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College of Midwives



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JOURNAL

OCTOBER 1999

10th ANNIVERSARY ISSUE

**Partnership Revisited: Towards
Midwifery Theory**

**Midwifery Partnership: Individualism
Contractualism of Feminist Praxis?**

**Midwifery Partnership: A Consumer's
Perspective**

**The Magical Moment of Birth - A
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**The Jean O'Neil Case: Civil
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ISSUE 21



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

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Information for Authors

These notes are intended as a brief guide for contributors.

Articles

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

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

Preferably the manuscript should be accompanied on a computer disk either Macintosh or IBM compatible. All submitted articles are peer-reviewed within the subject area of speciality.

Author Details

Please provide the following details:

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

References (Harvard system)

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

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

■ Karen Guilliland, Director, New Zealand College of Midwives.
Candidate, Professional Doctorate (Midwifery), University of Technology, Sydney.

Towards a new millennium in partnership

The last ten years have passed with a 'blink of an eye' but it has somehow seemed to fill a lifetime. The changes that have occurred within midwifery in New Zealand over those ten years have been so far-reaching and comprehensive that one could expect it would take a lifetime to achieve.

As we all continue the journey into the next millennium we should take the opportunity and evaluate the last ten years of personal and professional midwifery practice within New Zealand. What have we achieved for women and midwifery in the childbirth arena? Have we got it right? Will we know when we have got it right? Do we understand how it happened? Does our partnership model make a difference? The maternity outcomes for New Zealand women would suggest that the midwifery model has contributed significantly to better maternity services. When comparing the similar populations of New Zealand (NZHIS, 1996) and Australia (AIHW, 1996), New Zealand women enjoy less intervention in relation to caesarian section, induction and episiotomy. Women in New Zealand are able to choose their lead maternity caregiver (LMC) of midwife, general practitioner or obstetrician. As well as choices of LMC the vast majority also know the midwife who attends them at their birth (70- 80% HB, 1997).

New Zealand women can actively choose their place of birth and we are experiencing a gradual increase of birthing at home. Women are encouraged to develop their own birth plans in partnership with their LMC and make informed decisions about their own care. Women can also hold their caregiver accountable for the service they provide because of increased access to patient advocacy and the Health and Disability Commissioner. The outcome for their babies is also better with a national perinatal mortality rate of approximately 6.1:1000 (1995-defined as being between 28 weeks to seven days) in the years 1994-1997 (NZHIS, 1999). This compares to Australia's 8.1:1000 in 1996. The hospital neonatal admission rate has also dropped in New Zealand according to preliminary data.

New Zealand's midwife led maternity service, where almost 50% of midwives carry their own caseload as lead maternity caregivers and where approximately 60% of women choose to have a midwife LMC (HB, 1997), appears to have advantages over Australia in maintaining its workforce. True to our view that the relationship between the woman and the midwife has reciprocal benefits, New Zealand midwives stay in the workforce longer. Furthermore, because of the continuity/partnership model New Zealand fewer midwives are required which is more cost effective within education and service provision resources.

Australia has about one third more midwives than New Zealand per birth and is experiencing a shortage crisis apparently because of its shift/rostered midwifery workforce model.

Last, and by no means least if the Treasury has a say, the New Zealand maternity service under the LMC system has stabilised its budget for the last three years (personal communication, HFA, 1999).

The LMC model also has professional development advantages. All schools of midwifery now offer Bachelor of Midwifery programmes and postgraduate programmes are increasingly emerging. These programmes have developed out of practice and are therefore highly attractive to the midwifery workforce.

It is the area of professional autonomy that New Zealand midwifery services compare most favourably to other western countries excluding Holland. In America only 7% of women have a midwife at all (Birth, 1999). In Australia in 1996 only 3.5% of midwives considered their practice fully reflected the ICM definition (CDHS & H, 1996). Some 29% of Australian midwives knew of, or had read the Australian College of Midwives (ACMI) Standards of Practice and only 13.6% belonged to ACMI.

Conversely in New Zealand 83% of practising midwives belong to the New Zealand College of Midwives (NZCOM). In 1996 over 56% of New Zealand midwives (Guilliland, 1998) had undertaken NZCOM Midwifery Standards Review. In 1999 several hospitals have taken up NZCOM standards review for their caseloading midwives and almost all maternity units base their practice standards on those of the NZCOM.

It is fitting then that this special edition of the Journal examines the concept of partnership more fully some ten years down the track as we endeavour to articulate the partnership model which has achieved so much for women and midwives.

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Letters to the Editor

Congratulations

Dear Editor,

Congratulations to the Journal on its tenth birthday.

These ten years have been tumultuous ones for midwives. We have celebrated the coming of autonomy in 1990. Since then it has often seemed like three steps forward and two backwards.

Through these years the Journal has been the major source of information about what is happening in the profession for midwives. It is also an important source for those of us who want to keep up with what is happening in midwifery.

All the best for the next ten years of the Journal's life. As you serve a vibrant professional organisation, I know that the Journal will be around for a long time.

Kind regards
Rt Hon Helen Clark
Leader of the Labour Party

Feminism and Midwifery

Dear Editor,

Regarding "Feminism and Midwifery" written by Deborah Davies, Midwifery lecturer of Otago Polytechnic.

I found this a very interesting and obviously thoroughly researched article, but as a Christian I have some questions regarding "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".

In all my experience of my faith and reading my Bible I do not find this to be so. I notice that a lot of the quotes mentioned are from men's teaching, and are in direct conflict with the Scriptures. In the early chapters of Genesis it is recorded that "God created Man in His own image, Male and Female created He them" speaking of equality between the sexes. Another Scripture reads, when the Lord finished His creation, He saw that it was good. Sure, there is also mentioned in Genesis that there was evil but not in the form of Woman. With the advent of the New Testament when God had to send His only Son Jesus Christ as sacrifice for the sins of mankind, Jesus gave women their rightful standing alongside their men counterparts, when previously they had been cruelly oppressed by the culture of the day. They were elevated. Also, the Apostles and Disciples held women in high regard. They were counted amongst the Lords closest followers. In His resurrected body after the crucifixion it was women who He chose to appear to first - they were in the right place at the right time. Previous to the Crucifixion while the Lord was suffering on the cross as a criminal, for whom Pontius Pilate said "I find no fault in this Man", He saw to it that His beloved mother was adequately supported both materially and emotionally - no "Income Support" in those days! Unfortunately throughout the ages the Bible has been seriously misinterpreted, and unless it is read with the guidance of the Holy Spirit and with reverence it will continue to be so. Regarding our nursing medal, I think it is wonderful and I will continue to wear it with pride, when I am nursing in my "Florence Nightingale" way, embracing our intriguing past, but also very awed and invigorated by the present and awaiting the future with optimism. (I enjoy working with elderly folk, when I am not clucking around in a maternity ward and delivery suite being "with women" - such a privilege to share the time of birth, and going all gooey over their beautiful babies) I remain, ever the romantic Nurse and Midwife, proudly brought up and educated in New Zealand, but not always in the classroom.....

Anne Doherty, Staff Midwife
Dargaville.

P.S. Midwifery goes back and is enmeshed in Scripture also. The Hebrew midwives Shuah and Puah when ordered to destroy male babies refused, risking their lives in order to save the Israelites from extinction..... See Exodus iv 15-21!

A survey on the risk factors for Fetal Alcohol Syndrome and other Alcohol Related Effects in New Zealand

Dear Editor,

Fetal Alcohol Syndrome (FAS) and other Alcohol Related Effects (ARE) are birth defects seen in infants exposed to alcohol in utero. The effect of alcohol on the growing fetus follows the principle of teratology and hence is dependent on dose, time of exposure, conditions during exposure, and the genetic makeup of the mother and the child. We do not currently have sufficient information of drinking patterns in pregnant mothers in New Zealand to determine the possible levels of risk for FAS and ARE in this country. Anecdotal evidence has suggested that midwives are the professionals who are most aware of the drinking habits of pregnant mother. A pilot study conducted supported this evidence and we take the opportunity to thank the midwives who participated in the pilot study for their time and effort. The quality of feedback we received reflects the commitment of midwives in giving a high level of thought and care to the pregnant mother. Based on good responses to our pilot study, we are continuing with a New Zealand wide survey of midwives to assess the risk factors for FAS and other ARE in New Zealand. We hope by now some of you will have received this survey, and thank those who have already responded. The study forms part of the research being carried out for a PhD Thesis by Massey University student Sherly Mathew, and the work is supported by the Alcohol Advisory Council and Fetal Alcohol New Zealand Trust. Feedback on the results will be available to all participants, and we hope to write an article for the Journal or Newsletter once the work is completed. We anticipate that the results of the survey will be used to help develop additional resources giving information and support for midwives and mothers. If you have received a survey form in the mail, we hope that you will find the time to answer the questions and return it to us. The questionnaire is designed so that all you need to do is to tick or circle an option you think is appropriate, but you will also have the opportunity to provide additional comments if you wish. We will greatly appreciate the feedback we receive.

Sherly Mathew, Massey University;
Kathy Kitson and Patsy Watson, Project supervisors;
Institute of Food, Nutrition and Human Health,
Massey University, Palmerston North

Congratulations

Dear Editor,

We are honoured to be able to congratulate the New Zealand College of Midwives on this the tenth anniversary of your journal. It is as if you have collectively assumed responsibility and are successfully nurturing your profession - and your journal is a good example of this in practice. You are exemplary for any of us in fledgling organisations or professions seeking recognition in an environment that can be less than accepting.

If we are allowed a wish for the next ten years it is to be able to work more with you so that the complementary areas of our professions can develop together with the interest of mother and baby at the fore.

With best wishes from the staff at Weleda.

Phillip Melville
Pharmacist and Co-Managing Director

Partnership Revisited: Towards Midwifery Theory

Introduction

Ten years ago midwives in New Zealand celebrated the formation of our own professional organisation, the New Zealand College of Midwives, and in so doing took a major step towards articulating our identity as midwives. In September of that same year the New Zealand College of Midwives launched its *Journal* to provide midwives with another forum for sharing knowledge and giving 'voice' to midwifery's interests. From the beginning midwives claimed 'partnership' as a central tenet in our new understanding of ourselves as a profession (Donley, 1989; Guilliland, 1989). We recognised our political partnership with women as we worked to bring about the 1990 Amendment to the Nurses Act and regain our professional autonomy. We consciously challenged traditional notions of professions as we developed a structure and constitution for the NZCOM that required consumer membership at every level. We understood, even then, that what we were doing involved a shift in power from the professional to the woman (consumer). As Karen Guilliland (1989, p.14) told us then: *the only real power base we have rests with women.*

■ Sally Pairman
Midwifery Programme Leader
Otago University, Dunedin

Candidate,
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University of Technology,
Sydney.

In 1990 the power of this partnership was demonstrated when together women and midwives brought about the legislative change so pivotal to our development as midwives, as women and as a profession. The importance of partnership between women and midwives to midwifery was affirmed in 1993 when we published our *Code of Ethics* and *Standards for Practice* articulating partnership as an ethical stance and a standard for practice (NZCOM, 1993). Partnership is reflected in the composition of our *Midwifery Standards Review Committees* and our *Resolution Committees*. Partnership underpins the philosophy of all pre-registration midwifery education programmes. The ability to practise in partnership with women is considered so foundational to New Zealand midwifery that it is a competency for entry to the midwifery register (Nursing Council of New Zealand, 1996).

The notion of partnership has become part of our identity as midwives in New Zealand. It is one of a number of aspects that distinguish us from midwives internationally. We think we understand what partnership means. But do we?

This paper reflects on the model of midwifery as a partnership as articulated by Karen Guilliland and myself in 1994 and 1995. It addresses the central tenets of power sharing and reciprocity, women-centeredness, continuity and autonomy and briefly outlines the refinement of this model through research in 1996/7 (Pairman, 1998).

The development of the model

When Karen and I first began work on this model in 1994 it was an attempt to describe what we saw around us: politically in the collaborative political action of the late 80's and early 90's, professionally in the policy and processes of the NZCOM and most importantly in the daily work of midwives and women as they shared the experiences of childbirth. What we observed as practitioners, educators and politicians was reinforced in discussion with midwives and women and in the written submissions for both the 1990 Amendment to the Nurses Act and the 1993 Maternity Tribunal. Although we didn't know the language then, what we were doing was praxis - reflection and action upon the world in order to change it (Freire, 1972) or *the interactive reciprocal shaping of theory and practice* (Lather, 1991, p. 172). The theory we were developing came directly from our reflections on practice and in turn the theory itself shaped the midwifery practice we were attempting to describe.

In 1994 we presented the model at the NZCOM conference in Rotorua and this version was published in the NZCOM Journal (Guilliland & Pairman, 1994). By 1995 when we published the model in a monograph, we had provided more description and made some modifications to the model in order to make our meaning clearer (Guilliland & Pairman, 1995). For example, the terminology used to define the philosophical underpinnings and the theoretical concepts differs between the two versions. The model is still evolving. In 1997 I examined the model again as part of research for a masters degree, and presented a refined model that reflected the

findings of the research and the feedback of the participants (Pairman, 1998a; *ibid*, 1998b; *ibid*, 1998c).

No doubt the model will evolve further. As the midwifery profession in New Zealand develops and matures, so too does our understanding of the practice of partnership. As we practise we change the context in which we practise and the context in turn shapes our practice. Our practice then changes to reflect this new context. And so it goes. Through this cycle of practice and reflection, or praxis, we develop knowledge of midwifery and of practice. The one constant is the fundamental relationship between one woman and one midwife in the shared experience of childbirth. This relationship is at the heart of midwifery. In our recent history the context of midwifery practice changed so markedly that midwives and women lost this relationship, experiencing only moments of it in a fragmented and medicalised system. But we never lost the dream of it. In spite of the reality of the practice contexts in which we worked we knew that midwife meant 'with woman'. We knew that the WHO definition of a midwife expressed what we could be. We knew midwifery was different to nursing. Those early battles of the Midwives Section of NZNA were important steps to reclaiming our autonomy as midwives. We knew these things and so did women. They knew that midwives could be different - could help them take control of their own births instead of trying to control it. Their confidence in us built our confidence in ourselves. And when the legal barriers to being the kind of midwives we knew we wanted to be were removed, it was women who helped us find our way. Together we are relearning what it is to be midwives and in this journey together we are learning what it is to be in partnership.

The elements of partnership

Continuity of carer

One of the first things that happened with midwifery autonomy was the opportunity to be 'with' a woman right through her pregnancy, labour, birth and postnatal period. We got to know the women we worked with and they got to know us. Whilst as midwives we had real skill in quickly establishing rapport with women we had not met before and in stressful situations, many midwives were overwhelmed by the different quality of the relationships they could now have. As one

midwife, Heather, said:

"I worked in labour ward ... and you'd come in to a woman who was working hard halfway through her labour. You're a new face to her, you'd never met her before and as much as I found I could quickly and easily build up a rapport with that woman ... and depending on how long the labour process took it may be ... 'oh well I'm terribly sorry I'm off home now bye-bye'.... You've shared that intimate and very special time with them but you're still a stranger ... I'm not denying that when I worked in the hospital you did build up a rapport and trust and all those things but it was very different. You don't know anything of the family and the home situation and all those things that may be important to that woman and influence how she copes with that labour, the birth, the afterwards, the anything." (HA cited in Pairman, 1998, p.69).

Kate also found that the opportunity to get to know the woman over a period of 6 - 8 months made a big difference to her understanding as a midwife.

