

N E W Z E A L A N D

College of Midwives



JOURNAL

JUNE 2000

New Zealand College of Midwives
Education Framework

Understanding toxoplasmosis

Being safe in childbirth: What does it
mean?

Portfolios: A necessary evil?

Surfing the Net

Video Reviews

ISSUE 22

*Congratulations to Karen
on being awarded*

**The New Zealand Order
of Merit for Services to
Midwifery**





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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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Front cover:

Samantha Rendell (mother of two)

Contents

-
- 4** **Editorial** - Gillian White
-
- 5** **Letters to Editor**
-
- 6** **New Zealand College of Midwives Education Framework** - Sally Pairman
-
- 16** **Understanding toxoplasmosis** - Suzan Jeffries
-
- 19** **Being safe in childbirth: What does it mean?**
- Liz Smythe
-
- 23** **Portfolios: A necessary evil?** - Sarah Stewart
-
- 26** **Surfing the Net** - Sarah Stewart
-
- 28** **Video Reviews**
-

Let me introduce you to Gillian White



Gillian successfully completed a direct midwifery programme in the UK in 1971. She commenced practice in the community (although she was told she could only ever work in a

hospital) in Kent, England. Working with a partner in a GP group their caseload, at that time was about 12 homebirths per month.

Having realised she had a yearning for teaching Gillian undertook the Certificate in Clinical Teaching and became the first Direct Entry Midwife to be awarded the Midwifery Tutors Diploma after one years study from the Royal College of Midwives and the University of Surrey.

In 1975 Gillian moved to New Zealand and accepted a position as lecturer in maternal and child health at Wellington Polytechnic in the (then) new RCpN programme. Eight years later Gillian introduced midwifery into the tertiary sector

through the Advanced Diploma of Nursing at Wellington Polytechnic and was President of the Midwives Section NZNA.

Gillian later moved to Auckland Institute of Technology to continue teaching but resigned when it became apparent that midwifery was being subsumed into nursing.

Gillian continued her midwifery practice in a small, rural hospital and at St Helen's Hospital, Auckland until its closure. She spent two years working in a neonatal intensive care unit, and was a member of the direct entry midwifery taskforce.

Being very conscious New Zealand had a paucity of midwifery researchers Gillian joined Auckland Medical school to gain a wider understanding of research and was able to introduce the interpretive framework as a tool in research practice. That led to an opportunity to research primary health care for three years in Australia.

Since returning to New Zealand from Australia, Gillian has been a senior lecturer at Massey University, Albany Campus

specifically involved with teaching research design and methods, midwifery knowledge and maternal mental health. Gillian is the Group Co-ordinator at Albany and the Midwifery Programme Co-ordinator for the School of Health Sciences which includes Palmerston North and Wellington. Research involving transition to parenting and postnatal depression is Gillian's passion.

Working full time throughout her study years she holds a Bachelor of Education, Diploma in Social Sciences (Psychology), Master of Arts (Education), PhD (Primary health Care). Gillian's masterate concentrated on developmental psychology, neonatal development, and parenting. Her thesis is entitled: *Toward Autonomy: An examination of midwifery education in New Zealand 1990*. Gillian's PhD thesis concerned social and sexual boundary issues in medical practice and included an educational programme for medical students.

We are extremely fortunate to secure Gillian's editorial guidance and I know we will all give her our support.



To Helen

The first edition of this Journal was published in 1989. Helen co-edited that edition with Judy Hedwig and over the last 10 years has guided its progress from infancy to maturity as a polished, progressive publication its readers look forward to receiving. A successful journal depends on the calibre of contributing authors. Those authors enjoy the pleasure of seeing their work in print and the gratification when their ideas make a difference. Yet the Editor's contribution is rarely recognised. However, without the support of an enthusiastic and resourceful editor those authors would not be presented in a professional way and the value of their work would not be appreciated.

Helen has supported, guided, and assisted writers to publish their work over the years while applauding the growing pool of New Zealand authors and the burgeoning knowledge base of midwifery related issues. I am in a very privileged position to be able to take up the editorship in Helen's wake. I have been left a valuable legacy of the journal's history including the systems she has set up. Her entrepreneurial skills have placed the Journal in a healthy position and she has been extraordinarily generous in assisting me in editorship. The purple and black cover of the Journal is familiar, recognisable and well-loved, and it will continue to remind us of our first editor - Helen Manoharan.

The NZCOM Journal has come of age and it is important to continue its growth as an internationally respected Journal of New Zealand origin. To that end I would like to encourage the submission of manuscripts concerning midwifery related Research from midwifery researchers. In recognition, however, of the importance midwives hold practice issues it is vital that midwifery practitioners share their experiential and practical knowledge in a section devoted to Practice. To assist students with scholarly writing I urge midwifery students to submit articles to the Student section. Educators also have much to contribute and need a forum to raise midwifery Education issues and initiatives. Contributions from consumers of midwifery care and authors from disciplines which support midwifery practice are also welcome.

Gillian White PhD, Albany Group Co-ordinator
Midwifery Programme Co-ordinator, Massey University

Scope For Improvement

There is scope for improvement in the New Zealand maternity services. However, any scope for improvement must be based on maternal, child and family centred, multi-sectoral research (quantitative and qualitative), and communication. Evidence based research must inform the education and practice of relevant maternity service providers, fund holders, policy makers, and consumers. Sharing of ideas and knowledge and improving maternity care through debate, research and collaborative action, is the only way a transformation can occur. Rival educational organisations and professions committed to publicity regarding their own internal structures, their own agendas and interactions with each other and the State, only serve to destabilise the maternity service and rationalise government interference.

One of the incessant criticisms of the maternity services in the past was fragmentation. Changes to allow continuity of care, particularly within the conceptual framework of a lead maternity caregiver (LMC), have gone some way to address that criticism. Continuity of care allows for the development of trust which is essential in the health professional-patient/client relationship. Midwives in independent practice, for example, have demonstrated the efficacy of providing perinatal continuity of care. However, the concept (including the essential element of trust) has been devalued in that the realities of being an LMC extend beyond a defined scope of clinical practice into that of gatekeeping the socio-economic and political ideologies of the day.

A leading maternity caregiver in the current system is restricted by Section 51 and the market driven changes to the health services. Independent practice (used in its broadest term to mean medical or midwifery, institutional or individual), means competitive practice. While competition may be a powerful force for the market place the tenet of buyer beware (caveat emptor) is inappropriate where health is concerned. As Dyer (1991, p.66) states "The laws and mentality of the market-place have evidently replaced the principles of trust which underlie professional ethics." A user of the health services (maternity services) should not need to beware. They should enter the health arena with the optimal degree of trust.

Currently LMCs are holders, users and manipulators of funds; clinical experts within a scope of practice; overseers of competencies (self and others); counsellors, educators, information providers; and social police (with responsibilities relating to various Acts of Parliament). Each LMC acts according to their personal, professional or institutional philosophy and these are not always congruent. For example, guidelines for the midwifery profession are based on a model of partnership derived from critical social theory and the desire to emancipate and empower women. Guidelines for the medical profession are derived from what has been labelled a medical model based on rationality and an objective, scientific framework designed to improve the health of sick people. Guidelines are collective and do not necessarily reflect the philosophies of individuals, however the point is that all actions (including those by successive government), are guided by an underlying philosophy.

Women, and their families, have been subjected to sensationalist publicity, controlled by a media who have their own agenda in the market-place. Such publicity has contributed to confusion, erosion of an integrated maternity service, attrition on the part of the health professionals involved, reduction of choice, and lack of trust. Rational and critical debate is necessary in order to allow social integration to be based on communication rather than domination. The scope and practice for midwives needs to be recognised and discussed in relation to doctors and nurses. No profession has the knowledge and skills to dominate. The scope for improvement lay in each

profession practising in the way in which each does best and which each is prepared for, underpinned by collaborative and collegial communication and support.

The midwifery scope of practice is to 'be with women' throughout the childbearing cycle. This includes pre-pregnancy preparation and family planning. It also includes offering anticipatory guidance for parents on the care and development of babies and personal, physical and mental health. The transition to parenthood therefore falls into the scope of practice for midwives. Preparation for professional midwives thus includes the sciences, so that care is provided based on knowledge of anatomy, physiology, physics, chemistry, microbiology, mathematics, and empirical research. It also includes the arts and humanities, so that care is provided with an understanding of human development and behaviour, sociological implications of childbirth for women and families (which includes fathers), cultural and spiritual needs of individuals and groups, interpretive research, principles of education and of ethics.

The scope for improvement in midwifery begins with the professional education of students, practising midwives, academics and researchers. Unfortunately the market-place mentality has created a situation where midwifery students are becoming desperate for experience and Schools are competing with each other up and down the country for placements. Independent midwives are demanding compensation for teaching (which used to be accepted as part of the scope of practice), and hospital midwives cannot offer students the continuity of practice that they require. Paradoxically, the provision of that essential element trust in the LMC occasionally precludes the inclusion of a student into that midwife-woman partnership. Gatekeeping, however, is not a role for midwives and it would be sad to see it become one. Midwives should want to assist with the education of students entering into the profession. Indeed, if they do not there will be no midwifery profession in the next decade.

We must be careful not to buy into a theory-practice gap mentality. If we socialise students into the attitude that midwifery is practice and theory is 'ivory tower' then we will remain trapped in oppressed group behaviour. Midwives need to value and promote midwifery, the science and the art, the practice and the theory, the research and knowledge. Above all, midwives ought to value each other, the practitioners, the educators, the researchers and academics, the politicians and the students. If midwives maintain good relationships with each other we will be able to improve the maternity services through debate, research and collaborative action. We will develop trust in the profession, we will not buy into a market mentality, and we will practice as we are best able to with the confidence that we are not oppressed.

In this edition, Sally Pairman, outlines the College Education Framework. Current global trends are toward a knowledge economy. It is vital that midwives contribute to knowledge concerning childbearing and midwifery practice, as leaders in the field. A midwifery student, Suzan Jeffries, demonstrates the value of knowledge when, as a second year at Otago Polytechnic she wrote about understanding toxoplasmosis. This journal welcomes such submissions by students. Being safe in childbirth depends on using midwifery knowledge. Liz Smythe presents her interpretation of the meaning of being safe, taken from her doctoral research based on women's stories. Professional development is the focus of Sarah Stewart's examination of the concept of professional portfolios and is practice oriented. There is something for everyone in this edition.

The Female Principle

Dear Editor,

In the October issue Anne Doherty takes issue with the statement by Deborah Davies that "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".

Anne correctly points out that such a view is not scriptural, but fails to see that Deborah Davies' statement does not refer to the Bible, but to the structures of the Christian Church. These structures have deviated from scriptural truth a long time ago for a very simple reason: those holding positions in the Church realised that they could gain more power and wealth by imposing their own structures and so exploiting religion for their own gain than they could by following scriptural truth.

In her book *The Medical Mafia*, Canadian Dr Guylain Lanctot MD describes how women were considered a threat by the Church and how they were destroyed because of this. Women provided care for pregnant women before and during delivery, for children, and healthcare for the sick and the elderly - care which was based on experience, common sense, love, wisdom and compassion. Herbs provided inexpensive remedies which were available to everyone, rich and poor alike. Women enabled society to be self-reliant and independent from an outside system.

The Church looked at things differently. It wanted society to be dependent on the Church and said that sickness was a punishment from God for the sins one had committed. Sickness, suffering and death were therefore salutary and beneficial and the practice of medicine something to be discouraged. It was not until the 13th century that the Church allowed medical schools to start at universities, from which women were excluded. Official medicine, dominated by men, was born. It was strictly controlled by the Church and only those approved by the Church could practice medicine.

But the Church did not stop there. It considered anyone with intelligence, common sense and initiative a threat to its power and wealth and wanted such persons, which included midwives and herbalists, to be eliminated. In order to destroy them, the Church accused them of witchcraft and of heresy towards religious dogma. From 1257 to 1816, the Church tortured and burned hundreds of thousands of people,

some researchers say millions, most of them women. They were charged without due trial, had their possessions confiscated and were routinely raped and tortured until they "confessed" and were burned at the stake (the book *Witches, Midwives and Nurses* by Barbara Ehrenreich and Deidre English is recommended reading).

What we need to realise is that those who have inherited the power usurped at the detriment of the female principle continue their domination and exploitation today, and this domination and exploitation is still prominent in our modern religious, financial and scientific (including medical) institutions. A typical example of this is vaccination, a barbaric and insane practice which could only have been invented by male scientists devoid of the female principle. "Immunisation" is a monument to the stupidity of modern man who has been brain-washed to such an extent that he still accepts a hoax as a fact.

Erwin Alber
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PS For a complimentary copy of our quarterly newsletter *Informed Choices* please send an SAE to above address.

Education Framework November 1999

Sally Pairman
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Head of School of Midwifery
Otago Polytechnic

Introduction

This document provides a framework and guidelines for midwifery education at both pre-registration and post-registration levels. It is acknowledged that this framework will evolve in response to changes in the context of midwifery practice and education in New Zealand. The document will be revised and updated as necessary.

