
Conclusion

It has been noted that the burnout syndrome is a process with recognisable symptoms, which can be treated. Independent midwives who work using the continuity of care model are at risk of burnout or compassion fatigue unless they set up strategies to reduce the stressors placed on them by the nature of their role and the legal and economic constraints of their profession. By implementing these strategies they can expect to offer a service which, while not without tensions, is satisfying both to themselves and women. Thus the 'preserved midwife' can expect to enjoy this role over an extended period of time,

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BOOK REVIEWS

Author:

Varney, V., Kriebs, J.M., & Geggor, C.L.

Book Title:

Pocket Midwife (A companion to Varney's Midwifery, 3rd edition)

Publishers:

Jones & Bartlett

Year Published:

1998

Recommended Retail Price:

SA 69.95

Reviewed by Helen Manoharan - Midwife.

Varney's Pocket Midwife is a small, conveniently-sized book that makes a companion to Varney's Midwifery, 3rd edition. The Pocket Midwife contains a large amount of essential clinical content from Varney's Midwifery but in an easily accessible format.

- It covers women's primary health care and many aspects of pregnancy and childbirth.
- There is a space allowance for note taking to allow the reader to customise the content.
- It features numerous quick reference tables and illustrations.

However, being an American book it has been written with the American health care system in view and has documents of the American College of Nurse-Midwives in the Appendix - interesting but not valid here.

If you enjoy Varney's style of writing, this book will make a welcome addition to your collection.

Editor:

Hussein Rassool, G.

Book Title:

Substance Use and Misuse:
Nature, Context and Clinical
Interventions.

Publishers:

Blackwell Science

Year Published:

1998

Recommended Retail Price:

SA 72.00

Reviewed by Helen Manoharan - Midwife.

Substance Use and Misuse: Nature, Context and Clinical Interventions, is a comprehensive and practical text which covers the core elements of substance use and misuse in both the acute and community

settings. The text reflects those areas where health care professionals are assuming greater responsibility in working with those who misuse psychoactive substances. It adopts a skills-orientated approach, providing a framework of good clinical practice and is written by a group of clinicians and academics.

- It contains essential information on drugs, alcohol and tobacco but only has a small section in the book relating these to childbirth.
- It does cover screening, prevention and harm-minimisation but not specifically in pregnancy and childbirth.
- Included are generic responses to substance use and misuse in different settings (not specific to pregnancy and childbirth).
- The book uses case studies to illustrate the issues and associated problems with these substances.

This book would be of interest to all health professionals and could act as a resource for substance use and abuse research.

Author:

Irene Calvert with
photography by Angie Gawith

Book Title:

Birth in Focus

Publishers:

The Dunmore Press Ltd.
P.O. Box 5115,
Palmerston North.

Year Published:

1998

Recommended Retail Price:

NZ\$29.95

Reviewed by Sonia Pedersen - Midwife.

The information in this book has been written and presented in a way that is very inviting for all women and whanau involved in pregnancy and childbirth.

It explores all aspects of midwifery care and options for women in Aotearoa during the 90's. It contains numerous beautifully taken, informative photographs, enabling women and whanau to understand or get an insight into aspects of childbirth and perhaps what to expect at different stages during the birthing process and the early postnatal period. It is a reasonably short book (120 pages) with very precise information which

invites women to ask their Lead Maternity Carers more questions which relate to their preferred style of care. Incorporated within the book is a list of community organisations which are available to women within New Zealand.

It concludes with the varying comments from women and couples who have experienced different alternatives of care. I would certainly highly recommend this book as a resource for every midwifery/childbirth resource library.



CLASSIFIED ADS

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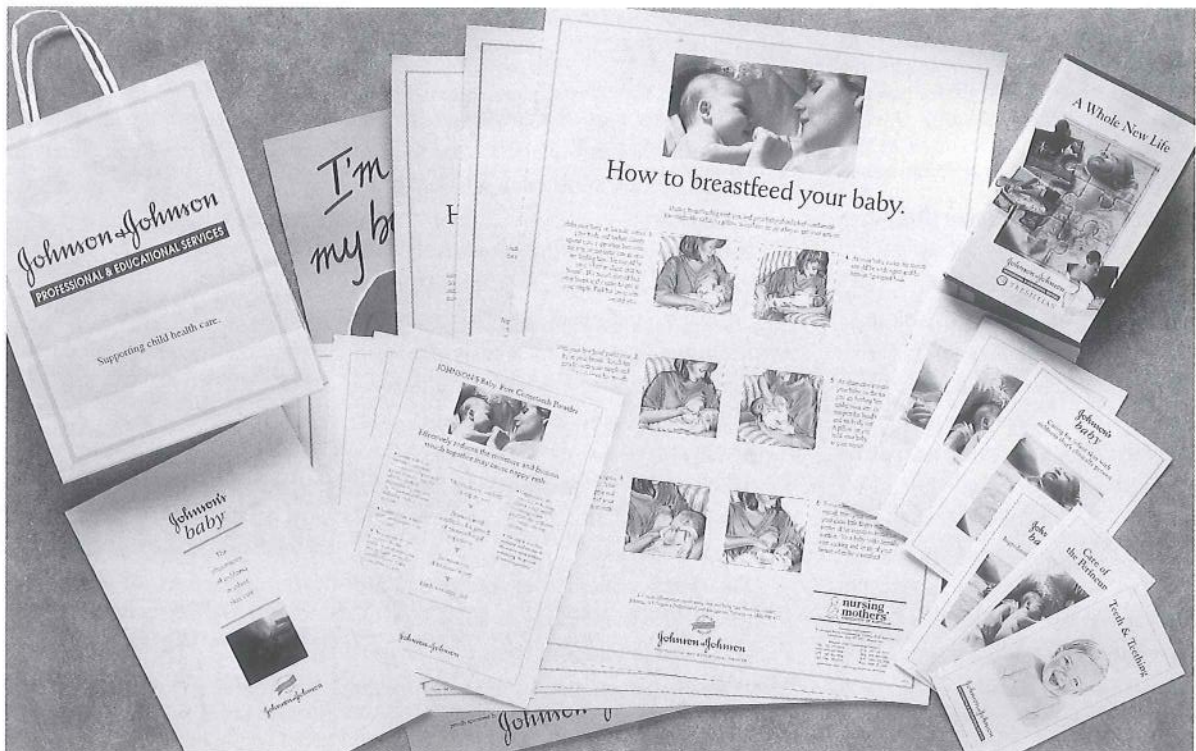
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