"I think it helps enormously because by the time you go with that woman into a birthing situation, she knows you, she knows that you know her, she doesn't feel the need to hold up, or present a false face and she knows that you know her in a non-stress situation. You know her in her own home, you know her family. My belief is that she's more able to relax and be herself and just let things happen." (KS cited in Pairman, 1998, p.70).

The relationships that develop between women and midwives through the childbirth experience from early pregnancy to 4 - 6 weeks postpartum were described by the participants in my study as 'professional friendships' because of certain characteristics that were common and similar to those of friendships between women (Pairman, 1998). These characteristics included getting to know each other on a personal level, relating to each other woman-to-woman, sharing common interests, feeling equal to each other and trusting each other. The relationships differed from friendships because of their professional purpose and time-limited nature (Pairman, 1998). The midwife/woman relationship is underpinned by continuity of care because time is intrinsic to getting to know one another and building trust.

Interestingly, in New Zealand we seem to have evolved a model of practice where two midwives work in partnership together. While this midwife pair may be part of a larger group practice, each woman meets only two or three midwives and therefore has the opportunity to get to know her midwives well. We appear to have very quickly tried and discarded the team model where each woman can meet up to six or eight midwives. Some of the earlier critique of partnership in New Zealand (Fleming, 1995) and more recent critique of similar independent midwifery models in the United Kingdom (Renfrew & Garcia, 1998) suggest that women only care about continuity of carer through labour and the rest is unimportant so long as there is a 'continuity of philosophy' amongst the other caregivers. These studies cannot be applied to New Zealand midwifery in 1999. Fleming's (1995) study conducted in 1993/4 looked at independent midwifery in the early development of models of partnership and before the evolution to a named midwife for each woman. Renfrew & Garcia (1998) ask women if they prefer continuity through labour and birth over continuity at other stages without those women having experienced continuity from one or two midwives throughout the entire experience. Obviously continuity in labour and birth is vitally important but it need not be an either/or choice. The practice models that have evolved in New Zealand offer continuity of care throughout the entire childbirth experience from one or two midwives with whom the woman has formed a close relationship. The fact that over 63% of women have taken up this option by choosing a midwife as their lead maternity carer shows we have developed a model that is meeting the needs of women (North Health, 1997).

Continuity of carer allows time for the woman and the midwife (and her midwife partner) to get to know each other, clarify their expectations of each other and develop trust. It allows time to get to know the family and understand the important people and values in the woman's life that will shape her choices. It allows time for discussion and sharing of information that is essential to informed decision-making. It allows time for negotiation of how to work with one another, how to share power and maintain a balance acceptable to both partners. Continuity of carer is fundamental to partnership because it provides the foundation and time necessary

for the relationship to grow and flourish.

Women-centredness

A woman-centred philosophy underpins the midwifery partnership because it places emphasis on the important person - the woman, and it directs midwifery care to the woman as a priority. The woman is seen as an individual within the context of her family and particular circumstances. As Bizz said:

"The midwife spoke about my pregnancy as a whole thing with me, Eric and the baby, rather than just my body and my baby inside it." (BF cited in Pairman, 1998, p. 183). Kate reiterated this when she said:

"It's the whole family dynamics, it's the people who are close to her. It's not just the woman, it's everyone that affects her and everything that affects her." (KS cited in Pairman, 1998, p.183).

The focus is on the woman who defines her needs. It is not a denial of the important part the family plays in the woman's life, but rather acknowledges that it is she who has the primary relationship with her family, not the midwife, and it is she who decides how her family will be involved in the experience.

It may be that in the early days of rediscovering the joy of being able to share the whole childbirth experience with women, some family members felt excluded. Again as we mature into our new roles as autonomous practitioners we are learning about how to take the focus from ourselves and put it firmly on the woman and her family. It is the family who will be there when we have gone and part of our job as midwives is to help the woman to strengthen her support systems. As Chris described:

"I take great delight in supporting I used to do all the back rubbing and getting this and getting that and now I take real delight in working for them, helping them to work together because it's their birth. I work quite a bit now at not being intrusive and supporting the husband to support the wife rather than just directly supporting the woman. I guess I do that as well but it's using her support people to do the work, to provide the support to make her feel cared for and loved and supported and everything else so that you're in the background rather than the foreground. But they're all things you learn. That's a progression" (CS cited in Pairman, 1998, p. 101).

Women-centredness just means working with the woman in whatever way she wants. If this means working closely with older family members, such as in some cultural groups, then that is what should happen. For the women in my study (Pairman, 1998), involvement of their families was crucial and their expectation was that the midwife would facilitate involvement of the family in this shared experience.

Practising independently

Autonomy brings freedom to practice. It enables midwives work within the full scope of practice as a midwife. In independent practice the midwife's primary relationship is with the woman and she is first accountable to her, rather than to hospital guidelines or protocols. To work within the full scope of midwifery practice requires continuity of care. This in turn gives time to get to know the woman and her family, to work through informed decision-making, to see the outcomes of decisions made and to develop a relationship of trust with the woman. As Kay says:

"I see what I do now as a complete job not part of it or bits of it or half of it. Because what you and the woman decide antenatally impacts on what happens postnatally ... it's given me freedom in that I am my own boss and I will make decisions with the woman about what happens." (KF cited in Pairman, 1998, p. 73).

Autonomy does not mean practising alone. Rather, it means that midwives will take responsibility for the professional judgments they make and their midwifery actions. These judgments may include deciding when to involve another practitioner such as another midwife or an obstetrician. They may also mean clarifying roles and expectations when working with another practitioner, either because the woman has requested 'shared-care', or because this is clinically indicated. For 'shared-care' to be successful within an independent model, both practitioners must recognise their equal status and responsibility and must be equally involved in decision-making with the woman remaining as primary decision-maker. Good communication is essential. Autonomy and accountability are also learned as we make our transitions from dependent to independent practitioners. As Kate explains:

"Before the Nurses Amendment Act I felt like I was employed, and doing a job, and

to me now, caring for women and being an independent midwife has got a totally different feel about it ... it's a whole lot more commitment ... I feel more accountable. That's been a growth process." (KS cited in Pairman, 1998, p.74).

The recognition of midwifery as an independent profession and what this actually means in terms of partnership, autonomy and continuity of care, is essential to the midwifery partnership. Partnership relies on midwives understanding that their primary professional role is autonomously working with women throughout normal pregnancy, childbirth and the postnatal period. As the maternity system context changes to reflect this primary health model, the next challenge for the midwifery profession is to define meaningful roles for those midwives who, for whatever reason, choose to work as core facility midwives. In a seamless maternity service based on the primary health model of midwifery partnership, these midwives in the facilities become the 'wise women' who facilitate and protect the midwife/woman partnership within the institution. They bring their knowledge and expertise of the institution and of secondary maternity care. They 'midwife' the woman and her primary midwife, supporting the relationship and facilitating the empowerment of all involved. This challenge of maintaining the midwifery model within the medically dominated institutions is one we are only just beginning to address and one that will evolve over the next few years.

Issues of power and reciprocity

The Partnership Model is drawn as two equal and intertwined circles to represent the equality of the partners. Equality is not to do with being the same. Rather it is to do with feeling equal. As one woman in the study, Bizz, said:

"I trusted her professionalism and all her knowledge, but I felt very equal with her ...I didn't feel at any stage that she was in any way above me." (BF cited in Pairman, 1998, p.117).

To feel equal it is important to acknowledge the interdependence of each partner. One is no more important than the other. The midwife cannot practise without the input of the woman who knows herself and her family best. The woman needs the midwife's knowledge and skill. Both

contribute to the relationship and both play a part in how the pregnancy and birth unfold and the outcome of the experience for both. As one woman, Amy, said:

"She was there to do her job and not be bossy and I was there to do a job and not push her around. We just cooperated I suppose." (AA cited in Pairman, 1998, p. 122).

Intrinsic to this equal relationship is the notion of reciprocity. By this I mean a two-way sharing in which both the midwife and the woman are active participants in creating the relationship and both are affected by it. Whilst health professional work is characterised by relationships with clients, there is no expectation of mutual benefit. In the midwife/woman relationship, however, reciprocity is evident and this mutual involvement strengthens and deepens the relationship that has positive effects on both partners. As Chris, a midwife, said:

"It's two way ... that the woman feels relaxed and comfortable, supported ... if she feels she can trust you with herself and particularly the vulnerability in labour ... I think that's a real privilege for us to have that trust, and it works the other way, that you trust the woman to tell you what her needs are and if she's not happy or wants something else." (CS cited in Pairman, 1988, p.122).

Reciprocity involves openness, mutual exchange, shared meanings and shared control (Marck, 1990). Neither partner holds sole accountability for the outcome of the encounter. Rather, *"through the mutual exchange of meaningful personal perspectives, the power to be and become through relation to others is facilitated"* (Marck, 1990, p.52). Reciprocity is a dynamic process characterised by exchange between people related to a common goal or shared purpose.

Because each woman and each midwife is different, no two partnerships will be the same. Both partners are shaped by their own families and value systems, education, gender, class and history as well as the wider context of New Zealand society. For midwives, part of our personal growth is to recognise these influences and the impact they have on who we are as midwives. Critical reflection is a tool that can help us uncover how our practice is shaped by our

assumptions and previous learning. By consciously recognising the underlying beliefs that drive our practice we are in a stronger position to change these if we wish. And sometimes we will need to change the way we do things. Sometimes we will work with women where the differences between us are huge and reaching a common understanding seems impossible. But then partnership is about recognising and accepting the other, communicating, striving for mutual understanding, redressing power imbalance and creating space for both partners to grow in their own way and achieve their own goals. When midwives say that partnership cannot work because ...the woman is poor, or uneducated, or of a different race, or wants the midwife to take charge, or won't participate . . . perhaps the question really is, what it is about that midwife or that situation that means that woman will not or cannot work in partnership with her? Partnership is always challenging and it always involves learning. Sometimes it will be easy and you and the woman understand each other very well and it feels great. More often though it will be hard work and asks a lot of us as midwives.

We have to learn how to work in partnership and this is not something we were taught in our training. Most of us came through education systems and worked in contexts where midwives were placed in positions of authority that allowed them to tell women what to do and thereby deprive them of control. Women trusted midwives as experts who 'know best' and placed themselves in the hands of midwives, giving them authority to make decisions on their behalf. Women still do this and it is tempting to go along with this as the woman's 'choice'. But it isn't her 'choice'; it is a product of our socialisation as women and the dominance of the medical model that sees the professional as 'expert'. This model is in direct contrast to the midwifery model that sees the woman as 'expert' on herself and the midwife as the facilitator for the woman taking control of her own childbirth experience. As Kay described:

"She started out that I would do all those things ... she said 'you tell me what to do about the vitamin K and ecobolic and I'll just do what you say' and I kept saying 'no. no. no' but by the end of the pregnancy she was very strong ... young women with manual labour jobs ... often they are the people who expect to be told what to do rather than the

40-year-old professional woman who has always made decisions and choices and just presumes that will happen ... it's education and expectations and social expectations." (KF cited in Pairman, 1998, p.165).

It is in the shift from the medical model that shaped us to the midwifery model that is in our hearts that challenges so many of us and where our real learning occurs. As Kate said:

"I've got far more belief in women's abilities and trust them to know and be able to do it, and trust my own abilities. I think it's very much more a power-balanced relationship now, whereas perhaps initially it was the worries of landing in the poo that kept things a little unbalanced ... protecting her, protecting myself as well." (KS, cited in Pairman, 1998, p.1 18).

In a partnership both partners recognise each other as having power. They are equal but not the same. It is the balance of power in the relationship that has to be negotiated and mutually agreed. The exchange is not necessarily equivalent but is *"a mutating changing, synchronous pattern of give and take which facilitates the movement towards a shared purpose."* (Henson, 1997, p.79). It is this facilitation that is at the core of the midwife's contribution to the partnership.

Power, according to Foucault (1980), exists around us and in us. It is not property to be given or given up. It is not 'top down' - imposed from above. Rather it *"exists in action"* and is exercised by *"individuals (who) are the vehicles of power, not its points of application"* (Foucault, 1980). Thus empowerment does not involve 'giving' power to another. Rather it involves recognition of one's own power by having one's critical consciousness raised (Lather, 1991). Facilitating empowerment therefore, begins with helping individuals develop a critical awareness of their situation and mobilise resources to take control of their own lives. The tools of empowerment are reflection, self-awareness, self-growth and resources that may be personal, social or economic. Gibson (1991) cited in Jones & Meleis (1993, p.8) defines empowerment as *"a social process of recognising, promoting, and enhancing people's abilities to meet their own needs, solve their own problems, and mobilise necessary resources to take control of their own lives."*

This facilitation or enabling power is at the heart of midwifery practice. When power is reconceptualized as enabling, midwives have access to power within themselves that is able to facilitate the empowerment of others (Falk Rafael, 1996). As Bizz said:

"I've learnt heaps myself so I know rather than having to rely on anyone else. That's another thing that MW was good at - often I'd say 'should we do this?' and she'd say I was doing the right thing - it restored enough confidence in me - it's my baby and I can recognise these things and trust my instincts." (BF cited in Pairman, 1998, p. 167).

This kind of experience is empowering for the midwife as well. Being part of a process where the woman takes hold of her personal power is affirming for the midwife and reinforces her belief and trust in women's abilities as well as her own ability to work 'with woman'.

Power can be exercised in a number of ways. One such is resistance. The woman who is never home when we call or who doesn't attend for antenatal appointments may not be unable to work in partnership but rather exercising her personal power by resisting our midwifery care or our approach to her. Again, critical reflection on practice can help us challenge our own practice so it is dynamic and evolving, able to respond to women's individual needs.

When power is shared, so is responsibility and accountability. In a partnership each partner is responsible for the contribution they make and both are accountable for the decisions they make together. This is another learning curve for midwives and women, made more difficult by our socialisation into the 'professional as expert' model that still dominates the context in which we work, despite generally increased understanding of notions such as informed choice and consent. In learning to work in partnership midwives need to role-model behaviour that promotes self responsibility. For example, being clear with the woman about your own boundaries and need for time off, and then sticking to these. On the other hand, shared responsibility doesn't mean that midwives can abdicate their professional responsibility. The only reason the midwife is involved with the woman is because she brings professional knowledge and skills of childbirth. The

bottom line is the well being of the woman and her baby. So every professional judgment cannot be a 'choice' for the woman to make. Nor can professional judgment be used as a rationale for imposing actions on a woman. It comes down to clear communication and trust, talking through the possibilities, the 'what if s?' the bottom lines. It requires time.

Negotiating power and control is complex and time consuming. It requires critical awareness of who we are and the forces that shape us. It requires listening and talking and working things out. It is what partnership is all about.

Ultimately partnership is about self-determination - the woman's, our own, the midwifery profession's - it can be individual and collective (Guilliland, 1996). The process of working together with women in partnership is emancipatory for us all. By taking hold of our own power we begin to understand childbirth in new ways. These new understandings challenge the right of medicine to define and control childbirth, offering instead an alternative model that arises from women's experiences. This new understanding returns control of childbirth to the woman and her family and to the community.

The refined model

A final stage of the study I undertook in 1996/7 into the midwife/woman relationship involved examination of the model of midwifery as a partnership (Pairman, 1998). By this stage the participants had been involved in the data analysis of the study and the findings had been fully discussed. In light of the findings it became clear to me and the participants that whilst the model itself was supported by the research, some minor adjustments could be made to help clarify the meaning of this partnership relationship to women and midwives. What follows is a very brief outline of the refined model of midwifery as a partnership. A more descriptive version will be published at a later date.