Section One sets out the role of the New Zealand College of Midwives (NZCOM) in relation to midwifery practice and education in New Zealand and the relationship of the NZCOM to other organisations with responsibilities for midwifery education. It also addresses the relationship between midwifery and nursing education in the context of the New Zealand maternity service.

Section Two provides background to the development of this Framework, including the consultation process and discussion of some of the contextual issues that have impacted on the development of this framework.

Section Three sets out the National Framework for Midwifery Education. It provides direction for midwifery educators and educational institutions offering midwifery programmes and represents the consensus view of NZCOM midwife-members throughout New Zealand of the focus they wish to see for midwifery education.

Section One

Introduction

This section describes the role of the New Zealand College of Midwives (NZCOM) in midwifery education. As the professional organisation for midwives in New Zealand, the NZCOM has a legitimate role in providing direction for midwifery education in New Zealand. This direction is set out through this National Framework for Midwifery Education.

Several other organisations also have a role at national level, in influencing midwifery education. The Nursing Council of New Zealand and the New Zealand Qualifications Authority both have legislative authority over approval of programmes and accreditation of educational institutions providing midwifery education. The Clinical Training Agency and the Ministry of Education have complementary roles in the funding of health workforce education in New Zealand. This section discusses the specific role of each of these organisations in midwifery education.

Finally, this section identifies the historical linkage between midwifery and nursing and traces the way in which the recent separation of these two professions in New Zealand has been reflected through changes to their education programmes.

1.1 New Zealand College of Midwives (NZCOM)

The New Zealand College of Midwives (NZCOM) is the recognised professional body for midwives in New Zealand. In honouring the principles of partnership, participation and protection inherent in the Treaty of Waitangi, and in acknowledgement of the essential role of women (as consumers) in midwifery, the NZCOM is founded on the principle of partnership. The partnership between women and midwives is reflected in the organisational structure of the NZCOM, in its Code of Ethics and Standards for Practice¹, in its policy development, in its Standards Review and Resolution Committee processes and in its political activity. Women consumers are members of the College at every level of the organisation. This active involvement of women as consumers within the College has strengthened midwifery at both a political and professional level. It ensures that midwifery continues to uphold the needs and wishes of women and influences the individual practice of midwives to ensure the one-to-one relationships with women are based on equality and negotiation.

Established in April 1989, the College provides a 'voice' for midwives, distinguishing midwifery from other professions with whom midwifery has historically been linked such as nursing and medicine. The College provides professional leadership to all midwives in New Zealand and provides industrial representation to self-employed midwives.

There are ten regions of the College throughout New Zealand, each with a regional chairperson and committee. Each region also has a Standards Review Committee and Resolutions Committee. The regional chair people form the National Committee along with three national consumer representatives, two national representatives from Nga Maia o Aotearoa me te Waipounamu², the President, and the National Director. In addition, the National Committee co-opts expertise from the Education Consultant and from the Midwifery Student representatives. Finally, Joan Donley, the College Elder and Mina Timu Timu, Kaumatua to the College, join the National Committee. Together they bring their partnership as Maori and Pakeha Kuia to benefit the College. The National Committee operates on a consensus model, requiring all issues to be fully discussed through the regions before any decisions are made at a national level. Consensus decision-making necessarily involves a lengthy consultation process and the College aims to involve as many members as possible

in this process.

As the professional body for midwifery, the NZCOM has a legitimate role in shaping midwifery education and practice in New Zealand. Education must strengthen the profession, reflect the current context of midwifery practice and maintain a high standard of midwifery practice that meets women's needs. The National Midwifery Education Framework, described in this document, provides direction from the midwifery profession for midwifery education at both a pre-registration and post-registration level. This Framework will provide guidance to midwifery educators, midwifery practitioners and other organisations with a role in midwifery education.

1.2 Relationship with other organisations with a role in midwifery education

1.2.1 Nursing Council of New Zealand (NCNZ)

The regulatory body for Midwifery at present, the Nursing Council of New Zealand (NCNZ) has legislative authority, under the Nurses Act 1977 and Amendments, to approve education facilities and pre-registration programmes for midwives. In this role the Council has set standards for registration of midwives and standards for the educational programmes to prepare midwives. The Council audits these programmes every three years.

Since the passing of the Nurses Amendment Act in August 1990³, the NZCOM has had the right to nominate one member to the twelve-member Nursing Council. This right ceased when the Health Occupation Registration Amendment Act⁴ was passed in October 1999. This legislation reconstituted the membership of the Nursing Council to include three registered nurses, two registered midwives, two members of Nursing or Midwifery educational facilities and four others, one of who can be a midwife and one of who can be a nurse. No professional organisation has the right to nominate the nurse or midwife members and the Minister of Health appoints all members. This new Council will be appointed over a transition year between 1999 and 2000.

Perhaps in recognition of the lack of midwifery representation on Council (one or two in each year), the Council, over the past four years, has entered into collaborative projects with NZCOM over matters of interest to both organisations. In 1996 Council developed its standards and competencies for midwifery registration in partnership with NZCOM⁵. In 1998 NZCOM was well represented on the Nursing Council Working Party that

developed the Competency-based Practising Certificate Policy for Registered Midwives⁶. This policy recognises the NZCOM Midwifery Standards Review Process as one mechanism by which midwives demonstrate on-going competency to practice. In 1999 Council passed a policy that determined that entry to the midwifery profession be by Bachelors degree only⁷. This policy is in line with NZCOM policy as outlined in this Midwifery Education Framework. The Nursing Council is now moving to develop policy on post-registration midwifery education and has asked for a copy of the NZCOM Midwifery Education Framework as a starting point for this work⁸.

1.2.2 New Zealand Qualifications Authority (NZQA)

Established under the 1989 Education Act, the New Zealand Qualifications Authority (NZQA) has legislative authority to approve undergraduate and postgraduate degree programmes offered within the polytechnic sector, and to accredit the institutions offering these programmes.

Until 1999 all five pre-registration midwifery Bachelor degree programmes were offered through polytechnic educational institutions. In 1999 Massey University amalgamated with Wellington Polytechnic to become the Massey University of Wellington. The New Zealand Vice Chancellor's Committee, through its Committee on University Academic Programmes (CUAP), now takes over the approval of the Bachelor of Midwifery programme previously provided by Wellington Polytechnic⁹. This is the first undergraduate midwifery programme to come under the University system for approval and accreditation.

As the professional body for midwifery in New Zealand, the NZCOM participates in the NZQA approval and accreditation processes for all midwifery programmes. NZQA recognises the legitimate interest of the NZCOM in midwifery education and seeks representation from NZCOM for each midwifery approval panel. The New Zealand Vice Chancellor's Committee approval process does not automatically invite involvement of the appropriate professional organisations and NZCOM will need to seek participation within this process.

1.2.3 Clinical Training Agency

In 1995 the four Regional Health Authorities (RHAs) jointly established the Clinical Training Agency (CTA) to take responsibility for the purchasing of post-entry level clinical training for health professionals. The CTA now performs this same role for the Health Funding Authority (HFA).

The CTA purchases post-entry level clinical training in line with its purchasing priorities and in accordance with certain criteria. These criteria include the following:

- Vocational, rather than academic and research based
- Clinically based, with a substantial clinical component where employment in a clinical setting is integral for completion of the qualification
- Post-entry, which occurs after entry to a health profession, so that a person is eligible to practise in a particular occupation
- Formal programme – trainees are formally enrolled in a training programme which leads to a recognised qualification
- Six months – the formal training programme is to be equivalent to a minimum of six full time months in length.
- Nationally recognised – recognised by the profession and/or health sector and meeting a national health service skill requirement rather than local employer need.¹⁰

Funding for purchasing of post-entry level education by the CTA came originally from the Government 'unbundling' exercise, where Crown Health Enterprises (CHEs) identified the costs of this clinical training to their budgets. Funding was then transferred from the CHE budgets to the CTA through Vote Health. Initially the CTA rolled over funding to sustain existing post-entry training activities such as medical registrar training. The CTA also discovered that the funding did not cover the cost of the activities.¹¹ Further unbundling occurred in 1998/9 from a 'deficit switch' of funds from Crown Company Monitoring Agency (CCMAU) to the HFA. This made up to \$5 million available to the CTA to support CHE employed registered nurses undertaking clinical training previously funded by CHEs.¹²

Midwifery has not had access to funding from the CTA for post-entry level clinical training programmes. Because of midwifery's historical association as a speciality of nursing, hospitals did not provide post-entry level training programmes for midwives. A large number of hospitals did fund registered nurses to undertake midwifery education, but although this was post-entry training for nurses it provided entry level to midwifery. This funding appears to have been lost within the unbundling exercises.

As midwifery develops its education framework and sets a direction for the future it is necessary to work with hospitals and self-employed midwives to obtain funding for post-entry level education from

the CTA. The nature of midwifery and the recent changes to the maternity services means that many midwives are no longer employed in hospitals and therefore do not fit CTA funding criteria. However, all midwives are still employees of the health system whether they are paid directly by the HFA or through employment contracts with hospitals. The increasing demand of pregnant women for midwifery care is leading midwives to seek opportunities for post-entry level clinical education. The Postgraduate Certificate programme outlined in this Midwifery Education Framework is particularly designed to assist practising midwives to extend and develop their practice skills. Practising midwives need access to CTA funding for these programmes so that they can be accessible to midwives throughout New Zealand.

1.2.4 Ministry of Education

The Ministry of Education funds pre and post-registration midwifery education through its equivalent full-time student (EFT) resourcing system. The Government funds different categories of education, subsidising the cost of education to each student to certain levels. Tertiary students in New Zealand also pay fees towards their education. At the post-entry education level, the Ministry of Education funds programmes that have less than 30% focus on clinical training. The CTA is expected to fund those programmes with more than 30% clinical training. At present the Ministry of Education funds all midwifery education, both pre and post-registration.

1.3 Relationship between midwifery and nursing education

The historical linking of midwifery with nursing education led to the establishment of the one-year separate midwifery programmes within Schools of Nursing at Auckland Institute of Technology (AIT), Waikato, Wellington, Christchurch and Otago Polytechnics between 1989 and 1992 (some of these one-year programmes were preceded by the Advanced Diploma of Midwifery (ADN)/Midwifery option).¹³

Over time, and following the passing of the 1990 Nurses Amendment Act, the recognition of midwifery and nursing as two separate professions began to be articulated through the changing of the names of Nursing departments to Nursing and Midwifery departments. From 1999 several polytechnics began to restructure using the faculty model. Within these institutions midwifery became a separate school within the Faculties of Health¹⁴. The separation of midwifery from nursing in this way highlights the separate nature of the two disciplines and is a further step in midwifery's aim of self-determination.

The 1990 Nurses Amendment Act

demanding a re-evaluation of the role of nurses in maternity services. Over the past nine years the maternity system has changed markedly. Over 60% of pregnant women now receive care from a midwife as their Lead Maternity Carer.¹⁵ Over 80% of pregnant women have a known midwife care for them in labour and birth.¹⁶ The role of the nurse in this system has also changed. Few maternity hospitals now employ nurses. Practice nurses have less involvement in antenatal or postnatal care as most women see their own midwife for this care.

The pre-registration education of nurses has changed to reflect this changed role of nurses in maternity services. Nurses need an understanding of childbirth within the family/social model. They also need to understand the maternity system and how to help pregnant women get the information they require to access the appropriate services. However, the traditional placement of nursing students in maternity hospitals is no longer appropriate or even possible in many areas. This re-evaluation of the nurses role is reflected in the guidance given by the Nursing Council of New Zealand to polytechnics regarding the 'obstetric' component of the comprehensive nursing programme in the May 1999 Handbook for Polytechnics¹⁷. This states:

Maternal and infant health nursing (previously obstetric nursing)

Registered Comprehensive Nurses must have an understanding of their scope of practice with regard to maternal and infant health. This includes understanding of the legal framework for practice, maternity services available to women and appropriate referral options. In particular, nurses must have knowledge of reproductive/sexual health, normal fetal development and the physiology of pregnancy, health promotion, the family experience of pregnancy, birth and the postnatal period, infant feeding, normal newborn development and contraception. All students should have some follow-up experience with a family experiencing childbirth. This may take the form of discussion with women and families after birth to explore issues related to new families and postpartum care. Management of maternity care and deviations from the normal are not included in this interpretation.¹⁸

Summary

This section has discussed the role of the New Zealand College of Midwives in relation to Midwifery practice and education in New Zealand. It has also examined other organisations with a statutory role in midwifery education in New Zealand, and shown the relationships between these organisations and the NZCOM.

The relationship between nursing and midwifery in New Zealand has been

examined in light of their relatively recent separation through statute, practice and education.

The next section traces the development of the Midwifery Education Framework in relation to changes in the midwifery profession and maternity service context. This includes documentation of the extensive consultation that occurred amongst midwives in the development of this framework.