The context

In recognising the midwifery partnership within the wider context of New Zealand Society, some of the participants wanted to emphasise the impact the maternity system had on their practice or experience. The ideology of medicalisation pervades the

maternity system in New Zealand. The dominance of this ideology has been challenged by women in an organised way since the 1950's, and since 1990 midwives and women together have been developing an alternative model of maternity care. Medical resistance to this alternative model, particularly 'midwife-only' care as experienced by most of the women in this study, has been extreme and public. Midwives and doctors are redefining their roles and relationships as a consequence of midwifery autonomy and women's choice of midwife as lead maternity carer. The wider political interests of the various professional groups also influence collegial relationships. These competing claims are being played out in the public domain and in time some form of temporary stability will be reached. In the meantime, though, women and midwives are exposed to the issues and the debate through the media and perceive their relationships and practice as being under intense scrutiny. The participants suggested the addition of another circle around the partnership to show the midwife/woman relationship within the context of the maternity system and health system. The outer circle would then show the wider context of New Zealand society, culture, the Treaty of Waitangi and the environment and the influence on the whole of history, gender and class.

The woman

Along with her knowledge of herself and her family, the woman brings her life experience, intuition and wisdom to the midwife/woman relationship (Guilliland and Pairman, 1995). The woman also brings certain expectations of the midwife and the kind of professional care she will receive. The women wanted midwifery care based on trust, respect, equality and openness. The women wanted to be actively involved in their care, to take responsibility for themselves and to be in control of their childbirth experience. In identifying the midwife/woman relationship as one between women, both partners bring themselves as women to the relationship. Thus, within the woman circle I have added the concepts of 'seeking professional care', 'seeking active participation, self-responsibility and control', 'seeking trust, respect, equality and openness' and 'being female'.

The midwife

The midwife contributes her midwifery

intuition, scientific knowledge and experience to the relationship (Guilliland & Pairman, 1995). The midwife also brings other essential attributes that contribute to a successful relationship with the woman. Discussed under the broad theme of being 'with women', these attributes are the way the midwife utilises knowledge, skill and self in her midwifery practice; her accessibility to the woman; the way in which she provides emotional support to the woman and her specific skill in supporting women in labour; and the way she brings herself as a woman to the relationship. In identifying the relationship as one between women, the participants in this study valued the different relationships they have with women as compared to men. These relationships were characterised by equality, intimacy, connectedness and listening. Thus, within the midwife circle, I have added the concepts of 'being female', 'giving support', 'being accessible', 'using knowledge, skill and self in practice' and 'being with'. In addition to the ability to be 'with women', the midwife also brings her ability to reflect on her practice and to develop and trust her practice wisdom.

Because of the importance of independence to the professional status of midwifery and the practice of midwifery as a partnership, each midwife must fully understand the meaning of independent

practice. The notion of independence is more than just a philosophy; it affects every aspect of the midwives' lives and is part of who they are as people and as midwives. Independence must be practised by the midwife and is therefore included in the midwife circle as 'practising independently'.

The philosophical underpinnings

The philosophical underpinnings in the original midwifery partnership model are supported by the findings of this study, emphasising the importance of these to the successful development of a midwifery partnership. Partnership, as described in the model, relies on the midwife (at least) holding these philosophical positions, which direct the practice of midwifery.

Theoretical concepts

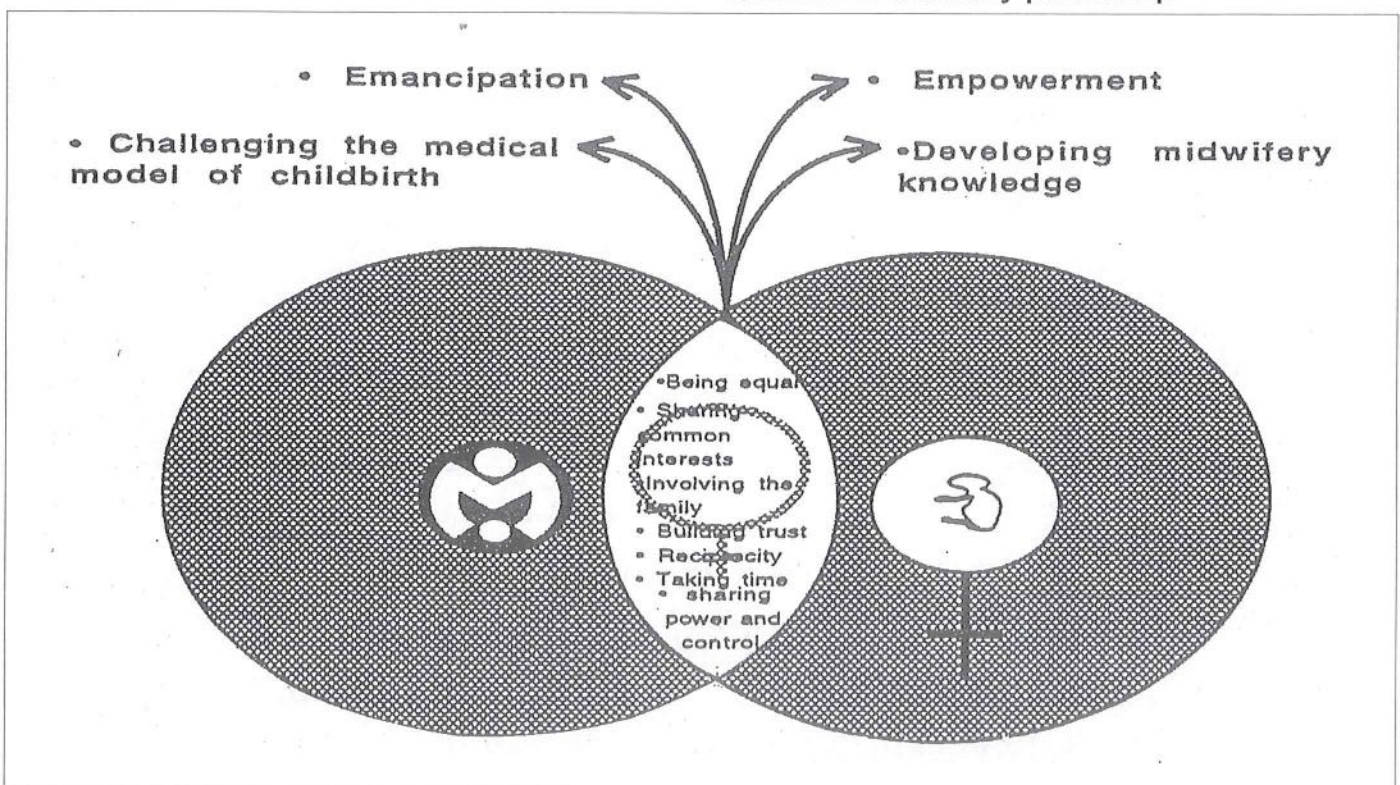
In examining how the midwife and the woman worked together, this study has enabled some 'teasing out' of the original theoretical concepts. It was found that, along with the midwife as a person, the concepts of 'being equal', 'sharing common interests', 'involving the family', 'building trust', and 'reciprocity' were important elements of the midwife and the woman getting to know each other. In working together the other main concepts were 'taking time' and 'sharing power and control'.

All the original concepts are still present but have been presented in a more specific way. This should increase our understanding of how the relationship works and what actually goes on between the two partners within a midwifery partnership. Empowerment is the only original concept not covered by the new concepts and this will be discussed below (Diagram 1).

The outcomes of the midwifery partnership

In the original model, empowerment was identified as occurring for both the woman and the midwife as a consequence of the partnership relationship. This notion is supported by the findings of the study. In addition, the midwife/woman relationship has been shown to have emancipatory consequences for the woman and the midwife as they recognise the existence of oppression within the maternity system and within society and begin to help others learn about this oppression. Within this study, the development of new knowledge about midwifery and birth and the challenge this alternative model of care poses to the medical model of childbirth, are two specific outcomes that result from empowerment and emancipation within the midwife/woman relationship.

Diagram 1 - Principles inherent within the partnership model and outcomes of midwifery partnership

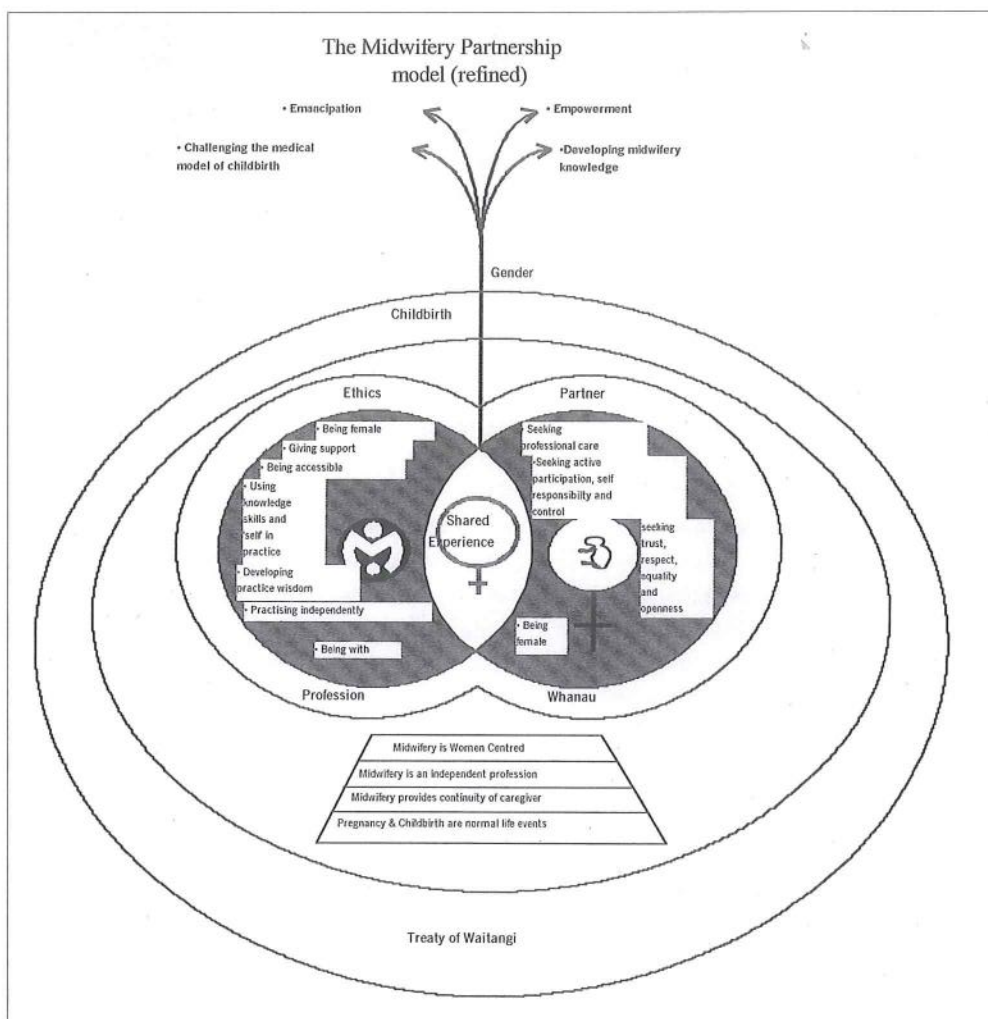


The original model does not show outcomes of the relationship although outcomes are discussed in the text description of the model. These outcomes are now added to try and demonstrate the dynamic nature of the relationship. As has already been discussed, the midwife/woman relationship exists within a certain timeframe and for a specific purpose. As we have seen this relationship can have empowering and emancipatory consequences for the woman and the midwife. In addition, through the practice of midwifery described in this study, midwifery knowledge is developed and the medical model of childbirth challenged.

Where to from here?

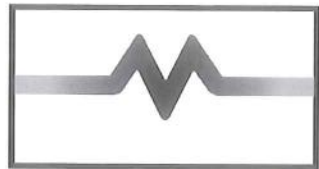
In revisiting the model of midwifery partnership I have attempted to address its central tenets and show how our understanding of these develops as we experience partnership with women. There can never be a time when we have got it 'right' for as in any relationship there is a constant process of communication and negotiation. Every relationship is different and as midwives our important skill is in remaining open to women and ourselves, thinking critically about our practice and how we can be more effective partners *this time, for this woman*.

I often hear statements like "partnership is thrashed to death" or "it's just rhetoric". Statements like these worry me. What partnership offers midwifery is a way to practise in congruence with our philosophical beliefs. There is nothing special about us just because we are women and midwives. We too can become a profession of 'experts' holding power over women and denying them control over their childbirth experiences. Just because our expertise may be in maintaining the normal does not make it any better than medicine's expertise. The only thing we can offer women is a different way of practising - in partnership - sharing power, negotiating, being equal, being accountable for ourselves. It is not easy and it doesn't happen just because we all say "I work in partnership with women". The challenge for midwives is to truly understand what partnership means and requires of us and to *practice partnership* wherever we work.



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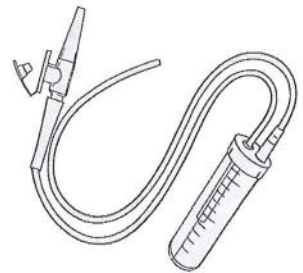
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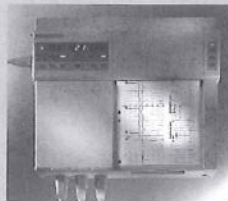
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Midwifery Partnership: Individualism Contractualism or Feminist Praxis?

■ Joan Skinner - Midwifery Lecturer
Victoria University,
Practising Midwife.

I have looked after Moana through two pregnancies and am currently looking after her for the third time. Moana is young, Maori and poor. Through her first pregnancy she was a street kid and heavily into glue and alcohol. She delivered prematurely and the baby went to relatives. The next baby was stillborn. Her third pregnancy was my first contact with her. She was off the streets but was a heavy drug and alcohol user. She was almost impossible to find; making appointments didn't work. She was morose, uncooperative and uninterested. One visit in particular I remember clearly was on a beautiful sunny morning She was at home but so were a group of her friends. They were all drunk and stoned. I did not stay long. She delivered the next day at 32 weeks. An aunt took the baby. On my one postnatal visit to her she told me to 'f. off out of my life'. "Once Were Warriors" looked like a picnic.

Prior to her fourth pregnancy she had a bad car accident but had been unhurt. This had changed her perception of the world somewhat and she was now off illegal drugs although alcohol and tobacco were still a very real problem for her. To me she seemed amazingly transformed and was happy to have antenatal visits with me. She subsequently shifted frequently, became lost to me for a while but did deliver at term and did breast feed for at least two weeks. I think we both enjoyed our visits together. I certainly enjoyed sharing a bit of her life and I think she trusted me and was quite happy for me to be about. I think that my input made little appreciable difference to her life. It was simply part of the rich tapestry of human interaction, each touching the others life for a while. For me it was a privilege.

I made 23 postnatal visits to her and but only found her five times, once in the local shopping mall. She did not attend for a 6-week check nor for her repeat depot injection.

As a practitioner I have struggled with the concept of partnership. I care for low income families. They are usually poor, dispossessed and non-Pakeha. They are often either suspicious and uninterested or overly compliant with no expectation of control. The midwifery partnership model is meant to involve: "... trust, shared control and responsibility and shared meaning through mutual understanding" (Guilliland and Pairman, 1995, p.7). It sounds good in theory but if I was to use this model in my practice it would mean that I would be left with a continual sense of failure as I strove towards negotiated control and responsibility but was inevitably left without it. What I have found in my practice, however, is a great sense of enjoyment and privilege as I build relationships with women whose lives I would never have otherwise touched and who have come to know me enough to trust that I will treat them with respect and honesty. It is not a partnership, it is a relationship.

So where then, and why, does the partnership model fail? Is it just a model for white, articulate, educated, middle-class women? Is it a model of unattainable perfection and if so is it any use? Surely a midwifery model should be most useful for the women who need good midwifery care the most: the poor, the inarticulate and the dispossessed? In this article I look at two sides of the partnership model as it has developed within New Zealand society, analyse these perspectives in terms of how it is presented within midwifery and look at some of the implications for practising midwives.

Guilliland and Pairman (1995), in their monograph, "The Midwifery partnership: A model for practice" discuss the relationship between the development of the partnership model and the developments within New Zealand society. They speak of the contribution made by the

debates around biculturalism and the Treaty of Waitangi and by the growing concern for issues concerning women. They did not, however, analyse the impact of the enormous philosophical changes that we saw both in the political and social life of New Zealanders which I think has contributed significantly to the concept of partnership.

Partnership as Individualist Contractualism

Politics of the 1980s in New Zealand changed radically. Partly as a response to fiscal crisis, the Government did a major about face in the philosophical approach to its role. A general ideological shift to the right led to the growth of individualism as a core belief. The government minimised its role in what had been previously considered state affairs. This resulted in corporatisation, privatisation and deregulation. Competition became a central concept in state activities including health. Choice and consumerism became of paramount importance (Boston, 1991). The implication of this was the growth of contractualism in which both social and political life is interpreted as a series of contracts. Partnership in this context can be seen as a manifestation of individuals contracting with each other. The language of the midwifery model of partnership tends to confirm this. Guilliland and Pairman (1993), state that partnership is dependent on the integration of "... individual negotiation, equality, shared responsibility and

empowerment, informed choice and consent." (p.44)

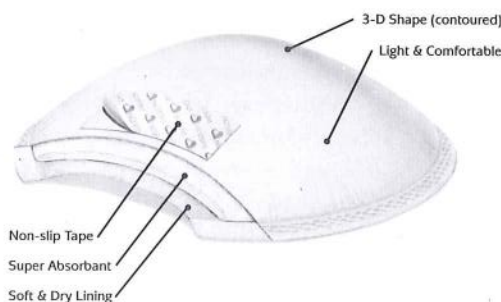
The drawbacks of contractualism are, however, that it fails to recognise unequal distributions of power and lacks the sophistication necessary to handle complex social relationships. It also leaves the agent (the midwife) accountable for all negative consequences. Moral and cultural factors tend to be ignored and questions concerning levels of delegated responsibility, limits of external control, types of monitoring, and levels of transparency remain unanswered (Boston, 1991). One of my major concerns about partnership as a model is that it does not make explicit the extent of the enormous power imbalance between midwife and mother especially regarding the differing knowledge bases from which they both come. It presumes that full and informed consent is always possible. This can leave both the midwife and the consumer extremely exposed. It also assumes that all women work from a basis of wanting partnership and control. In my experience this is often not true.

Yeatman (1995) in her article on contemporary contractualism makes clear that the origins of a contractual relationship reside in choice but that in actual fact in most cases of contract it is more a matter of appropriate participation, a concept I would more comfortably sit with. She is less

negative about the effects of contractualism and states that, for example, contractualism has worked well for the "... so-called 'new social movements' - feminism, the gay and lesbian movements, the various anti-racist, multicultural and indigenous people's movements" (Yeatman, 1995 p. 126). We could include the midwifery profession in this group as, in partnership with consumer groups, we have made remarkable progress in the last ten years. Partnership between midwifery and the consumer organisations has I think been extremely effective and powerful, and I would see the continuation of this partnership as crucial for the effective survival of both groups. It is partnership in the real sense of the word where both sides have the freedom and the power base to negotiate an equal explicit relationship with each other. However, I think it is dangerous to assume that because contractualism or partnership can be successful at a group level that it will automatically be successful at an individual level.

It is probably worth pausing here to look at the issue of bi-culturalism as much of what has been achieved through the Waitangi Tribunal is possibly an effect also of the current mode of contractualism. The Treaty of Waitangi is a contract and at its core was the concept of sovereignty or *tino rangatirota*, not partnership. In actual fact it was Sir Robin Cooke in the Court of Appeal in 1987 who first used the term partnership as a concept in relation to treaty issues (Christie, 1997). Christie proposes that neither Maori nor Pakeha had any commitment to being equal partners and that it is a modern construct. Guilliland and Pairman's premise that it is the Treaty of Waitangi which has taught us about partnership is incorrect. In actual fact contemporary contractualism has redefined the Treaty for us as a partnership. Maori may be more likely to want "*tino rangatirota*" respected and acknowledged. Central to the settlement of Treaty claims have also been the concepts of protection and equity. Protection means the protection of both partners and equality has inevitably meant equal ownership and control of resources and of access to power. Neither of these concepts I feel bears any

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resemblance to what is usually happening within the relationship of the midwife and the woman. I certainly do not mean to denigrate the vital importance of the Treaty for New Zealanders both Maori and Pakeha, but to see it as one of the origins of midwifery partnership is, I think, mistaken.

Partnership as Feminist Praxis

For practising midwives it is crucial to come to a profound understanding of the nature of patriarchy and its impact on society, on women and on birth. "The health care system, as all of her aspects of our society, operates within a structure which has to now be openly acknowledged as patriarchal. It is a system that 'treats' normal life processes as illnesses, and has no formal place for the basic health and human caring concerns of our nation's people" (Watson, 1990 p.62). It is Watson's opinion that the patriarchal world view is the issue in health care, health care policy and politics (Ibid.). This is especially true for midwifery which of its very being fronts up against the medical model on a daily basis. Midwifery is, as Katz-Rothman so eloquently puts it, a feminist praxis. She states:

"Midwifery works with the labour of women to transform, to create the birth experience to meet the needs of women. It is a social, political activity, dialectically linking biology and society, the physical and social experience of motherhood. The very word midwife means with the woman. That is more than a physical location: it is an ideological and political stance. Midwifery represents a rejection of the artificial dualisms of patriarchal and technological ideologies" (Katz- Rothman, 1989 p. 170).

If one assumes that midwifery is essentially feminist, then it should follow that the midwifery partnership model also is. However, when looking at the reality of practice it becomes obvious that there are some inherent weaknesses when trying to apply partnership in feminist terms. The danger of midwifery partnership as feminist praxis is that we need to assume some reciprocity about the meaning of birth between midwife and the woman. Both must share an understanding of the political nature of the decisions made around birth choices. We must then acknowledge that midwife and mother can be working together towards the same goals. The fact is though that many mothers do not understand the nature of what is being challenged and that they are

often going against the medical model by undertaking care by a midwife. What in effect often happens is that the mothers are still functioning with the assumptions of patriarchy and the medical model absolutely unchallenged while at the same time exploring the realities of midwifery care and appreciating the extras that it provides. A major concern that I feel for midwives is that in assuming we have a partnership with women, we expose ourselves to risk.

Examples of this exposure to risk can be found, not uncommonly when outcomes of birth have not been good. The midwife and the mother have formed a partnership, or have thought they had. They have jointly come to a decision about a proposed course of action, which may or may not be acceptable in current medical thought. The midwife discusses the possibilities with the woman and leaves her to make the decision. All is well provided the outcome is good. But when the outcome is not good the mother may, and often does return to analysing the situation from within the current paradigm, i.e. the medical patriarchal one, often with pressure from extended family and doctors. This is often the case even when a poor outcome would have happened even with medical protocols applied. The family moves paradigms, often rejecting the validity of any partnership agreement. The dominant ideology resurfaces. The midwife on the other hand is never in a position to reject the tenets of the agreement she has made. My question would be: can a partnership be valid where one party has the ability not only to extricate herself from the contract at any time but also to treat it as if it had never existed?

I think many midwives do not fully understand the nature of this paradigm conflict and expose themselves to unknown risk. I also think that consumers of maternity care are often confused when confronted with conflicting ideologies and it is the job of midwives to help make the transition to motherhood as smooth and as strengthening as possible. For some midwives and mothers the risks of attempting partnership may be worth it and it may indeed suit their personalities. My concern is that both midwives and mothers should understand the risks, the benefits and the reality of any contract they form. I do also have some concern that the very notion of partnership is in actual fact a patriarchal one in which the notions of negotiation, equality, choice and

consent are stressed at the expense of relationship, respect, trust and caring, and where the complexities of culture, class, value and expectation cannot be fully addressed.

Partnership at the practice level, I think, can be dangerous for the practitioner and misleading for the mother. It reflects a superficial analysis of society, neglecting to identify the dominant underlying right-wing philosophy of individualism, contractualism and patriarchy. It does not recognise inequalities in power, or access to resources and is culturally elitist. Midwifery has the potential to be intensely radical as feminist praxis. Partnership at a practice level does not. It is neither radical nor does it have much to do with what many practitioners are trying to achieve.

I am reluctant to end without offering some hope of alternative models. I was intrigued by Parker's (1997) analysis of the place for midwives in today's post-modern society. She analyses society's philosophical underpinnings quite differently from Boston.

"Today we are part of a social formation that has much in common with modernity but which is significantly different in a number of key areas. This is the era of postmodernity, that has a logic which is tied closely to our current socio- economic forms, changing technologies and the globalisation of culture" (Parker, 1997, p.420).

Bauman (1992), cited in Parker (1997), analyses the nature of today's society as one in which consumerism has taken a central place. It is characterised by variety and variability. She suggests that:

"In contemporary post modern culture, the role of the philosopher is as an interpreter, a mediator, translator or broker, with the function of facilitation of communication between communities and traditions" (Ibid. p. 422)

Parker comments:

"Midwifery, like all contemporary spheres of practice is within and part of a stable and coherent social formation known as post modernity. If midwifery is to have a place in this contemporary social formation, it must accept this and be open-eyed and hard headed about the implications for its practice of current social formations, institutional powers, discursive constructs and the nexus of power/knowledge" (Ibid.).

What she is saying, I think, is that midwives have to be much more aware and open to different ways of being in the world and be able to respond appropriately. She goes on to say:

"This means that midwives need to locate themselves in such a way that they can draw upon interpretative reason to mediate between different cultural traditions of childbirth and their implicated truths, virtues and beauties and those of western scientific medicine. Productive hybrids of practice must be constructed, that treat a multiplicity of cultures and a multiplicity of truths, virtues and beauties as worthy of their attention and respect" (Ibid.).

To insist on partnership as a model for all does presume a homogeneous population both willing and able to be partners. This will never be true. I was very heartened by reading Parker's article. I had personally abandoned the partnership model in my practice as the only way of being with women. Indeed, we might instead be post modern in outlook and describe the midwife as 'paradigm broker', moving between world views, between the multiplicity of the lives and experiences, hopes and aspirations of the families we care for. This is the model which is the 'non model', requiring sensitivity, skill and respect. It can apply in all situations, with all families, at all times, across all cultures.

One could also propose as useful the 'Health for All' model which has been proposed by the World Health Organisation since 1978 and is still very relevant today. This focuses care on the woman, her family and community. The implications for midwifery are considerable. It views midwifery care as being provided within the context of an integrated primary health service and involves five concepts:

1. Equity of the provision of health care.
2. Services should be promotive, preventative, curative, rehabilitative and integrated.
3. Services should be effective, culturally acceptable, affordable and manageable.
4. Communities should be involved.
5. Intersectoral collaboration between those dealing with housing, environmental pollution, food supply should occur (WHO, 1988, cited in Bryar, 1995 p.88).

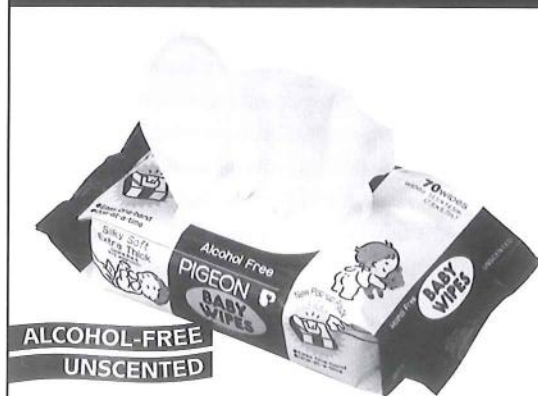
This would be a real challenge for midwives in New Zealand. We have tended to model our practices on those of doctors, developing isolated practices which lack interdisciplinary cooperation and integration. The result is that we care for mothers in isolation from other health care providers, from their surrounding communities and from the implications of societal pressures and changes that affect their health. Perhaps this model could be seen as one of Parker's "productive hybrids of practice".

So there are options. It is important as midwives that we develop models which not only work but that enhance our individual practice and protect and promote the health of the families we care for. They should also have the potential to be radicalising and expansive, not only of midwives and mothers but also of the communities in which we all live. I have not found the model of partnership at a practice level to be particularly useful. I accept the wonderful advances that we have made in collaboration with consumers to preserve and enhance both midwifery care and maternity practice in New Zealand and I am committed to the full participation of consumers within midwifery's professional organisation, but do not accept that partnership at a practice level is either possible or desirable as a useful model to take us through to the next stage of our development.

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PIGEON



Midwifery Partnership: Individualism Contractualism or Feminist Praxis?

■ Cheryl Benn - Associate Professor
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Commentary

It is 10 years since the establishment of the New Zealand College of Midwives as the professional body representing the interests of midwives, and six years since the Guilliland and Pairman (1994) model of partnership monograph was published. The critique of any practice, publication, model or institution is necessary if changes and growth in a profession are to be realized. Critique should not be aimed at the person but at the practice, object or model - a principled approach in which the goal is a wise outcome reached efficiently and amicably (Ury and Fisher, 1963). As part of the coming of age of a profession and its journal it is also necessary for opposing opinions and critique to be published. Article 19 of the Universal Declaration of Human Rights (1948) states that "Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers" (<http://www.un.org/Overview/rights.html>, retrieved 16/9/99). Freedom of expression and opinion, however opposing or controversial the views may be, are basic tenets and the inalienable rights of members of the human family, and are a means of promoting discussion and stimulating growth in a profession. The articles published in any

media don't necessarily represent the views of the profession or group or the editorial board and a disclaimer to this effect may be found on the inside cover of almost every professional journal. This commentary therefore is not to indicate that one opinion is better than another but to present another viewpoint which I hope will stimulate further discussion, debate and thought about the way midwives practice.

Skinner's article is a critique of the partnership model (Guilliland and Pairman) and of the foundations on which it is purported to be based. In this commentary I address two main issues, the first being the validity of the critique that partnership only works if the women are "white, articulate, educated, middle class". The second issue is the opinion expressed that partnership is not a foundational principle, which underpins the Treaty of Waitangi, New Zealand's founding document.

Partnership and Compliance

The explication of the partnership model was a bold step forward at a time when midwives internationally and in New Zealand were just starting to regroup and define themselves as different from nursing and from the medical profession. Some midwifery/nurse- midwifery models and some maternal-child nursing models had been developed by midwife academics/clinicians such as Jean Ball and by nurse academics/clinicians such as Reva Rubin and Ramona Mercer. Some of these models attempted to encapsulate the whole childbearing process while others focused on a portion of the process such as the postnatal period. Despite this apparent reductionist focus, these researchers/theorists did indicate that factors from the preconception period, the pregnancy and the social situation in which women live their lives have a major impact on what happens, for example, in the postnatal period. One aspect of a pregnancy cannot be seen in isolation from another or be separated from the context of women's lives. The partnership model, on the other hand, is an attempt to prescriptively describe the childbearing experience in which midwives are the lead maternity carers. I have chosen the word prescriptive to identify the type/category of model it is and to indicate that in many ways it is an ideal

conceptual model, a goal to be strived for. However, at the same time it is a description of the way some midwives practice. This latter point is being examined through research projects currently being undertaken or recently completed for academic qualifications. Examples include Sylvester's (1999) study of the first antenatal visit, Pairman's (1998) study on partnerships or professional friendships, Fleming's (1998) examination of the partnership model and Calvert's (1998) study on decision-making in the midwife-woman relationship. These studies are adding to or leading to the modification of our understanding of the concepts of the partnership model and future studies should continue this process.