Section Two

Introduction

This section traces the developments in midwifery education in New Zealand from the early 1980s to the present day. Alongside these changes the NZCOM has worked through various stages in the development of this Framework for Midwifery Education. Each stage has involved considerable consultation with midwives throughout New Zealand and formal adoption as policy by NZCOM.

2.1 Background

2.1.1 Separating Midwifery from Nursing

The Midwifery Education Framework outlined in this document has evolved since the late 1980's. Midwives began lobbying for changes to their education as soon as midwifery moved from hospital-based programmes to the tertiary education sector in 1979, and was reduced to an option within the Advanced Diploma of Nursing (ADN) programmes. Midwives believed that these programmes provided inadequate preparation for midwifery practice, and each year from 1980 onwards put a remit to the New Zealand Nurses Association (NZNA) annual conference to remove midwifery from the ADN programmes and establish separate midwifery programmes. This remit was finally passed successfully in 1986. By this time other changes were also occurring in midwifery.

The years 1986 to 1990 saw an awakening understanding amongst midwives that their practice could be expanded. The majority of midwives at this time practised in hospitals as part of a fragmented maternity system controlled by medicine. The only midwives practising with a sense of autonomy and understanding of continuity of care were a very small number of domiciliary midwives in the homebirth setting.¹⁹ However, there were some consumers who were aware of what midwifery could offer and they were determined to bring about change. A consumer group, 'Save the Midwives', was established in 1986 to raise awareness of the closure of rural and small maternity

hospitals and to lobby for an autonomous midwife who could provide an alternative to the dominant medical model of maternity care.²⁰

A sub-group of Save the Midwives formed the 'Direct Entry Midwifery Taskforce'. Their main objective was to achieve direct entry midwifery. These women believed the system of midwifery training following nursing registration was both inappropriate and a waste of resources. As a profession in its own right, midwifery needed its own education programmes to produce motivated, competent and autonomous midwives.²¹ So while midwives fought for separate one-year midwifery programmes for nurses to train as midwives, women challenged midwives to think beyond this to direct-entry midwifery.

The collaborative political activity of these consumer groups in partnership with midwives, culminated in the passage of the Nurses Amendment Act in August 1990. The passing of this statute meant that midwives regained their legal and social mandate for independent practice. The same legislation provided the opportunity for direct entry midwifery education. Section 39 of the Nurses Act 1977 was amended to allow the Nursing Council to approve direct entry midwifery programmes as experimental programmes in tertiary education facilities.²² By this time separate, one-year midwifery programmes were being offered at three tertiary education institutions, with ADN/Midwifery options available at another two.

The newly formed New Zealand College of Midwives provided a united professional voice to address midwifery education issues. The College utilised much of the work that had begun previously through the Midwives Section of the NZNA. In this forum, midwives throughout New Zealand had contributed to and endorsed the NZNA Midwifery Policy Statement.²³ The request for such a policy arose from the Midwives Section of NZNA and reflected their concern that the previous policy²⁴ was out of date in light of professional developments and community concerns. An ad hoc committee was established by NZNA to revise and update the 1981 policy. Three, of the five-member committee, were representatives of the Midwives Section. The extensive consultation process that followed included 140 women's groups as well as midwives throughout New Zealand in midwifery's first attempt to involve women in policy development.²⁵ The resultant policy statement clearly outlined a future for midwifery based on autonomy and continuity of care and a midwifery philosophy of practice. This policy called for discontinuation of the ADN/Midwifery programmes and supported direct entry midwifery education as one route to

midwifery registration.

At the same time as the policy statement was being developed, the Midwives Section of NZNA was working on the development of standards. Through an extensive and prolonged consultation process, the Midwives Section reached consensus on a philosophy of midwifery and standards for practice, education and service.²⁶ These were almost complete when, in 1989, these same midwives disbanded the NZNA Midwives Section and participated in the establishment of the New Zealand College of Midwives. The midwives took their work with them and the philosophy and standards were subsequently adopted by the College, and later reviewed (in both 1992 and 1993) and published within the handbook for practice.²⁷

2.1.2 Developing an Education Framework

At the same time as midwifery separated itself from nursing through establishment of the NZCOM and development of a philosophy and standards that articulated midwifery as an autonomous profession, the Direct Entry Midwifery Taskforce was working towards a complete change in midwifery education. The Taskforce, with the assistance of a grant from the McKenzie Trust Foundation, distributed a discussion paper and questionnaire to assess the feasibility of establishing direct entry midwifery education programmes in New Zealand.²⁸ The 691 replies indicated strong support for direct entry.²⁹ In February 1990 the Taskforce, in conjunction with Carrington Polytechnic School of Health Studies and with the endorsement of the NZCOM, released a discussion document and draft direct entry midwifery curriculum.³⁰ 826 copies were distributed directly by the Taskforce and again the responses were positive. Common themes included: the need for input from Maori and other minority groups; the importance of emphasis on quality clinical experience with a focus on the normal and continuity of care; modular structures to enhance distance learning and flexibility; and support for an apprenticeship model of clinical experience.³¹

In August 1990 section 39 of the Nurses Amendment Act paved the way for direct entry midwifery. Section 39 was an experimental clause that required the Nursing Council to inform educational institutions of any amendments necessary to achieve approval if the programme was initially turned down by the Council.³² Four polytechnics submitted curricula. The Nursing Council approved three initially and the Minister of Health later agreed to fund two programmes, one at Auckland Institute of Technology (AIT) and one at Otago Polytechnic. These programmes

were to undergo extensive evaluation before funding would be approved for further programmes elsewhere in New Zealand. Both programmes were three-year programmes but AIT awarded a diploma on completion while Otago developed a Bachelor of Midwifery degree programme.

The debate between degree or diploma programmes occupied the profession in the early 1990s. The Vision 2000 conference held in Auckland in March 1991 was the first opportunity the profession had for national debate on education issues. It resulted in the development of a National Framework for Midwifery Education. This framework was developed by a 'breakaway' group of midwives and consumers when it became clear that the process of development of a nursing and midwifery education framework was not going to meet midwifery's needs.³³ The National Framework for Midwifery Education identified the need for such a framework; recognised the foundation of the Treaty of Waitangi in all aspects of midwifery; identified the implications of professional autonomy on the regulation of midwifery, the role of the College and the pre-registration midwifery education curricula; set out expectations regarding the clinical experience to be offered to pre-registration midwifery students. The degree/diploma debate was identified as an area requiring further discussion by the whole profession.³⁴

This debate occurred in each region of the College throughout the remainder of 1991. In February 1992 the NZCOM held an Education Workshop in Wellington, bringing together midwifery educators, practitioners, regional chair people and consumers from throughout New Zealand. A number of workshops were held, one of which further developed the National Framework for Midwifery Education.³⁵ This Framework proposed that the three-year midwifery pre-registration programmes should be undergraduate degree programmes. It also set out guidelines for post-registration and postgraduate midwifery education through continuing education programmes, masters and doctoral programmes.³⁶ Following this workshop AIT moved to convert its direct entry diploma programme to a degree programme. Thus all of the first direct entry graduates in New Zealand in 1994 graduated with Bachelors degrees.

This Framework was further refined in May 1994 at the NZCOM National Education Workshop in Palmerston North. Representatives from each region of the College as well as midwifery educators, practitioners and consumers endorsed the 1992 Education Framework and developed a strategic plan to further implement the framework. At this workshop the main issues involved the following:

- Achieving entry to the midwifery profession by undergraduate degree only by 1997;
- Clarifying the relationship between NZQA and NZCOM;
- Developing competency-based practising certificates;
- Removing the experimental status of direct-entry programmes;
- Developing post-registration midwifery education, including obtaining funding;
- Funding clinical experience for pre-registration students;
- Reviewing overseas midwives registration requirements;
- Gaining midwifery representation on relevant education bodies such as the Nursing Council;
- Communicating midwifery education issues within the College.³⁷

These decisions were ratified at the NZCOM Annual General Meeting in August 1994.

The years 1994 to 1998 were years of consolidation of midwifery education. Further three-year direct entry degree programmes were commenced at Waikato and Wellington Polytechnics in 1996 and Christchurch Polytechnic in 1997. One-year diploma programmes ceased in Otago (1992), Christchurch (1996), Waikato and Wellington (1998) and in Auckland the last diploma programme is being run in 1999. Postgraduate midwifery programmes commenced at Massey University (1993), Victoria University of Wellington (1994), and at AIT (1999). Otago Polytechnic plans to commence postgraduate midwifery programmes in 2000.

The post-registration midwifery education aspect of the Framework was developed extensively through 1998. In March the NZCOM invited midwifery educators, practitioners, regional chair people, consumers, and representatives of the Nursing Council, Ministry of Health, Ministry of Education, Clinical Training Agency, and Women's Health Managers to a workshop. This workshop developed a draft, post-registration, midwifery education framework and established a small working group to carry on the project. The Framework was developed further at a meeting in April 1998, circulated to all regions of the College and ratified at the Annual General Meeting in Auckland in August 1998. Further detailed work was undertaken at a meeting of the working group in August 1998 and then again in September 1998.

The National Midwifery Education Framework presented in this document combines the earlier work on pre-registration midwifery education with the more recent developments in post-registration midwifery education. The Framework is being circulated to each

region for discussion and ratification at the National Committee meeting in November 1999. It brings together all aspects of the Framework for Midwifery Education developed and ratified by the College to date.

Section Three

Introduction

This section outlines the National Midwifery Education Framework and brings together in one document, the work done on an education framework by various midwifery groups between 1990 and the present.

The beliefs of the NZCOM in relation to midwifery education are presented. Each aspect of the programme is described, including the expectation of the NZCOM as to how these programmes will be developed and delivered. A profile of the graduates from each programme is described to demonstrate the linkage, expected by the college, between midwifery practice and education.

3.1 National midwifery education framework

The following framework proposes a pathway from pre-registration programmes that prepare for initial midwifery practice through to continuing education programmes for practising midwives, to postgraduate programmes for those midwives who wish to pursue higher education with a focus on midwifery practice. It is a cohesive framework, and one that the NZCOM hopes to see applied consistently throughout New Zealand by educational institutions offering midwifery programmes.

Underpinning this framework is the recognition by the College that all midwives are expected to work to the NZCOM Standards for Practice and Code of Ethics.³⁸ In meeting these standards midwives work in partnership with women during the childbirth experience, with each other in practice and with students when facilitating and supervising clinical experience.

The framework offers a series of programmes that build on each other and reflect aspects of midwifery practice. It sets out a variety of midwifery-specific education programmes and identifies the links between them.

Flexible entry and exit points facilitate access for all midwives and enable recognition of the knowledge midwives bring with them from practice, their previous education programmes and their wider life experiences. The framework provides a pathway for midwives planning their on-going education and allows midwives to select routes that meet their

specific needs

3.2 Underpinning principles/assumptions

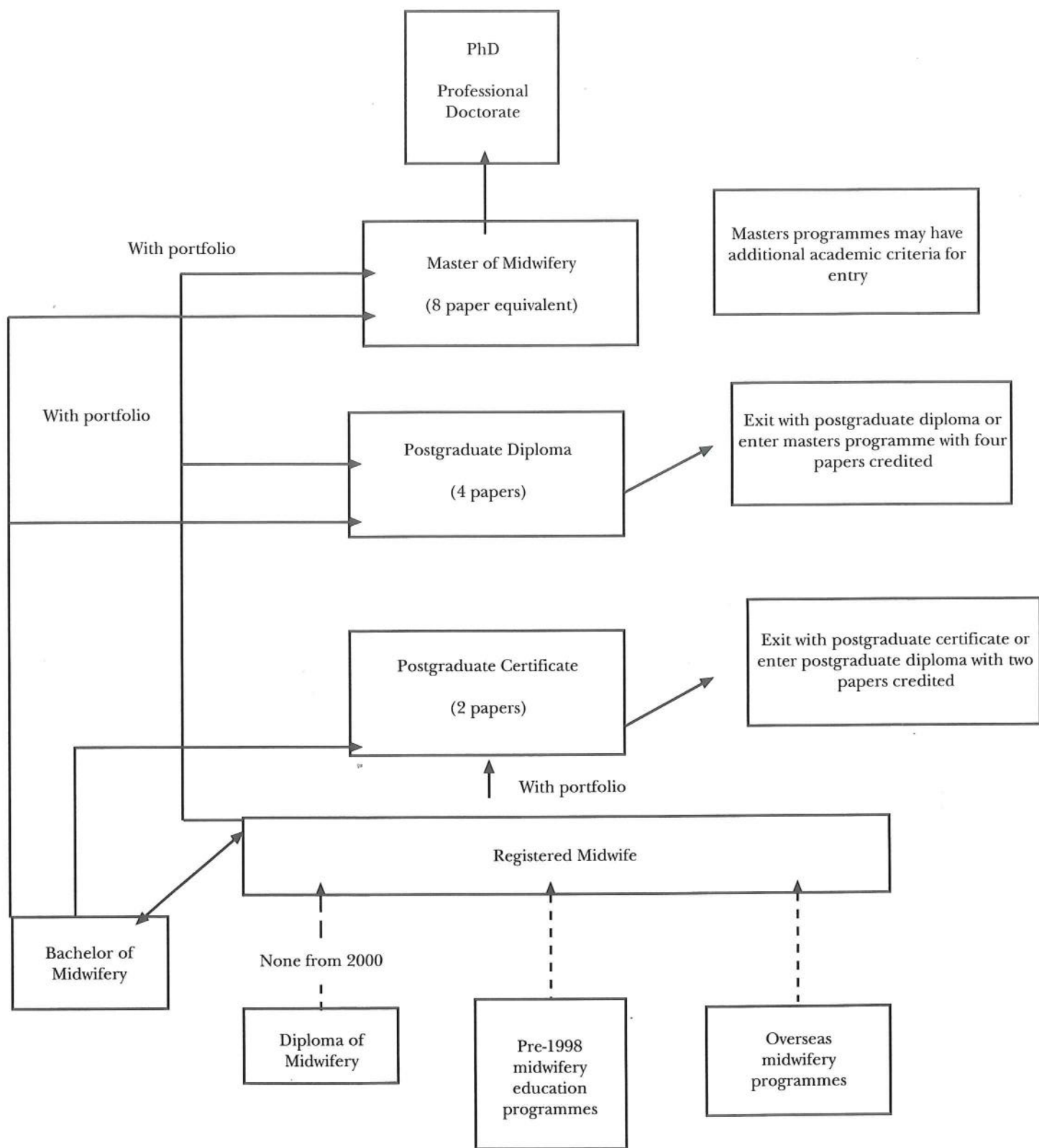
The New Zealand College of Midwives holds certain beliefs about midwifery education. These key assumptions underpin the National Midwifery Education Framework and include beliefs that:

- Midwifery is a profession in its own right and the NZCOM, as the professional body for midwives, has a legitimate role in shaping midwifery education and practice in New Zealand.
- Midwifery is a partnership between the midwife and the woman. This partnership exists within the cultural and political context of New Zealand society.
- The partnership between women and midwives is the strength and base of the profession.
- Midwifery education has its foundation in practice and reflects the centrality of women inherent in the Midwifery Philosophy.
- Midwifery education must reflect midwifery as an independent profession.
- Consumers must be involved in the development and on-going monitoring of all programmes. Curricula must also be developed collaboratively between the educational institution and midwifery practitioners, including representatives of NZCOM.
- Midwifery education programmes should be nationally consistent, with national standards and outcomes, and entry and exit points, but with local development within these standards to meet local needs.
- Midwifery education programmes should articulate with each other and lead to recognised qualifications.
- Midwifery education should be accessible to all midwives.
- Midwifery education programmes should be underpinned by recognition of prior learning (RPL) policies and processes that will enhance flexibility for midwives.
- All midwives are accountable for their practice and for maintaining and updating professional knowledge and skill in midwifery practice.
- Midwifery education is the interaction between students and planned learning experiences facilitated by teachers in a supportive environment.
- The midwifery education environment reflects the principles of partnership, protection and participation as identified in the Treaty of Waitangi.
- Learning is part of the students' wider education, and is the response to their total life experience within and beyond educational settings. Learning is the

Graduate profiles

	Master of Midwifery	Postgraduate Diploma in Midwifery	Postgraduate Certificate in Midwifery	Bachelor Degree in Midwifery
Knowledge	Actively develops midwifery knowledge through research and scholarly enquiry.	Identifies clinical or professional issues requiring investigation and research.	Increases knowledge and understanding with which to assess and manage clinical situations.	Identifies and articulates aspects of discipline-specific knowledge base for midwifery.
Practice	Develops theoretical propositions in relation to midwifery. Acts as a change agent in the provision of midwifery practice.	Critiques theoretical propositions in relation to midwifery. Continues to develop judgement, discretion and decision-making in midwifery practice. Utilises knowledge and skills to deal with uncertainty and change in midwifery practice.	Uses professional judgement as a reflective and critical practitioner in midwifery practice. Utilises reflection and self-knowledge to change practice.	Acquires knowledge and skills necessary for independent midwifery practice. Develops professional judgement through critical reflection and practice experiences.
Profession	Develops networks at professional, regional, national and international levels. Actively participates in the midwifery profession.	Participates in development of national clinical guidelines.	Maintains the midwifery focus within a collaborative and interdisciplinary context. Develops creative and innovative approaches to midwifery practice. Actively participates in the midwifery profession at local and national levels.	Utilises evidence as a basis for practice and clinical decision-making. Actively participates in the midwifery profession at local and national levels.
Political	Develops and influences health policy to improve health outcomes for women and babies.	Develops awareness of the impact of broad health policy and directions on midwifery practice.	Participates in development of national clinical practice guidelines.	Critiques and utilises nationally agreed clinical practice guidelines.
Leadership	Takes a leadership role in the midwifery profession.		Provides a positive role model of continuing professional and personal development. Provides guidance and support for midwifery colleagues and students.	Takes responsibility for own professional development. Provides guidance and support for midwifery students.

The Midwifery Education Framework



Continuing education/Midwifery Standards Review

Used as a basis of portfolio applications or recognition of prior learning within programmes

responsibility of the student and is enhanced by sharing experiences, critical reflection, acknowledging cultural differences and beliefs and valuing the contribution of each member to the learning of the group.

- Midwifery curricula reflect the needs of society and of women, particularly in relation to maternity services.
- Women have the right to decide where they will birth and with whom. They have the right to continuity of care from the midwife of their choice.
- As midwives are the only primary health providers who can provide continuity of care during the childbearing cycle, midwifery students must have priority of access to clinical experience with midwives.

3.3 Definition of the Midwife and Scope of Practice of the Midwife.

The New Zealand midwife accepts the World Health Organisation definition of a midwife, as adopted by the International Confederation of Midwives 1972, and the International Federation of Gynaecologists and Obstetricians 1973, which reads:

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studying midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

Scope of practice of the midwife

The midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant.

This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the woman, but also within the family and community. The work should involve pre-conceptual and antenatal education and preparation for parenthood and extends to certain areas of women's health, family planning and childcare. She may practice in any setting including the home, hospital and community.

3.4 Pre-registration Midwifery Education

The focus of the pre-registration

midwifery programme is on midwifery as an independent profession that works in partnership with women within the midwifery scope of practice. The overall aim of the programme is to prepare midwives to practice competently and independently in any maternity setting.

Each programme must provide a balanced integration of theory and clinical experience within an environment that promotes critical thinking, reflective practice and the application of research to practice. Clinical experience must encompass continuity of care and independent midwifery practice and each student must have the opportunity to experience homebirth midwifery practice as well as institutionally based secondary midwifery practice.

All pre-registration midwifery education is through a three-year Bachelors degree programme. Each programme must have sound policies and processes for recognition of prior learning so that midwifery students can gain credit and partial exemption for the experiences they bring to midwifery education.

Registered Nurses seeking midwifery registration may receive recognition of those skills and knowledge they hold in common with midwives, through RPL policies applied within the three-year degree programme. As such registered nurses may complete the Bachelors programme within a shortened timeframe.

Entry

Entry into pre-registration midwifery programmes is for direct entry students and registered nurses who wish to move to another profession. The entry criteria should be the same for both groups and include a commitment to women-centered midwifery, maturity and life experience, and the ability to cope with the academic demands of the programme. Midwifery is committed to increasing the numbers of Maori midwives as well as those for other cultural groups. This commitment should be reflected in the entry criteria and selection processes.

Graduate profile

Midwife graduates will be able to:

- Think critically and creatively
- Practice midwifery safely and competently
- Practice autonomously and in partnership with women in any maternity setting
- Utilise research evidence in practice
- Contribute to midwifery's body of knowledge
- Actively participate in the midwifery profession
- Take responsibility for ongoing learning

and maintaining competence in practice

3.5 Post-registration midwifery education

A variety of post-registration midwifery education programmes have been developed to meet midwives' specific needs. These programmes recognise that the depth and scope of knowledge on which professional practice is based, develops over time and in different ways. Whilst the College expects all midwives to participate in ongoing learning, each midwife must choose the education programme that best suits her learning needs, practice focus and interests.

3.5.1 Continuing Education Programmes

The Regions of the NZCOM offer continuing education programmes. These are short courses that cater to specific areas of interest and/or enable updating on specific skills such as infant resuscitation or breastfeeding.

Other providers include maternity hospitals that offer in-service education programmes for their midwifery staff.

Such programmes have no formal assessment and cannot award a formal qualification. They may award a certificate of attendance.

Midwives will continue to attend these programmes because of their specific nature. Indeed many midwives will attend these programmes, whilst at the same time participating in more formal ongoing education. While these programmes do not award qualifications, they may be used as evidence of professional development for portfolio applications into formal midwifery programmes or as evidence of continued competency to obtain a practising certificate.

3.5.2 Midwifery Standards Review

Each Region of the College provides a Midwifery Standards Review process. Any midwife-member with a caseload can present for review annually or more frequently if necessary. The review offers the midwife the opportunity to reflect on her practice over the past year with peers and consumers. The review has a supportive and educative focus and emphasises reflective and critical thinking about practice.

This process too, may be used as evidence of professional development for portfolio applications into formal midwifery programmes or as evidence of continued competency to obtain a practising certificate.

3.5.3 Midwifery Bachelor Degree Programmes

Undergraduate midwifery programmes are designed for pre-registration students and now provide the entry level to the midwifery profession. However, this entry level will only be consistent throughout New Zealand from 2000. There are still many registered midwives practising without an undergraduate degree.

Bachelors degree programmes sit at levels 5 (year one), 6 (year two) and 7 (year three) on the National Qualification Framework (NQF). The National Qualification Framework was designed by NZQA to attempt to provide some measure of consistency across education generally. The framework spans level 1 to level 8, with level 8 being all postgraduate programmes including both masters and doctoral programmes.

Utilising the RPL policies of the undergraduate midwifery programmes, registered midwives can be offered one-year midwifery Bachelor degree programmes. These programmes recognise that the registered midwife students have already met the registration requirements. Instead the one-year degree programme focuses on developing degree level skills such as critical thinking and reflection, research skills, academic skills and the development of discipline-specific midwifery knowledge. At level 7 on the NQF, these programmes may be particularly suited to those midwives who do not feel they possess the academic skills necessary for postgraduate study. Indeed, the education previously available to midwives has disadvantaged them in this area. The undergraduate midwifery programme for registered midwives provides a flexible way to acquire these skills while still recognising the extensive knowledge and experiences of these midwives.

The five educational institutions currently approved by the Nursing Council to offer pre-registration midwifery programmes provide undergraduate programmes.³⁹ These institutions are accredited by NZQA or CUAP to provide degree level education and their programmes have also received NZQA or CUAP approval.

3.5.4 Postgraduate Certificate

The postgraduate certificate provides two papers at level 8 (masters level) on the NQF. The NZCOM expects midwifery educators and practitioners to collaboratively develop these programmes. Accredited educational institutions, that award the qualification, provide the programmes. Teaching within the programmes should be by appropriately qualified educators and practitioners.

The main focus of these programmes is

on developing clinical midwifery practice and on providing the basis for further postgraduate study.

Entry is for registered midwives with a Bachelors degree or for midwives with a portfolio that demonstrates their ability to cope with the academic demands of the programme. Midwives should be given clear guidelines by the institution to assist in the preparation of portfolio applications.

Midwives may exit from the programme with a Postgraduate Certificate qualification, or they may choose to continue on into the Postgraduate Diploma programme with credit given for two of the four required papers. Alternatively they may apply for entry into the Masters programme and be credited for two of the eight required papers.

3.5.5 Postgraduate Diploma

The Postgraduate Diploma provides four papers at level 8 (masters level) on the NQF. As for the Postgraduate Certificate, midwifery educators and practitioners develop these programmes collaboratively, with input from the NZCOM and consumers. Accredited educational institutions provide the programmes and award the qualification. Teaching is by appropriately qualified educators and practitioners.

The main aim of these programmes is to expose students to a systematic review of current thinking and research relating to midwifery knowledge and practice and to prepare the student for independent scholarship.

Entry is for registered midwives with a Bachelors degree or portfolio; or for registered midwives with a Postgraduate Certificate. As above, a portfolio application must provide evidence of the midwife's ability to meet the academic requirements of the programme.

Midwives may exit from the programme with a Postgraduate Diploma, or they may choose to continue into the Masters programme with credit given for four of the eight required papers. It is likely that individual educational institutions will require some level of academic achievement for acceptance into the Masters programme. For example, a B grade in one or more papers. The individual institutions will specify these additional criteria.

3.5.6 Master of Midwifery

The Master of Midwifery programme provides eight papers at level 8 of the NQF. Generally there are two types of Masters programmes. The masters by thesis programme consists of four papers plus a four-paper thesis. The masters by papers programme consists of eight papers, of which a minimum of one, but up to three, relates to a research project or dissertation.

Educators, practitioners, consumers and the profession should also develop Masters programmes collaboratively. Accredited educational institutions provide the programmes and award the qualification. Teaching is by appropriately qualified educators and practitioners. Appropriately qualified staff must provide research supervision, with assistance from midwives if the supervisor is not already a midwife.

The main aim of the Masters programme is to provide the student with the opportunity to conduct independent research and scholarship in midwifery and to contribute to the knowledge base of midwifery as a discipline.

Entry is for registered midwives with a Bachelors degree, a Postgraduate Certificate, a Postgraduate Diploma or a portfolio. Individual institutions may have additional academic requirements that must be met for entry.

Exit is with a Master of Midwifery.

3.5.7 Doctor of Philosophy (PhD) / Professional doctorate

Registered midwives with Masters degrees may gain entry into doctoral programmes. There are currently two PhD programmes for midwives in New Zealand offered by accredited Universities that award the qualification. There are currently no Professional Doctorates available for midwives in New Zealand although one has recently begun in Australia.

Both PhD and Professional Doctorate programmes in midwifery focus on research and the development of the knowledge base of midwifery. The PhD usually requires one major research project, while the Professional Doctorate is located in practice and facilitates a number of research projects that directly relate to the practice domain of the midwife.

¹ New Zealand College of Midwives. 1993. Midwives handbook for practice. Dunedin: New Zealand College of Midwives.

² Nga Maia o Aotearoa me te Waipounamu is the Maori midwives collective, established to represent the interests of Maori Midwives. The partnership between NZCOM and Nga Maia includes NZCOM financially supporting two representatives from Nga Maia to attend its National Committee meetings.

³ New Zealand Government. (1990). Nurses Amendment Act. Wellington: Government Printer.

⁴ New Zealand Government. (1999). Health Occupation Registration Amendment Act. Wellington: Government Printer.

⁵ Nursing Council of New Zealand. 1996. Standards for registration of midwives. Wellington: Nursing Council of New Zealand.

⁶ Nursing Council of New Zealand. 1998. Guidelines for competence-based practising certificates for registered midwives. Wellington:

Nursing Council of New Zealand.

⁷ Letter from Marion Clark, Chief Executive Officer, Nursing Council to NZCOM, September 1999.

⁸ Letter from Marion Clark, CEO Nursing Council of New Zealand to NZCOM, October 1999.

⁹ Letter from Dr Ruth Anderson, Academic Director, College of Humanities and Social Sciences, Massey University to NZCOM, September 1999.

¹⁰ Review of the Diploma of Obstetrics and the Diploma of Obstetrics and Medical Gynaecology. A Report commissioned by the Board of the Clinical Training Agency, Christchurch. December 1996.

¹¹ Committee Advising on Professional Education (CAPE). 1997. Education and Development of the Health and Disability Workforce: recommendations from CAPE's consultation with health, disability and education sectors, September.

¹² Letter from Winston McKean, Director CTA, to various nursing groups, 10 June, 1998.

¹³ AIT, Waikato, Wellington and Christchurch Polytechnics all offered ADN/Midwifery options from 1979 when all nursing and midwifery education transferred into the tertiary education sector. Separate one-year midwifery programmes were approved in 1987 to commence in 1989. This was the result of extensive lobbying by the Midwives Section of NZNA and followed the release of the Department of Education (1987) report, Evaluation of the Advanced Diploma in Nursing Courses. The Working party on Midwifery, Short Courses and Related Courses was established in 1987 to make recommendations on the phasing in of these programmes, and in 1989 AIT, Wellington and Otago/Southland Polytechnics commenced one-year midwifery programmes. Waikato and Christchurch were required to continue offering the ADN/Midwifery option to provide control groups for the evaluation process. In the event student demand led to Waikato then Christchurch ceasing the ADN/Midwifery programme by 1991 and commencing one-year separate programmes in 1992. The Ministry of education review was not completed, as there was no market for the ADN/Midwifery option.

¹⁴ Christchurch Polytechnic and Otago Polytechnic.

¹⁵ North Health Regional Health Authority. (1997). Joint Regional Health Authority Maternity Project. Auckland: Author.

¹⁶ Guilliland, K. (1998). A demographic profile of self-employed (independent) midwives in New Zealand. Unpublished masters thesis. Victoria University of Wellington.

¹⁷ Nursing Council of New Zealand. May 1999. Nursing Department/Schools Handbook for Tertiary Education Institutions offering Pre-registration Nursing programmes. Wellington: Nursing Council of New Zealand.

¹⁸ Ibid p. 12.

¹⁹ Donley, J. 1986 Save the midwife. Auckland: New Women's Press.

²⁰ Strid, J. 1987. Maternity in revolt. Broadsheet, 153, 14-17.

²¹ Strid, J. 1988. Midwifery education for the future: a joint decision. Save the Midwives Newsletter, 15, May, p.1.

²² Donley, J. 1990. Autonomy for Midwives. New Zealand College of Midwives Journal, November, p.7.

²³ New Zealand Nurses' Association Inc. 1989.

Midwifery Policy Statement. Wellington: New Zealand Nurses' Association.

²⁴ New Zealand Nurses Association Inc. 1981. Policy Statement on Maternal and Infant Nursing. Wellington: NZNA.

²⁵ Bickley, J. 1989. Attempting to involve consumers in midwifery policy development. New Zealand College of Midwives Journal, 1st issue, 11-13.

²⁶ New Zealand College of Midwives. 1990. Standards for Midwifery Practice, Service and Education. Dunedin: NZCOM.

²⁷ New Zealand College of Midwives. 1993. Midwives Handbook for Practice. Dunedin: New Zealand College of Midwives.

²⁸ Jill White Eyres. 1988. Direct entry midwifery: the education of the future. Save the Midwives Newsletter, 15, May, 24-26.

²⁹ New Zealand College of Midwives. 1990. Direct entry midwifery update. Newsletter, 2, (5), February, p.11.

³⁰ Save the Midwives Direct Entry Midwifery Taskforce. 1990. Direct entry to midwifery. Save the Midwives Newsletter, 23, May, 12-20.

³¹ Ibid.

³² Judi Strid. 1991. The need for ongoing discussion and debate. Maternity Action & Save the Midwives Newsletter, 26, Autumn, p.1.

³³ Pairman, S. 1991. A framework for midwifery education. New Zealand College of Midwives Journal, May, 7-9.

³⁴ Ibid.

³⁵ New Zealand College of Midwives. 1992. A framework for Midwifery Education. Report on Education Workshop, February 1992, Wellington. Christchurch: NZCOM.

³⁶ Ibid.

³⁷ New Zealand College of Midwives. 1994. Education Workshop Discussion Papers, Palmerston North, May 1994. Christchurch: NZCOM.

³⁸ New Zealand College of Midwives. 1993. Midwives Handbook for Practice. Dunedin: New Zealand College of Midwives.

³⁹ AIT, Waikato, Wellington, Christchurch and Otago Polytechnics.

Understanding Toxoplasmosis

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Introduction

Many people have heard of toxoplasmosis, most think it is a disease that pregnant women get from cats, which while not untrue, is misleading and but a small part of a worldwide story. It is sometimes a very sad story for newborn babies and their parents, and the saddest part of all is that it is preventable. This essay defines toxoplasmosis, and discusses its prevalence, transmission, diagnosis, and the effects of the disease on the neonate. Screening and management methods are described. Midwifery practice, on personal, professional and political levels, is examined. The relevance of toxoplasmosis to New Zealand is included, and ethical issues relating to New Zealand

midwifery are raised.

Prevalence

Toxoplasmosis is a systemic protozoan disease caused by the infectious agent *Toxoplasma gondii* of the sporozoa family (Payling, 1995). It is prevalent worldwide and is found in mammals, birds, and humans. In the UK, three out of 10 people are infected by age 30 years old. The rate of infection in pregnant women is two per 1,000 or about 1,400 women a year, of which 40% will pass the infection on to their babies, so that close to 600 babies in the UK may be born infected each year. While only 0.8% of pregnant Canadian women acquire toxoplasmosis during pregnancy, and a similar incidence occurs in the USA and France, it is significant that if left untreated half of these women will pass the infection onto their fetuses (Fournier Ausman, 1993; Elliot & Torrance, 1998). In tropical countries and other parts of Western Europe up to 90% of adults are seropositive (Heitman & Irizarry, 1997).

Most cases of toxoplasmosis are asymptomatic, or mild, thus public health concerns focus on the risk of congenital infection when a pregnant woman contracts the disease just before conception or during pregnancy (Elliot & Torrance, 1998). Toxoplasmosis is also a concern to immuno-compromised people; those who are HIV positive or have AIDS; and those with cancer or kidney disease or organ transplants.

Transmission

Cats are the primary host of *toxoplasma gondii*, they harbour the parasite in the intestinal tract and the oocysts are excreted in cat faeces for three weeks after infection (Payling, 1995). Toxoplasmosis is acquired by humans by the following routes: handling dirty cat litter and garden soil contaminated with cat faeces, unpasteurised goat's milk and milk-products, and contaminated fruit and vegetables. It is also transmitted by eating undercooked meat, especially lamb or pork, containing the cysts (Holliman, 1995). Farm workers who help with lambing are at risk as lambing is a source of acquiring the infection (Dyke, 1998). Therefore awareness and knowledge of toxoplasmosis is of particular concern to New Zealanders.

Congenital toxoplasmosis occurs when the parasite is carried to the placenta in the mother's blood, establishes a local infection and passes through to infect the fetus. According to Holliman (1995) the placenta is a relatively effective barrier, less than half (40%) of women who acquire the infection during pregnancy will deliver an infected baby. The rate of transmission depends on the stage of pregnancy when the woman becomes infected; up to 25% of women infected in the first trimester will infect the fetus, this figure increases to 65% when the mother becomes infected during the third trimester. However, the chance of the fetus being badly damaged by the parasite is greatest in the first trimester and decreases as gestational age increases. Most pregnant women are not immune and are therefore at risk.

Toxoplasmosis and the Neonate

There are two categories of congenital toxoplasmosis in neonates: *clinical congenital toxoplasmosis* which is usually acquired from the mother during the first trimester; while the risk of fetal infection at this time is only 15-25%, the damage to the fetus is severe. Signs and symptoms include fetal death, hydrocephalus, brain damage resulting in retardation, epilepsy and learning disabilities, cerebral calcifications, retinochoroiditis (a pathology of the eye leading to visual impairment), jaundice, anaemia, and microcephaly (Payling, 1995). These symptoms are present at birth.

The other category is the most frequent form of the disease, *subclinical congenital toxoplasmosis*, which occurs when the fetus acquires the infection late in gestation (Payling, 1995). Transmission to the fetus at this time is frequent, about 60% of cases, because the placenta filters less. The risk of fetal death or clinical congenital disease is low while the incidence of subclinical disease is high due to the fetus' improved immune capacity. The neonate appears normal at birth but symptoms develop later in life, weeks, months or even years. The most common symptoms of this late gestation infection include cirrhosis,

encephalitis, neurological problems and retinochoroiditis leading to ocular lesions or even blindness. Eighty percent of neonates with subclinical infection will develop symptoms, especially retinochoroiditis in one or both eyes, either in infancy or up to 15-20 years later in life, most commonly during adolescence (Fournier Ausman, 1993).

The second trimester is the period of greatest risk. If maternal infection occurs between the 10th and 26th week there is a high risk of fetal transmission with high risk of congenital disease (Payling, 1995).

Diagnosis

Diagnosing toxoplasmosis in mothers who acquire toxoplasmosis just prior to or during pregnancy can be difficult, as infections are often asymptomatic or symptoms are non-specific (Heitman and Irizarry, 1997). It may present as a flu-like illness with fever, enlarged lymph nodes, headache, sore throat, and achiness which can persist for weeks (Payling, 1995). As the woman develops antibodies she gradually recovers.

Screening and Management

Few women are offered a blood test for toxoplasmosis during routine antenatal screening (Waters, 1996). A blood test is the only reliable diagnosis of toxoplasmosis, it detects two kinds of antibodies against the parasite: IgG and IgM (Payling, 1995). A raised IgG result confirms a prior infection, a raised IgM confirms that the mother is currently suffering from the infection. It is important that both tests are conducted at the same time and by the same laboratory in order to arrive at the correct diagnosis so that appropriate treatment can be offered. The goal of drug treatment is to prevent the passage of the parasite into fetal circulation, not to treat an infected fetus (Fournier Ausman, 1993).

If the results show either a raised IgG or a raised IgM the mother is treated with spiramycin, an anti-microbial drug which is taken orally every day as prophylaxis until the end of pregnancy (Payling, 1995). Spiramycin concentrates in the placenta and increases the ability of the placental barrier to prevent transmitting the parasite to the fetus (Holliman, 1995). Spiramycin is ineffective if the fetus is already infected; it has never been shown to be teratogenic. Most pregnant women are able to tolerate spiramycin; the side effects include mild nausea, diarrhoea and gastro-intestinal upset.