The scenario presented at the beginning of Skinner's paper is a good example of how individual and complex midwife's relationships with women are. Each woman is different and cannot be expected to comply with a standard view of the way pregnant women should be or should behave. I have deliberately used the word comply because I wonder if the issue that makes 'partnership' so difficult in relation to women who are other than white, middle class, educated and articulate, is that they do not comply, that they are 'naughty'. These women make it very difficult and risky for midwives to provide the care midwives think they should have. Compliance is a word/concept that does not fit well with midwifery and woman-centred care. In a review article by Wuest (1993) most of the literature considered was from the disciplines of nursing or medicine, and in relation to compliance with drug prescriptions or treatments. Maternity-related research in which compliance is mentioned refers to the use of bedrest for the treatment of women with pregnancy problems (Josten et al, 1995; Laursen, 1973; Crowther et al, 1992). Compliance suggests that someone (the health professional/midwife) is in charge and should be obeyed, while non-compliance suggests the woman is naughty and/or disobedient. Authors (Wuest, 1993; Buchmann, 1997; Rapley, 1997) have suggested that noncompliance is one way people/women who are not so well educated or powerful in terms of finances, possessions, or the skills of verbally articulating their needs or points of view, can exert or exercise their personal power. They do what is right for them in the context of their lives or as they view the world. As Wuest states: "This

(feminist thought) requires entrance into a dialogue that ultimately leads to understanding of the personal, social, and political factors that determine what this person views as possible and desirable at this point in time" (p.223). It may be a different view and may make midwives vulnerable to, or fearful of, litigation if things go wrong but that does not negate the possibility of a partnership existing. It all depends on how partnership is defined.

According to Skinner, Guilliland and Pairman (1993), state that partnership is dependent on the integration of "... individual negotiation, equality, shared responsibility and empowerment, informed choice and consent." (p.44). But does this mean that it is a contractual relationship or does it merely mean 'midwives and women are in this together'? As midwives and women talk with each other, work together when they meet for antenatal visits, labour and birth care and postnatal visits, they negotiate (talk about) needs, desires and practices with each other. The key is communication, as how will woman know how midwives work unless they tell the women and their families.

It is possible that on both sides some needs or desires may not be negotiated or discussed but will be done; for example, defaulting on or cancelling agreed antenatal visits. Does this mean that the woman and the midwife are no longer in partnership (in it together)? It may be that the midwife doesn't like what the woman has done, feels vulnerable and does not want to be subject to litigation if something goes wrong, and therefore refuses to work with the woman. Alternatively the woman may not like the verbal or non-verbal scolding she has received from the midwife and will withdraw or no longer want to 'be in it together'. Where does this leave both parties? Midwives feel guilty but relieved to be out of the situation and wonder how they can still work with women who want to work differently from the way they would prefer. If they remain in the partnership, they live in fear of the risks to their career, their livelihood and their personal lives. Documentation is an essential action that will not necessarily reduce the incidence of, but rather the risks associated with, litigation and will provide some of the evidence needed to explain the actions or decisions taken.

The woman may either find another midwife or health professional to provide her maternity care or may receive no care at all, with risks to herself and her baby. Would this scenario be any different if one gave the relationship between the midwife and the woman a different name? Is the issue what we call it or is it how the midwife and woman work together and the difference it makes to the woman, her baby and family, and to the midwife?

Partnership as a foundational principle of the Treaty of Waitangi.

According to a brief history of the Treaty of Waitangi (<http://aotearoa.wellington.net.nz>, retrieved 16/9/99), the treaty gave "the rights of governorship to the crown while guaranteeing a much stronger form of chieftainship over their land to the Maori". Whether this was intended to be a partnership is not mentioned in the Treaty but it is clear that the Maori (indigenous people) and the British (colonists) were to live in New Zealand. They were in it together. The one group was not intended to have sovereignty over the other but each would have sovereignty over their own group.

In *Treaty Issues*, a book which is a result of the study undertaken by Walter Christie (1997) of history, politics, economics, finances and sociology, he claims that "there can be no possibility that the Treaty of Waitangi formed a sovereignty partnership" (p. 13) and that the majority of the Maori chiefs accepted being governed by Britain. This is an interesting claim, which Christie further explicates through his book, with the assertion that all race-separatism and neo-tribalism, which is a result of the Treaty movement, should be abolished and that this would result in "equality both constitutionally and in every practical sense" (p. 165). Some other prominent people in New Zealand express similar views today in a book titled *Maori sovereignty. The Pakeha perspective* (Archie, 1995). For example, Glyn Clayton, editor of the *Christchurch Mail* for nearly 10 years states "... if we have Maori sovereignty, ... we have tribalism and tribalism is what's bugged up the world since it began" (Archie, 1995, p.37). In contrast, Sue Culling, the national coordinator for the funding agency CORSO sees Maori sovereignty as "Maori people regaining control, ... will mean there is a future for us and our kids" (Archie,

1995, p.91). In *Maori Sovereignty: The Maori perspective* (Melbourne, 1995), Hekia Parata, the manager of the world-wide consultancy firm, Arthur Andersen, "likens the Treaty of Waitangi to a marriage partnership which is never absolutely equal" (p.44). She goes on to say that "It becomes a dynamic relationship... We have to be flexible about what will work in a given circumstance and what, overall, is the net benefit for everybody." (p.44). This view concurs with that expressed in the partnership model, where equality is defined as "having equal status" (p.45), and where the relationship between midwife and woman is dynamic and flexible. As with the Treaty of Waitangi, in the midwifery partnership/relationship, the one person (the midwife) is not to have sovereignty over the other (the woman) but is to use her power, which is within, as she works with the woman, who exercises her inherent power during the childbearing experience.

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The organisations involved include the NZ College of Midwives, Nga Maia o Aotearoa Me te Wai pounamu, La Leche League, the Royal NZ Plunket Society, NZ Lactation Consultants Association, Parents centre, Dietetic Association, HHS Maternity Managers Network, Royal NZ College of General practitioners, Home Birth Associations, Pharmacy Guild, Ministry of Health, NZ Association of Neonatal Nurses, Healthcare Aotearoa, Crown Public Health, Family Education Services, Healthstar pacific, Federation of Women's Health Councils, Maori SIDS Prevention programmes, Perinatal Society and the Practice Nurses section of NZNO.

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Midwifery Partnership - A Consumer's Perspective

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I agree that we need to debate the concept of 'partnership', otherwise we risk that it becomes stale and empty rhetoric. Like Joan Skinner, I recognise the difficulties some midwives and birthing women face in putting partnership into practice. I do not agree, however, that we should therefore discard the word or the principle.

I am a consumer who has been actively involved in the home birth movement since the mid-1980s, and has had links to the New Zealand College of Midwives from its inception. This includes being a consumer representative on the National Committee between 1992 and 1997. My interest in maternity politics and feminist politics more generally has taken me into university studies and I am now completing a PhD on the ways in which the Aotearoa/New Zealand Home Birth Associations are responding to the health sector restructuring in the 1990s. Thus, my understandings of partnership are shaped by my dual positions as a consumer and a sociologist and by my observations of the unfolding of this concept over the last fifteen years.

Skinner makes a number of arguments with respect to partnership that I would like to comment on. My approach is somewhat different to Skinner's. I start from the premise that words or concepts like 'partnership', 'contracts', 'patriarchy', 'feminism' and even 'midwifery' all have multiple, shifting and contextualised meanings. In a way it could be argued that, more than anything else, the term 'partnership' is an argument against something - hierarchical, status based relationships between health professionals and consumers - rather than for something. Its meanings are defined simultaneously by what it opposes and by the debates amongst those midwives and consumers who are attempting to construct new ways of 'doing' the relationships between midwives and consumers individually and collectively. This approach comes out of postmodern feminist thought and it has political implications. It suggests that we can not 'discover' one true meaning of partnership. However, we may be able to agree that definitions of partnership may need to be flexible to take account of different contexts, and, that some ways of defining partnership may be less favourable than others. Skinner points to what some of these might be.

Firstly, Skinner suggests that midwifery partnership has been overtaken by 'new right' ideas of contractualism which ignore unequal distributions of power and access to resources. Furthermore, she argues, contractualism is culturally elitist and denies the complexities of social relationships. Certainly, over the last decade we have seen a great extension in the use of contracts in the health sector, not only the contracting out of health services and employment contracts for those who work in the health sector, but also the Code of Health and Disability Services Consumers' Rights and the lead maternity carer concept in Section 51. It is, perhaps, not possible for midwives and birthing women to escape the growing shift to contractualism. We can, however, think critically about how we each want to practice it.

Midwives can choose to ignore issues of differences in knowledge, cultural understandings and access to resources which may occur between midwives and birthing women. Or, they can think about partnership as a way of addressing these differences in the relationships they form with clients, through recognition, respect, sharing information and what is sometimes called 'women led care', where the midwife works to meet the needs of a client, as the client herself defines these. I think it is problematic to suggest that only white, middle class, educated women can assess and articulate their own needs.

Skinner remarks that one problem for midwives and birthing women is the continuing prevalence of the "patriarchal medical model" of birthing which can resurface, particularly when there have been unexpected outcomes. Thus women sometimes reframe events in hindsight and become critical of the midwifery care they received. Women, however, also do this with respect to medical care - and choose midwifery care for subsequent births. These, I suggest, are risks which are not confined only to partnership, but risks of any professional relationship, just as unexpected outcomes are a risk of birthing itself. An issue for midwives is that the medical model of birth is more supported by the political and legal institutions of our society

than is the midwifery model. Challenging this and establishing more credibility for midwifery is part of the continuing political engagement for midwife and consumer activists, and the concept of partnership is one of the resources we can use in this struggle.

Another argument made by Skinner is that some women are not interested in partnership. I have heard a number of midwives assert this, but I have never met a woman who did not want to be treated with

respect and understanding by her midwife. I have met women who are not interested in making decisions about issues such as Vitamin K or the management of third stage. For some women in the context of all the innumerable decisions they have to make on a daily basis, these things just do not seem very important. For another woman in a similar situation, it may be because she does not have control over so many aspects, that control over what is done to/for her in childbirth becomes critically important. But I would suggest it is not much of a

partnership if a midwife dictates a list of decisions that her client must make. Maybe partnership could embrace a mutual agreement on which decisions each person will make.

I am not convinced by Skinner's suggestion that the word 'relationship' is preferable to partnership. After all, there is nothing inherently positive in the word 'relationship'. We can have abusive relationships, dysfunctional relationships and hierarchical relationships as well as good relationships. Partnership is a form of relationship that evokes ideas about equality and working for shared goals. Skinner juxtaposes partnership based on negotiation, equality, choice and consent with relationships of respect, trust and caring. I want to argue that we should work towards practices of partnership that incorporate all of these.

My own story is that I was not always an activist and an academic. I accidentally embarked on motherhood when I was young, single, travelling the world and very, very unprepared. The birth of my baby was, as for many young single women in 1984, an horrendously disempowering experience. I felt I was treated like a transgressive child and I behaved accordingly. I was rude and non-compliant and within 24 hours of having given birth, I had been threatened with a Social Welfare referral.

I begged my doctor to discharge me, which he eventually did, and he organised for a home birth midwife to provide postnatal care. I never felt she was judgmental about my lifestyle, my chaotic house and flatmates, but she helped me find some measure of control over the chaos. She did this by giving me information gleaned from the experiences of other women and her midwifery practice. She presented me with options so I could find my way into motherhood with a few more cards under my belt. In this she conveyed to me something even more important - that I could make the right choices for me and my baby even if they were not the same as the ones she would have made - or that I would make now. She established what we now call a partnership relationship with me. As a consequence, I became an advocate for midwifery, not as it was practised in the hospital where I birthed, but how it was practised in the home birth networks. It also left me with a deep sense of the critical difference good postnatal care can make for a woman's transition to motherhood - but that is another story.

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The Jean O'Neil Case: Civil Negligence in Obstetric Care

■ Rebecca M. Keown
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Abstract

This paper examines the requirements for the tort of negligence as set out in *Bolam v. Friern Hospital Management Committee* in light of professional liability in cases of obstetrical negligence. Focus is placed on the New Zealand Nursing Council decision in the Mary Jean O'Neil case in comparison with the Medical Practitioners Disciplinary Committee decision in the Dr Howard Clentworth case. Criticisms are made regarding the notion that the reasonable midwife standard includes underlying assumptions of the reasonable male practitioner standard. Essentially, it will be argued that this is of negative consequence since the Bolam test is a gendered concept based on the reasonable male. The 'unpacking' of this legal standard reveals that accepted obstetrical practices are falsely assumed to be acceptable and that adopting the reasonable woman practitioner standard alone does not solve the Bolam problems.

Introduction

Since the enactment of the Nurses Amendment Act in August 1990, midwives in New Zealand have been legally able to assume full responsibility for the antenatal, intranatal and postnatal care of pregnant women independently from medical practitioners. (Donley 1990) Although these amendments represent a positive step forward for the midwifery profession and for pregnant women in general, there are those who allege that the 1990 changes to the Nurses Act are the cause of increased cases of professional misconduct on the part of registered midwives (Brett, 1996). Dr Tony Baird, president of the Royal New Zealand College of Obstetrics and Gynaecology claims that New Zealand's standards of maternity care have been reverted back to standards similar to those of the Victorian era (Brett, 1996). He argues that independent midwives hold a dangerous ideological commitment to "natural" or "non-interventionist" birthing which is endangering the lives of women and babies (Brett, 1996).

This paper, through focusing on the recent decision of the New Zealand Nursing Council in the Mary Jean O'Neil (NZNC, 1998) case, will examine the requirements for obstetrical liability in the tort of negligence and will argue that the charge of professional misconduct in the O'Neil case is not consistent with the charges that an obstetrician or medical practitioner would face in similar circumstances, as was seen in the Dr Howard Clentworth case. The inconsistency between the Nursing Council decision and that of the Medical Practitioners Disciplinary Committee is due largely to the notion that the "reasonable midwife standard" carries an underlying gendered concept of the "reasonable practitioner", or the Bolam test, found in the requirement for civil negligence, and due to the notion that the medical model of childbirth is in essence synonymous with this standard.

Case Background

The following section will provide a brief outline of the two cases that are the foci of this paper.

Mary Jean O'Neil Case

On March 24 and May 21, 1998 the Nursing Council of New Zealand found Lower Hutt midwife Mary Jean O'Neil guilty of professional misconduct on the grounds of negligence (NZNC, 1998) in the November 30, 1996 (NZ Herald May 1998) birth of a severely brain damaged baby, Cullen McMillan, who later died (Catherall, 1998.) After a long labour, O'Neil ruptured Mrs. McMillan's membranes, noted fresh meconium and contacted an obstetrician who performed an emergency caesarean section (Stent, 1997). A complaint was filed with Health and Disability Commissioner, Robyn Stent, who stated that O'Neil had breached Right 4 of the Health and Disability Consumers' Rights Code which provided all consumers with a "right to services of an appropriate standard" (Health and Disability Commissioners Report, 1997). The Nursing Council then found O'Neil guilty of failing to arrange for a satisfactory CTG, promptly act upon the abnormal heart rate and contact a specialist and inform Mrs McMillan of the risks to the fetus (NZNC, 1998). The Council ordered that O'Neil's name be removed from the midwifery register, that she only be allowed to continue practising as a registered general and obstetric nurse under supervision for twelve months and that she pay \$21,592.60 towards costs (NZNC, 1998).