To diagnose fetal infection amniocentesis and cordocentesis (taking a sample of fetal cord blood) are undertaken when the fetus is 20-22 weeks gestation (Payling, 1995). An ultrasound scan may also be conducted at this time to check for

severe abnormalities. If no IgM antibodies are present a combination of pyrimethamine and sulphadiazine drugs may be given to prevent damage occurring to the fetus. These drugs are contraindicated during the first trimester as they damage fetal development. They are taken in three week courses, with spiramycin taken continuously to the end of pregnancy.

Payling (1995) suggests that if fetal blood or amniotic fluid samples show raised IgM, and therefore fetal infection, a termination of pregnancy can be offered, particularly if the fetus shows signs of severe damage on ultrasound scan. At birth, a sample of neonatal whole blood in non-preserved anticoagulant and a sample of placental tissue are required for parasite detection. Maternal and neonatal serum samples are taken to measure antibody levels, and the neonate is screened for signs of toxoplasmosis. The neonate's eyes are examined and skull radiology is recommended. If the neonate tests positive long-term drug therapy is often required. Clinamycin and corticosteroids may be used, and further blood tests may be carried out at six weeks, three months and then two monthly intervals up to one year to check antibody levels (Payling, 1995). If all antibody is lost during the first year the child is not infected and the seropositive results at birth reflect passive acquisition of maternal antibody (Holliman, 1995). The seropositive child at age one will require therapy, and often continuing specialist medical care, some for their whole lifetimes (Payling, 1995).

The Midwife's Role

Professional

Midwives need to have a sound knowledge of toxoplasmosis in order to advise women about the disease and how it can be prevented. Prevention, not treatment, is the key to reducing the incidence of neonatal toxoplasmosis.

Two independent studies demonstrate significant gaps in midwives' knowledge of the disease, both in how it can be prevented and the implications and management of positive tests. A 1993 study by The Toxoplasmosis Trust (TTT) surveying how midwives in the UK address toxoplasmosis found that routine information is given to clients at 59% of clinics and that advice is rather 'hit or miss', the disease isn't specifically mentioned unless the woman has cats (Asbury, 1994). While 95% of UK clinics test for the disease on demand, only 45% of clinics offer testing for women reporting flu-like symptoms, and 22% of antenatal clinics test on the basis of a woman owning a cat. Screening is largely consumer-led. While the majority of midwives responding to the survey perceived

themselves to be adequately informed, nearly half were not aware of whether action would be taken for a client with a current infection and the other half did not know what the action should be (Asbury, 1994). Only half of respondents knew that follow-up should be undertaken on a baby born to an infected mother.

A 1998 study in the UK found that many midwives have misconceptions about routes of infection and how to avoid risk before and during conception (Dyke, 1998). Little emphasis was put on food sources despite the fact that infection is almost always caused by ingestion of the organism on unwashed fruit and vegetables and undercooked meat. Sixty one percent of midwives responding to the 1998 survey would advise women to avoid emptying cat litter trays while only 32% would advise cooking meat thoroughly and only 23% would advise washing fruit and vegetables. While 30% identified farming as a lifestyle risk only 3% knew that lambing is a particularly risky activity. None of the midwives were aware that unpasteurised goat's milk is a source of infection. Dyke's study also found that midwives' knowledge of the clinical symptoms of congenital toxoplasmosis was poor. Eye damage is the most common outcome but was only mentioned by 29%, brain damage was identified by 19%, but only 6% specified hydrocephalus.

Midwives' knowledge of testing for and management of toxoplasmosis infection is limited. Only 51% participating in the 1998 study knew about antibiotic treatment for the mother, few were aware of diagnosing fetal infection via amniocentesis or cordocentesis. As Dyke (1998, p.146) states "these midwives would have been ill-equipped to counsel women about the implications of a blood test." Indeed, Baines, a midwife who is a volunteer local co-ordinator with TTT asks "how can women make informed choices if their carers are not fully aware of what choices are available to them?" (cited in Waters, 1996, p. 17).

Prevention

Primary prevention is the first line of defence regarding toxoplasmosis in pregnancy, midwives must have clear understanding of sources of infection and routes of transmission to give clients the best preventative and precautionary information (Dyke, 1998). Education of midwives is a prime factor in prevention.

- 1) Hygiene: handwashing after handling raw meats, fruits, vegetables, washing kitchen surfaces that come into contact with raw meat, fruits, vegetables, wash all vegetables and fruit well before eating.

- 2) Cooking: cook meats thoroughly (over 60 degrees Celsius, avoid microwaving meats and smoked meats. Avoid raw eggs.
- 3) Gardening: wear gloves when gardening
- 4) Animals: use gloves around cat litter, wash hands and gloves well afterwards. Dispose of cat litter daily. Avoid unpasteurised goat's milk.
- 5) Sandboxes: keep children's sandboxes covered when not in use or avoid contact with them.
- 6) Meatworks: avoid assisting with lambing and meat-packing work. (Dyke, 1998; Elliot & Torrance, 1998; Fournier Ausman, 1993; Holliman, 1995).

Personal

Knowledge of possible clinical outcomes of congenital toxoplasmosis is important in order to counsel women adequately. The midwifery 'partnership' with women is a very personal relationship, and the midwife's knowledge and recommendations are highly valued by women. Midwives play an important personal role in counselling and supporting women with an infected fetus or neonate. Parents need support and counselling to come to terms with the tragedy of a baby born affected by toxoplasmosis (Payling, 1995).

Political

The philosophy statement of New Zealand midwifery states that midwifery is *collaborative with other health professionals*, and that it *promotes health awareness and enhances the health status of the baby* (New Zealand College of Midwives (NZCOM), 1993).

Midwives can forge the path to eradicating congenital toxoplasmosis by active *collaboration with other health professionals*. Midwives can initiate 'toxoplasmosis education days' for themselves, GP's, school nurses, public health nurses and occupational nurses to play a role in educating students, adolescents, and workers (especially those on sheep farms and working in meat-packing plants and freezing works), about prevention and transmission. For example, in the UK, the Toxoplasmosis Trust organised a series of four study days, and developed an information pack for use in clinical and educational settings (Dyke, 1998).

Some midwifery researchers advocate a national screening program for toxoplasmosis, such as the routine screening program in place in France (Payling, 1995; Waters, 1996). Others take a more middle ground, saying that routine screening for toxoplasmosis needs further investigation (Asbury, 1994). Still others such as Holliman (1995) oppose routine screening arguing that harm to women exceeds the benefit and constitutes an experiment. It

would be of ethical interest and a challenge for midwives to research, debate, and develop a New Zealand response to a proposal of routine screening for toxoplasmosis.

Conclusion

Toxoplasmosis is a zoonotic disease that affects nearly all warm-blooded animals and humans. Most cases are asymptomatic and public health concerns focus on the risk of congenital infection. The consequences of congenital toxoplasmosis depend on the gestational age of the fetus when primary infection occurs. Severe infection in pregnancy can lead to spontaneous abortion or stillbirth, or a host of devastating effects on the neonate which may cause future suffering for the infant and parents, necessitating costly long-term care.

Prevention, not treatment, is the key to reducing the incidence of congenital toxoplasmosis. The most effective and least expensive way of preventing the incidence of toxoplasmosis is through professional, public and client education. Midwives currently demonstrate a lack of knowledge on prevention, implications, and management of the disease. Professionally, midwives need sound knowledge of toxoplasmosis in order to educate and advise women. Study days and written information packs would be useful to improve education of midwives and other health professionals.

On a personal level, midwives are relied upon for counselling and supporting women and families affected by the distress of congenital toxoplasmosis.

Politically, midwives can increase collaboration with other health professionals for education, information and awareness, to improve preventative education of women pre-conceptually. The ethics of a national screening program needs to be investigated and debated to determine the benefits versus the harm it would extend to women.

Midwives can play a considerable role in bringing about an end to a preventable, increasing and tragic disease that causes long-term distress to families.

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'Being safe' in childbirth: what does it mean?

A phenomenological / hermeneutic approach

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Introduction

Midwives know what it means to 'be safe' for it is within their every experience of practice. They also know what it means to be unsafe. They go home with a sick feeling, wondering if they could have done anything different to have prevented the unexpected outcome. Phenomenology, the approach of this study, suggests that we take for granted the meaning of phenomenon such as 'being safe' that lie at the heart of our everyday lives. We simply assume that we all understand what it means to be safe. This study looked beyond that assumption, and considered afresh 'what does it mean to be safe?'

Approach

The study was informed by the philosophies of Heidegger and Gadamer. It sought to understand meaning uncovered from the stories of experience. I came to this research with my own prejudices about the meaning of being safe, born of delivery suite practice at a base hospital maternity unit, and more than a decade of teaching midwifery students. While my interpretation strove to be open to the meanings of others, the analysis comes from the interplay of all the attitudes, thoughts, experiences, values and emotions that are embodied within me. What I offer the reader is not, therefore, the unbiased objective truth. It is simply my interpretation of what 'being safe' might mean that has grown out of several years of dwelling with the data of this study. You are invited, as reader, to continue this journey of interpretation from your own background of understanding. This is the nature of the hermeneutic partnership between researcher and audience.

Background

I interviewed 6 midwives and 4 doctors, asking them to tell me what 'being safe' meant to them. I then listened to the stories of 10 women who described their childbirth experiences, paying particular attention to times of feeling safe or unsafe. Throughout this process of interviewing, transcribing and engaging with the data, I came to an embodied engulfment of meaning. The method of phenomenology is to write what it might mean, to ask the question "what am I trying to say?" and to begin the writing again. The writing uncovers a deeper layer of meaning, and each re-write arrives at a new depth. The philosophy of Heidegger gave me the insights about 'being human' that shed a strong beam of light into my writing and helped me come to new places of understanding.

Insights

The nature of the phenomenological report is to take the reader by the hand and retrace the journey of coming to find the new insight. The constraints of a journal article do not allow such a process. I therefore take the liberty of laying my findings out before you. It is a leap of trust, for I leave much unsaid and unexplained.

Unsafe may already be there

The nature of childbirth is that it is always open to what Heidegger (1927/1962) called 'thrownness'. The pregnancy itself is thrown upon the woman. It may proceed without complication, or problems may develop. They simply happen. The problem is already there when the midwife meets with the woman. Women of 19th Century New Zealand were mindful of the thrownness of childbirth, as described in this comment from a 31 year old woman expecting her first child "I let myself plan for the near and far future, but I am not at all sure that I shall see either. I don't feel in the least despondent, however, but I know I am not very young and that next month must bring its risk" (Porter & MacDonald, 1996, p.353). This woman understood that childbirth in itself had the potential to take her to her death. In today's world it is assumed that the midwife or the doctor, supported by the wonders of modern medicine, will prevent such a death occurring. Antibiotics, blood transfusions, caesarian sections and many more technological advances have significantly reduced the possibilities of death. What has not changed, however, is the initial thrownness that first creates a life threatening problem. The beginnings of complications such as placenta praevia, pre-eclampsia, mal-position, simply are there. The unsafeness is there waiting for the woman or the practitioner to find.

The darkness

So much of the knowing that could inform practice lies in the darkness. Heidegger

(1927/1962) tells us that phenomena lie hidden, covered up or in disguise. Our task is to uncover and bring to light, while all the time being mindful both of what still lies in the darkness, and what might be fooling us in its disguise. This midwife describes her experience of the darkness:

Because of the fragmented way that my antenatal practice has come over the years in the big institutions, I never saw anybody all the way through the pregnancy, until I started to practice for myself. And I had this terrible paranoia when I first started to practise, that somewhere in the early thirties [30 weeks gestation], and then towards the latter part of pregnancy there'd be these patches where baby didn't seem to have grown. And it wasn't till I talked to other practitioners who said "that's alright, babies grow in spurts" that I could relax and wait for the next time without rushing her off for a scan to see if there was a problem.

The thing is, you can make a mistake quite easily, or put down to just a flat patch in the growth spurting, when in fact there is actually poor growth going on. So there are areas when you can sort of get trapped with the abnormal mimicking the normal. You come to learn that you can't always tell in advance and that's the trouble ... that around birth you do most of it with your eyes shut. And whether that's a safe decision is often only known in retrospect, because it can only be known in retrospect.

The fetus lies both metaphorically and literally in the darkness. It cannot be seen in its own self. The 'appearance' of a growing fetus can be seen from one visit to the next. An 'announcement' can be made by the woman who tells you she can no longer wear the clothes she had on last time. Heidegger, however, reminds us of the 'semblance' of the growing fetus. We can so easily be fooled into seeing a normal pattern, when in fact it is the abnormal mimicking the normal. Being safe is therefore about respecting the unknowness of the darkness, and not assuming that what you think you see is how it really is.

The spirit of safe practice

The safe practitioner knows that there is always potential for problems to develop, and what is more, is aware that the problems could already be there, even though they have not yet shown themselves. They therefore bring to each practice situation a spirit of engaged concern. How does concern show itself in practice? It shows itself in **mindfulness**:

I look at all possible angles that might happen, and also anticipate as much as I can what might happen for her and the

baby. And I make sure that I am doing all those things, in my mind I am turning them over, so that I can give her safe practice, so that she can feel that it's safe

It shows itself as **watching**:

I say 'this might be your sickest woman, but watch this woman here, that woman there, and that woman there.

You need to watch them, because they are reporting their movements are less. This woman has had a bleed before, she may not be having it now, but watch her, watch those things.

Watching is the vigilant embodiment of the alertness that is ready to see, and waiting to see.

It shows itself as **anticipating**:

A person with high blood pressure, you know they are going to go down a certain road, and there are several tracks in that road. It's about planning out. Planning 'is this going to happen?' 'what might happen?' 'let's plan for this, let's hope it is going to be normal but let's plan for this'. And then suddenly those things just start to fall into place. And you think 'ah ha, this is it'.

Anticipation respects the darkness that covers what cannot be seen. It is always attending, considering, discussing, evincing, determining. It is always in process.

The spirit of safe practice is seen most clearly in engaged **doing**:

Your main thing is to know when you've got a problem, and then know what to do about it. You see, I go to a birth and I assess the woman, and if there's something there that needs adjustment, and I feel I can do it, then I do it. I just respond to what's happening. I mean I don't do anything arbitrarily, because you never know the hidden potential for the woman you are looking after, or even the hidden inadequacies. So you just have to be alert to things. But you can't say 'oh well this is what is happening, this is what I do, because that's not what I do necessarily.

The doing brings to light the concerned mindfulness of practice that is totally focused on what is happening right now, without ever forgetting what may have already happened, and always anticipating what might be about to happen next.

Heidegger (1927/1962) says concern, in its positive mode, falls within two extremes: **to leap in and to leap ahead**.

To leap in is to take care away from the other, to take over for the other. The other

becomes dominated and dependent.

To leap ahead is to go ahead of the other, not to take away their care, but to give it back to them. It is authentic care, where the 'other' (the woman) is free to determine her own experience.

The safe practitioner must judge when to leap-in and when to leap-ahead. In this story the midwife does both:

It was a homebirth. The woman had made no progress at all. Her sister was stuffing around. I didn't pick it up right away that that's what the problem was, because her sister was being very attentive. And so eventually her labour stopped. I took the woman aside and I said "well, what's the problem?", and she said "well, it's my sister and I can't ask her to go home". I said "I'll ask her to go home", so I explained to her that labour had stopped and it would probably be a good idea if she went home and let the woman have a rest. What it turned out was, that this girl had been sexually abused by her brother, and when she had told her sister, the sister denied this could have happened to her. So there was all this hostility between them. As soon as her sister went, away went labour and she had a nice normal birth.

This midwife leapt-ahead to enable the woman to recognise for herself what the problem was. When the woman said she couldn't ask her sister to go, it was the cue for the midwife to leap-in and take that decision away from her. The spirit of safe practice has the courage to both give away decisions and take decisions on behalf of. The wisdom of practice lies in knowing when to give and when to take.

Judging is the hallmark of the safe practitioner. How does judging happen. T.S. Eliot describes the still point of the dance:

*At the still point of the turning world ...
neither from nor towards;
at the still point, there the dance is.
...
Where past and future are gathered.
...
Except for the point, the still point,
there would be no dance, and there is only
dance.*

*I can only say, there we have been: but I
cannot say where.
And I cannot say, how long, for that is
to place it in time.*

T.S.Eliot, *Four Quartets*.

I believe that the judging of practice happens within the turning world of the dance of practice. Who can say when a pondering comes to the mind, who can say when a cue from the past gives rise to a

premonition of danger in the future, who can capture the still point amidst the ever-moving, ever-changing complex world of practice. Yet, for the safe practitioner, the still points are like beacons that guide the way forward. Each fresh burst of light reveals more, and leads to more. Still points arise from the mindfulness of concern: from watching, anticipating, and doing. They **come** to the safe practitioner from their engagement with the dance of ontological practice. They bring light to the darkness. They reveal what is safe and what is becoming unsafe.

Indifferent and neglectful modes of safe practice

We must not assume that all practitioners, all the time, go to their practice with an attitude of concern. Heidegger (1927/1962) reminds us that there are indifferent and deficient modes of concern: leaving undone, neglecting, renouncing, taking a rest (Heidegger, 1927/1962, p.83).

One practitioner in my study, having described a run of nights with no sleep, commented: "I was just exhausted ... I'm a bit worried about that sort of situation, when I can't be bothered, I'm too tired". Tiredness, poor health, stress, distractions of personal life and many other features of 'being human' are likely to take away from alert, mindful engagement. Yet, we work within a climate of being expected to cope. I have a sense that all too often safe practice is a semblance. The practitioner may go through the routines of what is normally done in such a situation, but they are not being mindful, they are not watching, they are not anticipating, they are not engaged with what is actually happening in this specific case, and as a result their judging has no meaningful foundation. The problem is that even when the practitioner admits to themselves that they are heading for indifferent or neglectful practice, colleagues and employers do not make it easy for them to make such a confession, nor are the strategies to nurture the safe spirit readily to hand. The semblance of 'safe practice' will continue to be an acceptable mode of practice until we dare to consider what it really means to be safe.

The vulnerability of the spirit of safe practice

The practitioner, even with the best intentions and capabilities, is never in complete control of a situation. They are "pressed upon and hemmed in" (King, 1964, p.81). It is a with-world, where others, in both their presence and absence, prompt us into what we do, or do not do. It is a world where the resources we take for granted and without a second thought use within our practice, may let us down. It is a world of

thrownness for both ourselves and our clients, where things can happen above and beyond our wanting, expecting, or ability to deal with. They simply happen. The problem is already there, waiting for us. Consider this situation:

The woman was 35 weeks. The midwife who was looking after her and I, said to each other "oh help, all these risk factors, why is she here?" we asked ourselves. "Why is she not downstairs in delivery suite?" We had told the medical staff that she shouldn't be here, but no, no, they were too busy to look at it.

Each shift of midwives, with concern, closely monitored the baby all day.

They said to the night staff, "if you get one dip, take this woman to delivery suite, don't even ask, one dip". So, that happened, down went the dip, but everything was fine, except for that one dip. So they didn't ask questions, down she went.

They were still busy downstairs. Now this woman was on her own for sometime, and she was on syntocinon to bring her labour on, and the baseline of the fetal heart trace goes up with those shoulder dips on it. By the time the person discovered she had this tracing it was awful. They rushed around and did a caesarian section. And that baby is her first baby, knocked off.

Was the practice unsafe, or is this a story of the pressing hemming world of practice, where the practitioners were too busy to be safe? Or, is it a story of an unborn baby that had already been thrown into danger long before the time of birth? Was it already too late to change this outcome? Would the midwife who took this woman for the caesarian section go home with the burden of 'being unsafe' on her heart, or would she recognise that she had been as safe as she could be within that pressing hemming duty?

Walt Whitman asks us:

Have you heard that it was good to gain the day?

I also say it is good to fall, battles are lost in the same spirit in which they are won

(*Song of Myself 18, 1855*).

Judging care unsafe

An unexpected, undesired outcome does not necessarily declare unsafe practice. In a situation where a midwife is called to account for her practice, this study suggests that some of the questions that need to be asked are:

- Was the unsafeness already there?

- Was it already too late for a practitioner to influence the outcomes of this situation?
- Did the practitioner bring a spirit of safe practice, or were they working from a semblance of safe practice?
- Did the pressing, hemming world of practice rob the practitioner of the opportunity to be safe?

None of these questions stand alone. They are all intertwined. Those who judge look back with the enormous advantage of now knowing what for the practitioner once lay hidden in the darkness. It is so easy to see retrospectively and so difficult to see when the problem still lies hidden in the darkness, perhaps showing itself as a semblance of being normal. Beyond these questions are the broader ones of 'who is responsible?' Is it the person who was there? Is it their partner or the management who saw that the practitioner was tired and stressed, yet expected they keep on going? Is it the funding body who did not provide enough resources to stop the world of practice from 'pressing down and hemming in'?

Closing thoughts

Practitioners can make a difference to the safety of a situation, but they cannot necessarily make what is already unsafe, safe. The nature of childbirth is that some things lie in the darkness. Some things simply happen. Sometimes the world of practice entraps the intention of 'being safe' and leaves the practitioner's concern hammering at a locked door. In this age of litigation, the challenge for the profession is to know the difference between safe practice, and the indifferent and neglectful modes. The maternity services, in all its configurations, must be on guard against the semblance of safe practice. To be seen to go through the rituals of safe practice is not enough. Each situation is like no other. Each has the potential for the unexpected to descend upon it. The safe practitioner is always mindful of the uniqueness, always watching for the unexpected, always thinking ahead, always ready to respond in the manner that is most appropriate. Perhaps it is the 'always' that presents the biggest challenge.

The spirit of practice wants to do its very best wants to save the woman from all harm wants to have the perfect baby wants the woman to feel safe wants to be seen as safe wants to be safe.

The spirit of practice never sleeps never gets discouraged never gives up

*never takes short cuts
never ceases from vigilance*

*It has a knowing
as precious as gold*

*At the still point
the spirit is born again
in the judgement,
living again
in all its consequent
being and showing*

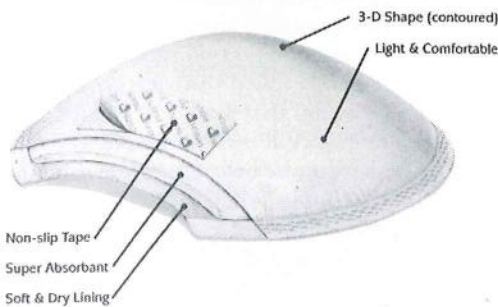
*The spirit
So vulnerable
to what stands in its way
So easily misguided
by the disguise
So blinded
by the darkness*

*The spirit of practice
where is it right now?
in the humdrum of everyday*

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Portfolios - a necessary evil?

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Otago Polytechnic

Introduction

It appears that midwifery regulatory bodies both in New Zealand and overseas, have embraced the concept of professional portfolios or profiles, to such an extent that the maintenance of a portfolio will become a requirement for sustaining midwifery competency (Nursing Council of New Zealand, 1999). What then is it that makes the New Zealand registration authority believe that a portfolio is vital for a midwife's professional development? Why do midwives appear to have the opposite opinion, and throw up their hands in horror whenever the subject of portfolios is raised? In this paper, I wish to examine these questions, and using literature and my own personal experience, endeavor to provide some answers that will prepare midwives to explore the issues further.

Whilst I use the term 'portfolio', the Nursing Council of New Zealand (1999) employs the terminology, 'profile'. The terms are used interchangeably in literature (Brown, 1995) to mean a collection of evidence which illustrates the continuing acquisition of skills, knowledge, understanding and achievement.

What is a portfolio?

Portfolios have been used for some time in the teaching profession as a vehicle for teachers to display their duties, expertise and growth in teaching (Doolittle, 1994), to promote better teaching, and at consideration for tenure or promotion (George, 1996). However, it is only recently that the use of portfolios has become an integral part of midwifery registration (United Kingdom Council for Nurses, Midwives and Health Visitors (UKCC), 1995; Nursing Council of New Zealand, 1999).

A portfolio provides information about a midwife's professional and personal development (Richardson, 1998), and is a record of her practice (Nursing Council of New Zealand, 1999). It contains current activities and evidence, as well as works in progress and reflective writing (Crist, Wilcox & McCarron, 1998). Zubizarreta (1999) maintains that when cultivated properly, the portfolio challenges practitioners to cross-examine what, how and why of practice with the aim of improving practice.

Portfolios commonly take the form of ring binders that allow material to be added and removed at will. There are various commercial portfolios available from organizations such as MIDIRS Midwifery Digest and the New Zealand Nurses Organization. The advantages of these are that they provide a ready made structure (Hull & Redfern, 1996) which is especially useful for midwives who have no idea what a portfolio should contain. However, ready made portfolios can be restricting and the midwife may decide to design her own.

A portfolio should contain factual information; evidence of professional performance; record of goals and action plans; record of formal learning and working hours (Stewart, 1998). Midwives who undergo the New Zealand College of Midwives' Standards Review process already collect the evidence, and carry out reflection on practice as required in a portfolio by the Nursing Council of New Zealand (1999). I have found by my own experience that preparation for the yearly midwifery Review is not anything as time-consuming as some practitioners complain. I just go to my portfolio and take out the evidence, information and reflection that I have carried out during the year and present it to the Review Committee. After review, I then place back the material with a written contemplation of the process itself, with my aims and goals for the following year, and the certificate of participation from the Review Committee. Thus, I find the portfolio and review process are interconnected, and they each accentuate the value of the other.