Dr Howard Clentworth Case

In June 1994 the Medical Practitioners Disciplinary Committee censured Lower Hutt obstetrician Howard Clentworth for 'conduct unbecoming a practitioner' on the basis of professional misconduct in the birth of a permanently brain damaged infant on August 16, 1991 (Medical Practitioners Disciplinary Committee, 1994). He was found guilty of conduct unbecoming for failing to satisfy himself that staff were monitoring the labour, to communicate properly with the mother in the postnatal period and to provide the mother with adequate postnatal care (Medical Practitioners Disciplinary Committee, 1994). The Committee ordered that Dr Clentworth be censured, pay a penalty of \$500 and pay \$24,734.35 which amounted to 50% of the costs of the inquiry (Medical Practitioners Disciplinary Committee, 1994).

Regulating Professional Conduct

A. The Tort of Negligence

In New Zealand, there are three categories for which a medical practitioner can be found liable under the law of torts. The categories are, in descending order of seriousness, disgraceful conduct in a professional respect, professional misconduct, and conduct unbecoming a medical practitioner (Deutsch, 1990). Medical negligence, which O'Neil was found guilty of, would rank as the mildly serious offence of professional misconduct (Deutsch, 1990) whereas Clentworth was found guilty of the lesser offence of conduct unbecoming a practitioner. According to Black's Law Dictionary, negligence is defined as "the omission to do something which a reasonable man, guided by those ordinary considerations which ordinarily regulate human affairs, would do, or the doing of something which a reasonable and prudent man would not do" (Nolan, 1990). In order for the tort of negligence to be recognised a plaintiff must establish that a duty of care was owed by the doctor to the patient, that the doctor was in breach of the appropriate standard of care imposed by the law, that the breach of duty caused the patient harm or injury recognised by law as meriting compensation and finally, that the extent and quantum of the loss that has followed from the breach of duty is recoverable in law (Kennedy & Grubb, 1989). In both O'Neil and Clentworth a duty was owed by the medical practitioner to the pregnant woman and her child by the mere fact that the consumers were under their care

and, in the case of O'Neil, were protected under the newly instituted Health and Disability Consumers' Code of Rights of July 1996.

The notion of civil negligence as defined above first surfaced in a very primitive form in a Roman statute of responsibility called the XII Tables from which evolved an objective duty of care (Deutsch, 1990, p.287) This duty recognised as standard the behaviour of the diligent bonus paterfamilias (Deutsch, 1990, p.287. Paterfamilias essentially means the 'good father of the family'). This standard eventually became based on conduct "which a prudent man would have pursued under the same circumstances" first used in the 1837 English case *Vaughan v. Menlove* where a man was found negligent of constructing a hay-rick too close to his neighbour's property which ignited causing the neighbour's house to burn to the ground. The defendant was found guilty of negligence on the grounds that a prudent man would not have stored the hay in a manner that could cause it to ignite. Twenty years later, in *Blyth v. The Birmingham Waterworks Co.* the man of ordinary prudence became the "prudent and reasonable man" (Parker, 1993).

B. The Bolam Test

The standard of care owed to the consumer by the medical practitioner is determined by the standards set out in the 1957 English case *Bolam v. Friem Hospital Management Committee*. In this case, an action was brought against a physician for providing Mr. Bolam with electroconvulsive therapy without administering a relaxant drug or restraining his movements by manual control. As a result, Mr Bolam suffered fractures of the pelvis (p583). The Queen's Bench ruled that Dr Allfrey was not culpable and Justice McNair clarified that a physician "is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act" (p.587). In *Sidaway v. Bethlem Royal Hospital Governors*, Lord Diplock termed this the Bolam test or the reasonable person standard.

Almost fifty years since Bolam the reasonable practitioner standard is still used in deciding medical negligence cases. This is evident in the O'Neil case where the Nursing Council adopted the "standard of a reasonably competent midwife in similar circumstances" and found O'Neil guilty of professional misconduct on the grounds of

failing to meet this standard (NZNC, 1998). Similarly, Clentworth was found guilty, by the Medical Practitioners Disciplinary Committee, of conduct unbecoming a medical practitioner for failing to provide a reasonable standard of care to his postpartum patient (Medical Practitioners Disciplinary Committee, 1994, p.255). Although the Nursing Council adopted the reasonable midwife standard against which to measure the behaviour of O'Neil this paper will question whether that standard did not actually involve a tendency towards a male, medical model of the reasonable practitioner. In a society where the field of obstetrics is dominated by male physicians is it truly possible for the "reasonable midwife" to be disconnected from the heavy hand of medicalisation?

A Gendered Notion of the Bolam Test

The following section of this paper argues that since the "reasonable midwife standard" can often take on presupposition of the reasonable practitioner this standard, as it currently exists, is appropriate in name only. The tendency to pack the presumptions of the reasonable practitioner standard or Bolam test into the reasonable midwife standard should be abandoned. The difficulty with the Bolam test is that it involves a gendered concept that excludes the female perspective, presumes falsely that medical practices that are accepted or employed by the medical profession are acceptable practices and perpetuates the notion of unfavourable power imbalances between obstetricians and midwives which results in unjust treatment for women in cases of civil negligence.

A. The Fiction of Universality

The purpose of the Bolam test is to provide an objective, universal standard against which to judge the behaviour of medical professionals in similar circumstances. Essentially, this standard views as proper medical practice which conforms to the attitudes and beliefs of responsible schools of thought within the medical profession. This school of thought is most often that shared by the dominant group of practitioners in society (Parker, 1993, p.107). As is evident from the history of the reasonable practitioner this standard is not objective but is rather biased towards male perspective (Parker, 1993). When the reasonable man (used to mean human kind)

standard was adopted in *Vaughan v. Menlove* in 1837 no woman in the entire Western world was eligible to vote; women were not even considered to have full legal capacity (Parker, 1993, p.108). Thus, the reasonable man standard was exactly that a standard which took into consideration what a prudent man would do in similar circumstances. Even though the name of the standard has been changed to the reasonable practitioner standard, to provide gender neutrality, the requirements are the same as they were under the previous name; the perspectives of women are still ignored and thus it lacks universality (Parker, 1993.p.108.; Allen, 1988, p.424).

In *Ethics and Action*, Peter Winch discusses the spectrum along which moral judgments lie (1972, p.151-170). At one end lies the universality position, advocated by R.M. Hare, which argues that once individuals have taken into account what is at stake each will weigh the components in the same manner and arrive at the same conclusion; if a different answer is arrived it will be considered wrong (Winch, 1972 p.160). On the other end of the spectrum is the relativist position, advocated by Protagorus, which reads "whatever an individual thinks is right will be right" or a "man is the measure of all things" (Winch, 1972, p.164). Winch does not take either position but argues that if an individual says that an action is the morally right action for her to take and if another individual similarly situated says that the action advocated by the previous individual would not be the morally right action for him to take both individuals would be correct provided that what they considered to be at stake was similar (Winch, 1972, p.160). In essence, the Bolam test would lie at the universality end of the moral judgments spectrum since the actions of the "reasonable" practitioner are used as an objective standard against which to measure behaviour. Winch criticises universalizability in a manner that also serves to criticise the Bolam test. He argues that when individuals are weighing what is a stake in a situation they will not always come to the same conclusion even though the elements of what they are basing their decisions on are the same; they will tend to weigh certain elements higher than others would (Winch, 1972, p.164-5). The following sections will attempt to show how the Bolam test lacks objectivity.

B. Accepted versus Acceptable Practice

A second criticism of the Bolam test is that it presumes that the notion of a practice being accepted as a school of thought by a responsible body of medical opinion is sufficient for that practice being considered acceptable. This position is similar to the reasoning used in the Protagorus position of moral judgments - if A believes that X is the right thing to do for a patient, then X becomes the right thing for A to do by the mere fact that A thinks it is (Winch, 1972, p.165). Ian Kennedy and Andrew Grubb also share this criticism of the Bolam test (Kennedy and Grubb, 1989, p.460). They claim the test fails to separate description (explaining what the current state of common medical practice is) from prescription (determining minimal standards for what acceptable medical practice ought to be) (Kennedy & Grubb, 1989, p.460). This confusion of terms is problematic since there is a wide range of understanding between medical practitioners, especially between midwives and physicians, of how pregnancy and childbirth should be managed (McLoughlin, 1993, p.67).

In addition, this semantic confusion poses legal problems for medical practitioners, like English consultant gynaecologist and obstetrician Wendy Savage, who introduce more women-centred practices into their care (Sheldon, 1998, p.30). Savage was suspended from her position in 1985, but was eventually exonerated, pending an investigation into a case where she had allowed her client to have a trial labour even though the baby was in the breech position and would probably need to be delivered by caesarean section (Sheldon, 1998, p.30). She believed that it was psychologically important for women to experience for themselves that vaginal delivery was not a possibility. Essentially, her suspension was as a result of failing to conform to malestream standards of medical practice (Savage, 1987). Ironically, there was no evidence to suggest that her practice posed any greater risk to her patients than any other and the investigation into it did not arise as a result of complaints made by her patients. Since her practice was not considered accepted by a responsible group of medical opinion it followed that it was therefore not considered to be acceptable practice.

C. Power Imbalances in Obstetrics

A third criticism of the Bolam test is that it perpetuates an unfavourable power imbalance between midwives and physicians which results in unjust treatment for women in cases of civil negligence. In their article on "Knowledge and Power in the Clinical Setting", John McMillan and Lynley Anderson (1997) argue that Howard Brody's understanding that physicians possess Aesculapian (Greek Asklepios God of Medicine) power (by virtue of the physician's medical training), charismatic power (based on the physician's personality characteristics) and social power (arising from the social status of the physician) accounts for the power imbalance in physician patient relationships but it does not account for power imbalances between junior and senior physicians (McMillan and Anderson, 1997). In order to account for this type of power imbalance another category of power needs to be added to the scheme - that of hierarchical power (McMillan and Anderson, 1997, p. 270).

This notion that medical practitioners possess both social power and hierarchical power also accounts for the power imbalance between physicians and midwives under the tort of negligence. In comparing the O'Neil and the Clentworth case, the midwife has Aesculapian power due to her professional training as an independent midwife and she has charismatic power as a result of her personality characteristics. Under the midwife-client relationship she also has social power by virtue of her being a medical professional within the healthcare system. Like the power imbalance between junior and senior doctors, there is also a power imbalance under the category of hierarchical power between the midwife and the physician. It is worth noting that not all power imbalances are unfavourable. Sometimes it is desirable to be on the lesser end of a power imbalance, especially if you are a patient in need of medical care.

Unfavourable power imbalances between midwives and physicians often occur as a result of an over tendency towards technology or an interventionist position on the part of the physician. Generally, physicians and obstetrician tend to over-medicalise pregnancy and childbirth by categorising pregnancy as either low or high risk, employing technologies which inevitably lead to other technologies being used (MacDonald, 1992) and labelling pregnant

women as patients which contributes to their assumption of the sick role (Sherwin, 1992, p. 196). Technology itself is seen as powerful because it represents progression, innovation and making unhealthy patients well again. Since physicians, rather than midwives, take the interventionist approach they are bound to be viewed as having more power in the technological sense. This is evident in the O'Neil case when O'Neil finally called in obstetrician Howard Clentworth who performed a caesarean section on Mrs McMillan. At the Nursing Council hearing it was Clentworth who provided evidence against O'Neil claiming that she had waited too long before obtaining help. Before the Nursing Council Clentworth was viewed as having the greater hierarchical power because of his status as obstetrician and his ability to use the most current technologies in dangerous situations. This also accounts for Clentworth's lesser charge of conduct unbecoming a practitioner before the Medical Practitioners Disciplinary Tribunal. As well as their greater power in the technological sense, physicians are also viewed as having greater power than midwives in the social sense (McMillan and Anderson, 1997, p. 267). On the face of it, it appears more difficult to account for the difference in social power between midwives and physicians as it was for McMillan and Anderson to account for it between senior and junior doctors

In the case of the senior and junior power imbalances the cause is a difference in the Aesculapian power that they possess (McMillan and Anderson, 1997, p. 269-270). It can also be argued that midwives and physicians also possess different levels of Aesculapian power. Since midwives are experts in normal childbirth when childbirth becomes abnormal or involves complications they must resort to the aid of, and usually technology of, an obstetrician. Since the obstetrician is trained in using this technology, he is viewed as having more Aesculapian power which, according to McMillan and Anderson, accounts for his increase in social power (McMillan and Anderson, 1997, p. 270). The Bolam test or reasonable practitioner standard perpetuates this hierarchical and social power imbalance between the midwife and the physician by essentially basing the reasonable practitioner standard on the perspectives and experiences of the average male physician. Through recognising this perspective as the right perspective not only are midwives left with

less hierarchical and social power than physicians but their practices are also considered incorrect simply because the physicians view other methods as more favourable.

Fixing the Bolam Problems

A. Reasonable Woman Practitioner Standard

As was outlined above, the difficulties with the Bolam test are not with the notion of having an objective 'yardstick' against which to measure the subjective experiences of the practitioner but rather with the nature of this yardstick (Allen, 1988, p.420). Essentially this nature revolves around the notion of the reasonable male perspective. It is useful to incorporate the perspectives and experiences of women into this allegedly objective standard in order to provide a more universalised approach to examining cases of civil negligence and professional misconduct. In cases of sexual assault or physical and mental abuse, the use of the reasonable woman standard makes women's accounts believable "within a system that puts the reasonable man on a pedestal and denies legal protection to unreasonable behaviour" (Cahn, 1992, p. 1408). Likewise, in cases of obstetric negligence the perspectives of the female medical practitioner would be taken into account and would not be found unacceptable by the mere fact that male physicians did not support such perspectives.

In her article on "The Looseness of Legal Language" Naomi Cahn points out two general theoretical underpinnings of the reasonable woman (p.1401). The first perspective is the "sameness" theory which explores the similarities between men and women and argues that the reasonable woman standard is too limiting and would support the reasonable person standard since it is applicable to both sexes. The difficulty with the sameness theory is that it uses a male perspective to explore similarities and differences between men and women (Cahn, 1992, p. 1411-1413). The second perspective is the "differences" theory which is concerned with the differences between men and women and the similarities among women (Cahn, 1992, p. 1411). A differences theory would argue that the reasonable person standard is not sufficient since only the language rather than the underlying content has changed (Cahn, 1992, p. 1411). This theory would advocate both a reasonable woman standard that takes into account the

perspectives of women and a reasonable man standard that incorporates and recognises the different perspectives of men (Cahn, 1992, p. 1411). In the following section this notion of the reasonable woman standard will be taken further to include the reasonable midwife standard of care.

B. Reasonable Midwife Standard

The challenges to the Bolam test need to go beyond a feminist objection of the assumptions of reasonableness (Cahn, 1992, p. 1404) to include challenges to the model under which the behaviour of the practitioner is measured. It is worthwhile examining the notion of reasonableness in light of the model of pregnancy and childbirth which it presumes to be accepted in order to show that the difficulty with the Bolam test is not just gender based although it is tightly packed into the concept.

When dealing with obstetric negligence the reasonable person in the Bolam test is a male medical practitioner operating under the medical model of pregnancy and childbirth. Essentially the medical model involves two basic elements. The first element is the mechanisation of the human body which focuses only on the specific ailing parts of the individual resulting in a fragmented and objectified understanding of the body (Bryar, 1995, p. 55). The second element concerns the understanding of the nature of disease where the disease process is viewed as independent from the patient (Bryar, 1995, p. 79). In contrast, the New Zealand midwifery model of childbirth recognises as problematic the fragmentation of the body and thus tends to the physical, as well as the psychological, aspects of the pregnancy and birth. In addition, the non-interventionist midwifery model empowers women to detach themselves from the "patient" label often given to them under the medical model and to recognise that they are pregnant within a unique, interconnected web of relationships (Bryar, 1995, p. 82) Under this model the midwife and her client form a professional partnership through discourse (Guilliland and Pairman, 1995, p. 23) In order to modify the reasonable practitioner standard to be used in cases of obstetric civil negligence where a midwife is involved it is necessary for the "reasonable midwife standard" to include both a subjective and a semi-objective element. The subjective component would examine the course of events and the action the midwife took or failed to take at the time

and the semi objective component would measure the findings of the subjective component against the yardstick of a reasonable midwife similarly situated (Cahn, 1992, p.62). Peter Winch's position on moral judgments would work well for this standard since he recognises that individuals who share the same moral background can arrive at different moral decisions and both be correct in their judgments (Winch, 1972, p.165).

Conclusion

In conclusion, there is a need to expose and challenge the foundational presumptions of the law that society functions from a 'common sense' perspective (Sheldon, 1998, p. 31). This view of the world is not only falsely universal but is packed tightly into a malestream notion of the reasonable practitioner. The Bolam test should be re-examined to include perspectives of the female practitioner under the midwifery model of care rather than solely those of the male medical practitioner under the medical model. From the arguments made above, it is evident that the O'Neil case should be examined using the reasonable midwife standard, which is distanced from the heavy hand of medicalisation, rather than the reasonable practitioner standard or even the reasonable woman standard. Therefore, in civil negligence, a "truly integrative standard which imports notions of relationships and interconnectedness should be employed so that the standard of care reflects 'caring for' and not simply 'being careful'." (Parker, 1993, pp. 111-112).

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The Magical Moment of Birth - a Biochemical Perspective

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A baby is about to be born

Roughly 40 weeks from the date of the last menstrual period or 38 weeks after conception human labour begins. What causes labour to begin? This is not just an academic question. An understanding and appreciation of the basic biochemistry and physiology involved makes it easier to support women in labour by optimising the natural processes involved, as well as confronting the problems of preterm (or post term) labour.

Normal length of gestation is highly species specific and in general labour occurs when the growing fetus has lost the need for dependence on the respiratory and excretory functions of the mother. Therefore, the timing of parturition is closely related to the stage of maturity of the fetus. The basic structure and function at a cellular level in the uterus ensure that normally gestation proceeds and that the fetus is not expelled long before term, but that the powers and passage are primed and ready to go at the appropriate time. This is determined by maternal hormonal state which determines cervical ripeness and uterine contractility. For sheep, exciting research that was pioneered by Professor Liggins, of the National Women's Hospital in New Zealand in the late 1960s, showed that the fetus initiated labour, (Liggins, 1979). This work led on to the use of prostaglandins for promoting cervical ripening, and the maternal administration of glucocorticosteroids, such as dexamethasone, for promoting lung maturity in the fetus.

In humans (and other primates) however the process proved to be both different and more complicated, with (some!) of the pieces of the puzzle only coming together over recent years (Pepe et al, 1995; Mesiano et al, 1997; Miller, 1998; Smith, 1999).

Some biochemical/physiological aspects relating to the passage and power

The two key tissues in the uterus are the muscle cells, or myometrial cells, and connective tissue. There is a progressive increase in the proportion of connective tissue towards the cervix and a corresponding decrease in muscle cells. Connective tissue is non-elastic and resists expansion. Muscle tissue is elastic and can expand. The result of this distribution is that throughout most of pregnancy there is a slow distension of the body of the uterus which is high in muscle cells and low in connective tissue. By contrast, towards the cervix, the higher proportion of connective tissue resist distension and the cervix remains closed. Under the influence of progesterone, the cervix acts as a sphincter with the collagen fibres held tightly together, helping to ensure retention of the fetus and protecting it from infection, a process aided by progesterone stimulated cervical mucous. As well the lower segment of the uterus, with relatively high content of connective tissue, also functions as a sphincter and, until labour is imminent, the presenting part is kept high and unengaged.

With the onset of labour, softening of the cervix is required, allowing effacement to occur. The required 'ripening' of the cervix is the result of changes in the structure of the connective tissue. Connective tissue consist of protein collagen fibres in a matrix of mucopolysaccharides (a specialised type of complex carbohydrate also found in Whartons jelly). During pregnancy these collagen fibres are tightly packed in a regular structure. By contrast in the 'ripe' cervix there are fewer collagen fibres and they are loosely and more randomly distributed. There is also more mucopolysaccharide and fewer collagen fibres. As well the type of mucopolysaccharide is different. Dermatan sulphate, which binds tightly to collagen fibres, predominates early in pregnancy. Keratan sulphate, which preferentially binds to water instead of collagen, is present in much higher concentrations in the ripe cervix. (A way of visualising this is when a resin backing on a fabric degenerates loosening the fibres and allowing them to be pushed apart), Leppert (1995), Hutton (1986).

These changes in connective tissue allow cervical effacement and are triggered off by the action of locally produced prostaglandins, particularly prostaglandin E and by the production of collagenase, an enzyme which breaks down collagen fibres. It happens gradually, about 2-3 weeks before the onset of labour a visible sign being when 'the head drops'.

The walls of the uterus contains two major sheets of involuntary muscle that provide the power at birth. But their elasticity enables the growing fetus the best accommodated throughout pregnancy. This is achieved by the arrangement and distribution of the myometrial cells as described in any relevant anatomy text.

At the cellular level, the myometrium consists of thousands of individual myometrial cells containing contractile fibrous proteins called actin and myosin. During contractions these fibres slide into each other, resulting in shortening of the muscle fibres. This process involves another protein called troponin and is triggered by an influx of calcium ions into the cell. Marked acidosis inhibits this required calcium flux, and hence maternal acidosis may slow labour. Calcium flux is also affected by fluid and electrolyte balance. Labour requires that as many of the individual myometrial cells as possible contract at the same time in a coordinated manner - in other words a good 'team effort'. This requires the formation of connections - 'gap junctions' that link the individual myometrial cells. Both oestrogens and prostaglandins have been implicated in promoting the increasing formation of these gap junctions towards term.

Their presence allows a coordinated intracellular influx of calcium ions and hence a coordinated contraction so that the whole uterus behaves as one large syncytium with peristaltic like waves (Nathanielsz, 1996, Leppert, 1995. & Hutton, 1986). Oxytocin of course stimulates ('switches on') contractions in the uterus. However, for this to happen the oxytocin needs to bind (or 'plug in') to specific protein receptors in the cell membrane. These are not present in early pregnancy and hence the uterus does not contract in response to oxytocin early in pregnancy. Just before and during labour, these receptors appear in increased numbers, causing increasing sensitivity of the uterus to oxytocin in synchronisation with the

softening of the cervix. Both prostaglandins and increasing levels of oestrogens have been proposed to cause this increase, (Leppert 1995, Hutton 1986 and Smith 1999).

Binding of oxytocin to receptors on the myometrial cell membrane promotes calcium flux into the myometrial cells. However an excessive dose of oxytocin (over 8mmU/minute) has the opposite effect (Hutton, 1986). The uterus also has adrenergic receptors (Beta-2 receptors). Binding of adrenalin and noradrenalin (collectively called 'catecholamines') to these receptors inhibits calcium ion flux into the cell. This is the rationale for using adrenergic drugs such as Salbutamol to delay or slow down premature labour. It also explains how stress may inhibit the progress of labour, since, under these circumstances, these hormones are produced as part of the body flight /fight response. (Also, since their production is associated with arousal it may be partly responsible for the fact that most human babies are born at night, or why labour may stop after a mad flurry of preparation!). Appropriately, during the second stage of labour this response to adrenalin switches in the opposite direction - and promotes a 'lets get on with the action no going back

adrenalin buzz' effect in the uterus.

Factors involved in initiation of human labour and the role of the passenger

Traditionally oxytocin is the hormone associated with uterine contractions. This is the basis for the use of syntocinon, but also one of the benefits when after birth the babe is put to the breast. However, while during labour oxytocin is important for stimulating contractions, it does not initiate spontaneous labour. For the actual initiation of labour, factors that have been identified include genetics, myometrial stretch (such as with polyhydramnios, multiple pregnancy) and fetal and placental hormones including increasing oestrogen levels (and relative decreasing progesterone levels), prostaglandins, and other membrane factors (Pepe, et al 1995; Mesiano, et al 1997; Miller, et al 1998; Smith, 1999 and Nathanielsz, 1996).

In sheep it has been shown that the trigger for the onset of birth was the release of the hormone ACTH (adrenocorticotrophin) by the fetal pituitary in response to corticotrophin releasing hormone (CRH) produced by the hypothalamus. ACTH acts

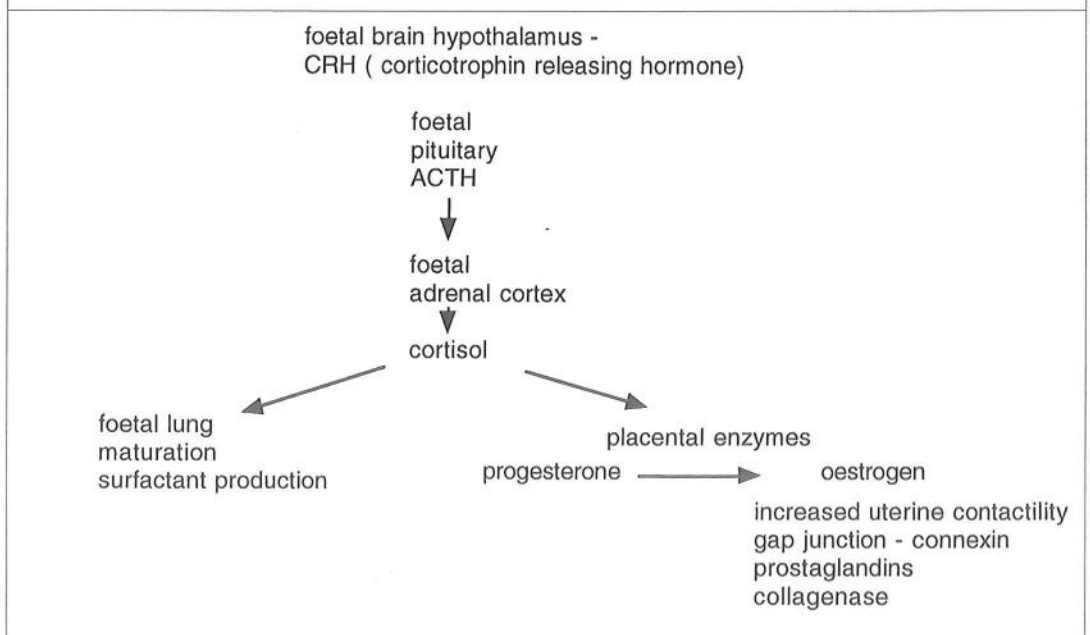
Diagram 1. Events leading to labour in sheep

Prof Liggins, at Auckland National Women's Hospital, using sheep established the prime role of fetal ACTH and fetal corticosteroids in initiating labour.

Thus, for example, he showed that

1. Destruction or removal of the foetal pituitary or foetal adrenal cortex caused gross prolongation of gestation.
2. Conversely, infusion of ACTH into the FOETUS or administration of betamethasone (Betnesol, a synthetic glucocorticosteroid) to the MOTHER, resulted in birth a few days later, even though normal gestation time was only half complete

NOTE ACTH does NOT cross the placenta, glucocorticosteroids DO - and hence can be used prenatally to promote lung maturation in the foetus.



on the adrenal cortex and stimulates the production of glucocorticosteroids such as cortisol. In sheep and in other species, the hormone progesterone has an inhibitory effect on the myometrium. In contrast oestrogens are stimulatory to the myometrium. During pregnancy the hormonal balance is in favour of progesterone effects, with inhibition of uterine contractions. At the end of pregnancy, so that birth may occur, the balance has to be switched promoting myometrial contractions. Hence the onset of labour is associated with a shift to oestrogenic effects. In the fetal lamb this switch over is mediated via cortisol. As the blood from the fetal lamb passes through the placenta, cortisol in the fetal blood stimulates the placenta to produce enzymes that convert progesterone molecules into oestrogens, thus causing a decrease in progesterone and increasing oestrogenic effects (see diagram 1). Thus, in sheep, synthetic equivalents of cortisol, such as dexamethasone (Betnesol, glucocorticosteroid) will promote lung maturation as well as premature labour. However, in humans and other primates, this is not the case. In these species, glucocorticosteroids are effective in promoting fetal lung maturation, but do not cause premature labour. Also, in humans maternal levels of progesterone do not decline. Therefore different mechanisms operate. A key difference that has been identified is that an important source of CRH is the placenta, not the fetal brain. As in sheep, this hormone promotes fetal ACTH production and cortisol production and fetal maturation. In addition, in humans, ACTH with CRH stimulates the production of D H E A - S (Dehydroepiandrosterone Sulphate). This occurs in a specialised section of the adrenal gland which is present only in the fetus. In the human, instead of using progesterone, it is DHEA-S which acts as the precursor for the production of oestrogens. (This knowledge was the rationale for using maternal oestriol levels as a biochemical test for

'fetoplacental function'). However the picture is more complex and has been challenged (Miller, 1998) (so stay tuned !).

It is also incomplete. What trigger causes the placenta to make CRH, and what controls how much is made has not been answered. What has been reported is that CRH levels vary between women. In general, those with the highest levels early in pregnancy (by 16-20 weeks) were most likely to deliver prematurely. Based on this research, measurement of maternal blood CRH has been proposed as a possible clinical tool for identifying mothers at risk of premature delivery, (Smith, 1999). The reasons for these differences are not clear but genetics and nutrition could play roles. It has been shown, however, that once the placenta begins to produce CRH fetal cortisol production will promote its continued secretion. So also in humans, there is fetal input into the onset of labour, optimising appropriate timing of fetal maturity with labour (see diagram 2).

In both humans and sheep, acting in opposition to progesterone, the relative increase in the level of oestrogens promote labour. They do this in part by instructing the lining of the uterus (the decidua) to increase

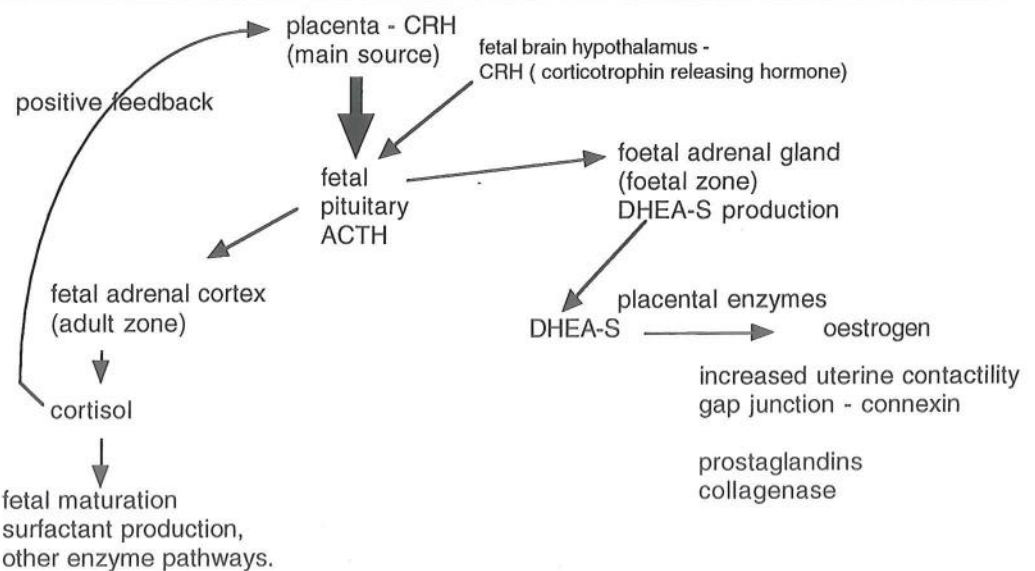
the production of prostaglandins resulting in softening of the cervix, the production of oxytocin receptors and gap junctions that promote uterine contractility in synchronisation with cortisol stimulated fetal maturation. Once started, positive feed forward systems ensure that many factors operate to increase the strength of uterine contractions. This includes increased production of placental CRH in response to rising levels of fetal cortisol (see diagram). But also, stretching the cervix by the baby's head as labour progresses stimulates the release of more oxytocin from the Mother's posterior pituitary gland by way of a nervous reflex along nerve fibres that run from the cervix via the spinal cord to her brain. Rupture of the membranes, spontaneously or artificially, promotes further production of prostaglandins.

Power supplies

Effective muscle contraction requires a continuous input of energy. This applies equally to all muscles, in the endurance athlete or in the contracting uterus. The molecule that provides this energy in a form that is biologically available is called ATP. ATP is produced by enzymatic pathways in the cell by the process of cellular respiration.

Diagram 2. Events leading to labour in women

According to Smith (1999), in women the placenta, rather than the foetal pituitary, is an important source of CRH. This hormone then promotes foetal ACTH and cortisol production, as in sheep. Increasing levels of cortisol promote lung maturity as well as other enzymes required for extra-uterine live for example maintenance of blood glucose by gluconeogenesis. The rising levels of cortisol also promotes the ongoing, increasing production of CRH. With ACTH, CRH stimulates the production of DHEA-S, in the foetal adrenal gland, which acts as a precursor for oestrogen resulting in the changes associated with labour. However this theory has been challenged, and other factors also may play key roles such as prostaglandin synthetase, relaxin, growth factors, cytokines, platelet-activating-factor (PAF), endothelin and nitric oxide withdrawal.



As well as an increase in both the number and size of myometrial cells and the actin and myosin fibres, there is an associated increase in the ATP producing enzymes. This increase facilitates the extra energy production required for the work of labour. Cellular respiration for the production of ATP requires a food energy source such as fatty acids or glucose and oxygen. Ketones, lactate and amino acids can also be used for ATP production, but only in the presence of oxygen. Though some ATP can be produced in the absence of oxygen this process is highly inefficient and comes at a cost, the build up of lactic acid, which may cause acidosis (Newsholme, et al 1994; Aldoretta, et al, 1995). Maintaining a good supply of oxygen, therefore, promotes efficient contractions as well as ensuring adequate oxygenation of the baby. This is compromised in the woman who is severely anaemic due to the reduced oxygen carrying capacity of her blood. For the same reason she will also, of course, develop shock more readily with haemorrhage. Dehydration results in hypovolemia due to fluid loss from the extra cellular fluid compartment. The resulting reduced circulatory volume will result in a less efficient supply of oxygen (and nutrients) to the contracting uterus. Labour increases insensible losses, hyperventilation may result in a loss of half a litre per hour. Absorption from the gastro-intestinal tract is reduced during labour. Therefore it is important to replace fluids early to maintain circulatory volume, orally or intravenously as appropriate. Oral solutions should be hypotonic, since this will promote water absorption. Also hyperventilation results mainly in water rather than electrolyte loss. Nausea associated with the use of pethidine and the risk of acid aspiration syndrome if general anaesthesia is required in the 'at risk' pregnancy may limit oral intake. Hence i.v. isotonic saline may be used in some circumstances.

The preferred fuel for muscles is glucose. Athletes know this and talk about 'carbohydrate loading' and stack up on complex carbohydrates the day before the big event. Fatigue and reduced power output in an endurance event is associated with depleted carbohydrate stores.

Perhaps carbohydrate loading may also be appropriate before the big event of labour! The fetus does, laying down large glycogen

stores in the third trimester. Compared with adults, the term fetus has 2-3 times more liver glycogen, 3-5 times more skeletal muscle glycogen and 10 times more cardiac muscle glycogen (Blackburn, et al 1992; Aldoretta, et al 1995).

During labour and delivery maternal blood glucose consumption increases markedly to provide the extra energy required by the uterus. The hormone insulin is produced in response to a high blood glucose and promotes its uptake and use by cells. During labour oxytocin has been demonstrated to act similarly to insulin and promote glucose oxidation and use. With a prolonged labour, carbohydrates stores may become depleted, and there will be an increased use of fat as an alternative source of energy. High fat use is associated with the production of ketones. Their build up may result in ketoacidosis which will reduce the efficiency of contractions, oxygenation and may aggravate acidosis in the hypoxia fetus. Avoiding a low blood glucose as well as maintaining adequate hydration will help to counter this. For an uncomplicated pregnancy, if there is no pethidine associated nausea or risk of a need for general anaesthesia, frequent small sips of a diluted isotonic 'sport drinks' or fruit juice may be a good idea. They are better than soft drinks or undiluted fruit juice (250 ml - about a cup - will contain 25 g - about 5 teaspoons of sugar!). The latter are much too high in sugar and will result in reduced water absorption, which will be reduced already during labour.

However, a high maternal blood glucose should also be avoided since it may aggravate hypoglycaemia in the neonate. Again athletes know of this and talk about a 'sugar crash'. Both are caused for the same reason - a very high blood sugar peak is followed by a peak in insulin secretion - which then causes blood glucose to drop. Therefore the aim is to provide a moderate sustained supply. After all, labour is generally not a sprint but an endurance event! Another important problem with excessive blood glucose is that, under anaerobic conditions, it is converted into lactate and result in potential lactoacidosis in the neonate. A link with build up of lactic acid in the fetal brain has been proposed as a possible contributing factor to cerebral palsy. However, in utero, the baby has been shown to readily utilise lactate, like glucose, as an energy source provided it is supplied

with an adequate amount of oxygen, but this may be compromised during labour.

A baby is about to be born, the timing the result of sophisticated, subtle two-way communication systems, between mother and babe. Both play key roles in this intimate relationship. The start signal comes from the baby (in conjunction with the placenta), that ensure she/he is ready to go. There is a 'warm up' time, with the production of increasing levels of DHEAS, cortisol, surfactant, glycogen stores and the other molecules and enzymes required for both the work of labour and life outside the uterus. However, as the momentum increases, maternal and fetal mechanisms combine to promote safe, efficient delivery in an amazing team effort.

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Surfing The Net

■ Sarah Stewart - Midwife

I have made a significant move to Dunedin since my last column, to work as a midwifery lecturer. The disadvantages to this move are that I am huddled over the computer wrapped in thermal vests and longjohns, which I have never worn in my life. One of the advantages is that I now have access to a much more powerful computer, which means I can spend even MORE time surfing the net. Here are a few more sites for you to investigate.

<http://whba.homepage.com>

This is the Waikato Home Birth website and one of my current favourites. It gives lots of information about the 'whys' and 'how' of homebirth; advantages of home birth; choosing a midwife; qualities of a midwife, and the rights and responsibilities of the woman. Consumers will find this information invaluable, and midwives can download it for their resource files. It is very clear and attractive, with useful links to other homebirth and parenting sites.

The immunisation debate is presented by the Immunisation Awareness Society

<http://webpages.netlink.co.nz/~ias/ias.htm>

and The National Network of Immunisation Coordinators

www.imac.auckland.ac.nz

Both websites present their views about immunisation, discussing the diseases; vaccination schedule; advantages and risks of vaccination. I found it beneficial to visit both sites and read both sides to the argument.

Action on Pre-Eclampsia (PET) has a web site that provides concise information about PET and gives contact information for the New Zealand branch. Again, useful for midwives to download to give to their clients.

<http://mysite.xtra.co.nz/~nzapec/page1.html>

www.nzhealth.co.nz/health.html

This website gives great links to health organisations all over New Zealand, for example, the Maternity Services Consumer Council, Diabetes New Zealand, Eating Disorders Association, and the New Zealand Epilepsy Association. Another link goes to the New Zealand Incontinence Association. They provide an excellent page about the pelvic floor and pelvic floor exercises. I think this web site is an especially good resource for students.

Dr TJ Sprott has his own web site in which he gives lots of information about cot death, and expands on his theory of mattress wrapping.

www.cotlife2000.com

Now, I know I'm slow off the mark but I have only just found a website that allows access to abstracts of the Cochrane database, free of charge. I'm especially pleased about this discovery because it saves me having to get up and walk across to the library to access the database there.

www.update-software.com/ccweb/cochrane/revabstr/mainindex.htm

Another interesting resource for students of 'pain in labour' is this site.

www.manbit.com

It gives lots of detailed information about pain in labour; the nature of pain in labour; methods of pain relief, and how to prepare for labour. However, one must remember that it is written by four Australian anaesthetists - not that I mean to be insulting, but they may have a particular slant on the subject than a lot of midwives, although they do discuss 'natural' approaches to pain relief as well as medical.

This brings me nicely to my next concern, and that is critique of World Wide Web resources. I have found that I have markedly expanded my use of the Internet in my new role, and have become increasingly aware of the dangers of believing everything you read on the Internet. Virginia Montecino has written some guidelines on how to critique a web site. She has also linked her site to other authors who have written equally useful guidelines. I think these links are very important to utilise as you become more conversant with the Internet.

<http://mason.gmu.edu/~montecin/web-eval-sites.htm>

Another recommendation is for anyone interested in teaching. The Teaching Learning Forum is a website run by the Murdoch University, Perth and is based on a series of annual conferences about teaching. It covers all sorts of teaching issues such as performance assessment of student learning; using the Internet as a teaching tool; development of critical and creative thinking at tertiary level.

<http://cleo.murdoch.edu.au/asu/pubs/tlf/tlf99/contents.html>

Finally, Jane Sandall has written a useful article about using the Internet, and has included some very beneficial website address and databases.

British Journal Midwifery, July 1999, volume 7, number 7, pages 440 - 442. This article can also be downloaded at www.city.ac.uk/barts/midwfdp.htm

Don't forget the New Zealand midwives mailing list that you can subscribe to if you drop me a line at Mazza@clear.net.nz

Finally, in my other current role as mother to a rapidly growing daughter of 11, I found the Tampax website.

www.tampax.co

This website gives heaps of very clear and mother/daughter friendly information and advice about adolescence. I really like the site. I especially like the pages for people who teach school children about adolescence, and the work sheets that you can download that discuss 'growing up', and dispel a lot of myths around this issue.



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International Confederation of Midwives

PRESS RELEASE

July 1999

Midwifery and reproductive health research mailbase list

During the 25th Triennial Congress of the International Confederation of Midwives, held in Manila, the Philippines, in May this year, a meeting was called for any participants who were involved in midwifery and reproductive health research. It was felt there was a need for an open forum for discussion on issues relating to research in these areas.

One of the results of this meeting was the decision to set up a list of interested people. This list will form the basis of an international network of people who are eager to share information (eg. workshops, seminars, conferences and new research) and to promote links, collaborative working, joint problem-solving and mutual support.

How to join the list

If you wish to have your name included on the list -

send an email message to:
mailbase@mailbase.ac.uk

containing the single line:
join midwifery-research firstname lastname
eg. join midwifery-research Jane Sandell

The Mailbase computer will ask you to confirm your membership by sending back a unique code. This is a security measure.

For more information

Further details are available on the website:
<http://www.mailbase.ac.uk/lists/midwifery-research/>

or by sending an email message to:
midwifery-research-request@mailbase.ac.uk

Dr Jane Sandell, Reader in Midwifery, Dept of Midwifery, City University, London E1 2EA, Tel: +44 171 505 5871 Fax: +44 171 505 5866

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The Porirua Union and Community Health service is currently reorganising their maternity services. Applications are called for two full time midwives. These are salaried positions with attractive conditions of employment. The midwives would be at either the local maternity hospital at Kenepuru or the base hospital in Wellington.

These positions would commence in January 2000 or soon after.

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Porirua Union and Community
Health Service,
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Porirua.

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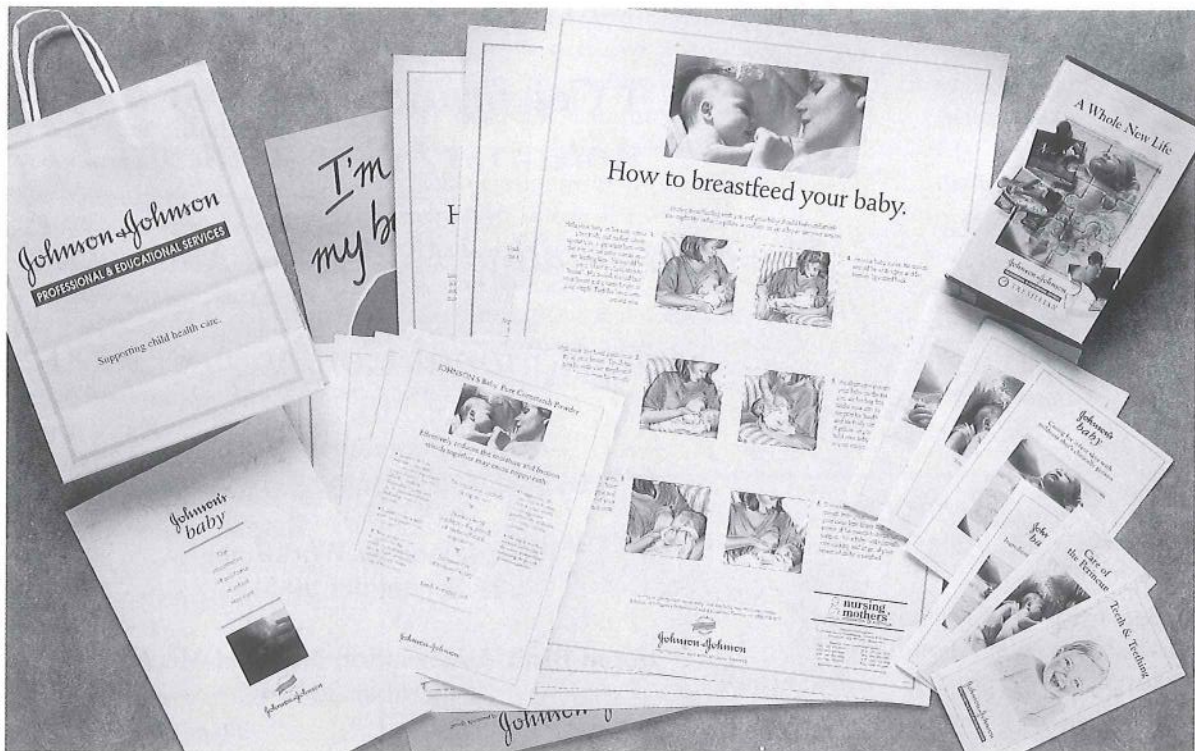
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