Experiential learning

The strengths of the portfolio is that it values experience as a learning opportunity (Alsop, 1995a). One can achieve as much learning from an every day incident in practice, an article one has read, or a paper one has written, as from attending numerous study days. The problem that Woodhouse (1999) has noted is that practitioners who have portfolios have not recorded what they have learned, or how they have applied their learning to practice. The UKCC (1999) in their audit of portfolios have found that many nurses, midwives and health visitors have regarded the portfolio as merely a collection of certificates and have shown no evidence of reflection. By recording the activity one has undertaken in a portfolio, documenting the learning and its outcome, one is able to demonstrate that professional development has taken place (Alsop, 1995b). The evidence one collects must substantiate the professional development that is being claimed (Crist et al, 1998).

Recognition of skills and knowledge

When the midwife uses the portfolio for self-analysis, she will find the portfolio enables her to identify and value her strengths (Nursing Council of New Zealand, 1999), and formalize the everyday things that are not normally given credibility. Thus, it will add to the midwife's self-esteem and increase her confidence (Ryan & Hodson, 1997). In turn, this self-analysis

enables one to make out weaknesses and areas than require further development (Kratcoski, 1998). One can then go on to formulate plans to rectify gaps in experience and knowledge (Alsop, 1995b). This self-analysis in a portfolio will likewise provide the means for review of one's career, and the development of a career plan (Alsop, 1995b). Price (1994) notes that action plans connect into each other and supply directions for professional interests. Thus, the portfolio provides the stimulus for growth and lays the foundation for active evaluation based on genuine evidence (Zubizarreta, 1999).

Value of writing

The question that I have struggled with is why do I have to put everything into writing. This question has been coupled with my other query about what exactly I should be writing. Even after seven years of keeping a portfolio, I am never quite sure that I have written enough, or too much. My concerns about the process of writing have been reflected in the limited amount of research that has been carried out on portfolios (Woodhouse, 1999; Gerrish, 1993). Gerrish (1993) found that the subjects of her research considered they had to be fluent writers in order to be able to successfully record their personal feelings and the spirit of their understanding. Jasper (1995) advocates that midwives need help with developing writing skills. I have found in writing down my experiences that I have become clearer about what happened, and what I have learnt from the experience; what I learnt from reading an article and how I am going to apply that to practice; what my

goals for the next five years are and how I am going to implement them. The value of creative act of writing according to Rolfe (1997) is that knowledge is produced during the process. Rainer (1989, cited by Mitchell, 1994) also contests that a catharsis occurs when writing and problem skills and creativity are promoted and Lyotard (1992, cited by Bolton, 1998) suggests that we write in order to find out if what to say and how to say it. These sentiments accurately vocalize my experience with documenting my practice in a portfolio.

Time constraints

I believe that one of the perceived problems of keeping a portfolio is that it is so time-consuming, and an added burden to practitioners who are already balancing the demands of their profession. I agree that maintaining a portfolio is a real commitment (Woodhouse, 1999) but have found that it becomes easier when I keep up-to-date with entries - memories of facts and details diminish with time. I also believe that its value is increased if the entries are prospective as well as retrospective (Crist et al, 1998). For example, documenting one's action plan for career development is of little worth after one has already achieved one's aims and objectives.

Support for midwives

In order for portfolios to be truly beneficial for midwives, I believe that there must be support for midwives from colleagues, management, and the profession itself. Thorogood, Mason, de la Harpe and Radloff (1999) argue that

support is needed because portfolio development is a slow and progressive activity. Midwives need to see the value of the portfolio rather than see it as a paper exercise. Midwives who are already undergoing some sort of review or appraisal/assessment will be proficient with recognizing their strengths and weaknesses, and with documenting their practice. I concur with Jasper (1995) when she concludes that portfolios have great possibilities as long as the practitioner perceives its relevance and merit, and the educational and managerial infrastructure of support is in place. Uncertainty about what is expected of midwives is likely to have a negative effect on the motivation to keep a portfolio (Mitchell, 1994). I would like to suggest that managers and educationalists work together to facilitate information sessions and workshops, and that midwives are encouraged to seek constructive advice and support from peers and mentors about portfolio development (Richardson, 1998; Stewart, 1998).

Portfolios are empowering

Finally, as much as I agree that portfolios are a valuable tool for professional growth, I also have to acknowledge that there has been little research into how practitioners use their portfolios and the benefits to individuals, the provision of midwifery care and the midwifery profession. I would suggest that research needs to be carried out into such issues as how midwives utilise portfolios; what they see as the advantages and disadvantages; have they needed to submit a portfolio with a job application, and has presenting a portfolio strengthened their case; how have they utilised portfolios, if at all, whilst undergoing review?

There appears to be mixed feelings about the benefits of portfolios with some questioning that portfolios are as useful as claimed. However, there seems to be agreement that the main benefit of the portfolio is that it recognizes experiential learning. What is significantly different about the New Zealand experience of the portfolio is its connection to the Review Process which I believe will prove to validate the value of keeping a portfolio.

The problems are that keeping a portfolio is time-consuming, and practitioners need help with improving writing skills, and require managerial and educational support. My own personal experience with keeping a portfolio corroborates these findings. I must add that once

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keeping my portfolio became a part of my professional practice, interrelated with the Standards Review process, the benefits far outweighed the disadvantages. I know that midwives in New Zealand find the same empowerment in their experiences of keeping a portfolio as I have.

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Surfing the Net

I would like to start this journal's review of websites by firstly recommending two midwifery journal articles that give clear, basic information about the Internet, and which are particularly appropriate for those of us who have a minimal understanding of how the Internet works. These articles are a good springboard for midwives who are new to the Internet, but I wouldn't rush off to get them if you are a lot more knowledgeable.

Drake, E. (1999). Internet Technology: resources for perinatal nurses. *Journal for Obstetric, Gynaecological and Neonatal nurses*. Jan./Feb/. p 15-21.

Huntley, A. (1999). Midwives in cyberspace. *Midwifery Today*. Spring, p 20-21.

<http://www.vhpublishing.com/woman2woman>

I have come across a variety of websites in the last six months, which have been of varying benefit. The 'woman to woman' quarterly newsletter is published by Cathy Hartt, CNM.

I didn't find the newsletter particularly helpful, but the site has a number of useful links to other midwifery sites such as: <http://nursing.miningco.com/health/nursing/msubmidwife.htm> This site, in turn, has great links to midwifery and childbirth-related sites.

<http://www.knowledge-basket.co.nz/kete/nzsearch.html>

The knowledge-basket is a New Zealand-based search facility that specialises in legal, government and Maori documents. I used this site the other day to find details of the 1993 Privacy Act for a lecture I was giving. My only criticism is that it took a little time to find my way around the site.

<http://www.stats.govt.nz>

A useful and attractive site I recommend to students is the Statistics New Zealand website. One can find vast and diverse information about New Zealand and New Zealanders, ranging from the total overseas debt to the birth rate amongst women according to their age. I would recommend bookmarking this site, especially if you are investigating the New Zealand scene.

<http://www.geocities.com/Heartland/Prairie/2944/face.htm>

Another page I tell students about has a wonderful picture of a baby being born with a face presentation. You may not want to hang on to this page, but it is a great tool for teaching about face presentation.

<http://www.babyscoming.co.uk>

Virginia Howes is an independent midwife in the UK and has just got her own web page up and running. There are quite a few pages under construction, but when it is finished, I think it will be a very interesting site.

<http://sites.netscape.net/dawsonpauline/Midwifery.htm>

Pauline Dawson is a student midwife in Wellington who has her own site with a number of useful links, in particular to Ina May Gaskin who is the guest speaker at the NZCOM conference in September.

<http://www.geocities.com/HotSprings/4993/>

Another one of Pauline's links is to the Domino Midwives in Wellington.

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

A further personal website I have found is that of Michelle Lord, an independent midwife in Hamilton. I have found it very interesting to visit personal sites and compare the numerous styles developed by midwives for their Internet pages.

<http://www.mdx.ac.uk/www/rctsh/ebp/main.htm>

A site that may not appeal to everyone but I found very stimulating is the Teaching/Learning resources for Evidence Based Practice (EBP). The site provides resources such as a teaching plan and strategies for implementing change that can be downloaded and used for teaching and learning EBP. I had trouble downloading the MS Word 6 files, but was able to download the portable document files. However, to be able to do this you need the software, Acrobat Reader 4.0. If nothing else, this site provides questions we can ask that will stimulate our thinking on EBP, which is particularly helpful when we are involved in looking at policies and guidelines.

<http://www.womens-health.co.uk>

The women's health information site is maintained by Danny Tucker who is an obstetric and gynaecological registrar working in the UK. This site provides an array of information for women and their partners about issues around pregnancy choices, investigations and complications. It also has a journal watch, which reproduces a summary of articles of interest published in such journals as the Lancet, British Medical Journal, and the Journal of the American Medical Association. I found nothing major to complain about in the page on breech birth.

<http://womenshealth.medscape.com>

The Medscape site is a huge American site that specialises in providing information for health professionals. I am automatically linked into the women's health page, which covers a whole range of women's health issues. It provides information about clinical management, treatment updates and practice guidelines. It is a very 'busy' site that takes time to navigate and find something of relevance and interest to midwives. What I find most useful is the weekly newsletter that comes via e-mail, which contains an index of key news and features that are compiled by the Medscape editors.

Finally, a story that came from a Technical Support Line. A woman called the Canon help desk with a problem with her printer. The technician asked her if she was "running it under Windows". The woman then responded, "No, my desk is next to the door. But that is a good point. The man sitting in the cubicle next to me is under a window, and his is working fine."

Don't forget the New Zealand Midwives mailing list. To subscribe, drop me a line at Mazza@clear.net.nz

Sarah Stewart

Video Reviews

REVIEWER: Leslie Monigatti, Childbirth Educator, Waitemata Health

Well Mother Exercise and Massage: Exercise in Pregnancy

Produced by Mark-It Television " 1998

Cat. No. MITV 0046

Running Time 45 minutes

This video offers good quality advice about exercising, an important corollary to the health and self care of pregnant women. It is presented by Suzanne Yates, noted shiatsu practitioner and childbirth educator, and also features interviews with other midwives. Although best suited to a session devoted exclusively to exercise and relaxation, it would also be helpful to the client at home with guidance from a health practitioner.

The points covered are:

- Posture in pregnancy
- Breathing and relaxation
- Exercises for special situations
- Integration of exercise in daily life
- Bonding with the unborn child
- Exercise with a partner
- An exercise sequence specific to pregnancy

The video introduces and explains the exercises clearly enough for most clients. It demonstrates the exercises appropriately, taking into account special situations such as for women with multiple pregnancies or skeletal problems. The sections on pelvic floor exercises and optimum foetal positioning are skillfully presented. Pertinent, and important, emphasis is placed on the need to avoid over-exercising and care for the back. Surprisingly, however, there is not a mention of warm-up exercises prior to stretching, and important component of injury prevention.

No session about exercise in pregnancy would be complete without some devotion to squatting. The video demonstrates this judiciously and shows a variety of techniques, but there is insufficient emphasis on keeping the feet flat on the floor to avoid injury to the Achilles tendons.

There are minor faults in the presentation, such as the visual focus being on one body part while vocal instruction is on another, but these detract little from the clarity of the procedures overall. This is a good resource for childbirth educators, provided it is used with appropriate supervision.

Well Mother Exercise and Massage: Baby Massage

Produced by Mark-It Television " 1998

Cat. No. MITV 0045

Running Time 30 minutes

This video on baby massage is a worthwhile tool for augmenting the parent-child relationship. Presenter Suzanne Yates, shiatsu practitioner and childbirth educator, is ably supported by other professionals, including one who discusses the technique from the Asian woman's perspective.

The points covered are:

- Baby massage sequences
- Adaptation to the older child
- Massage and exercise to enhance the child's development
- Parental/child relationship enhancement
- Massage as communication
- Benefits for baby and parents
- Involvement of fathers and siblings

The video introduces the topic well, and offers sound advice about the oils to use and which to avoid. It emphasises the benefits of incorporating baby massage into the daily routine and how this can foster a good relationship between the parent and the baby. It would be helpful to know, however, whether this is empirical or evidence-based.

The presentation includes exercises for child development and helpful hints for parents on conditions such as 'cradle cap'. There is an appropriate focus on safety, including useful advice as to the care required during certain movements. However, although viewers are warned to remove jewellery and cut their fingernails to avoid scratching the baby whilst massaging, this is sometimes inconsistent with what is being shown.

Some of the massage techniques involve the baby lying on his stomach. Whilst encouraging parents to assist the infant's development in this way, the video also reminds them of the importance of the 'back to sleep' philosophy.

Repeatedly, caregivers are urged to heed the baby's cues to ensure he is relaxed and not objecting to the movements. The message is that the technique promotes communication with the receptive infant, but should be phased out as his needs change.

This video is a valuable resource for any midwife's or childbirth educator's library.

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Style as follows:

- Pairman, S. (1999). Partnership revisited: Towards a midwifery theory. *New Zealand College of Midwives Journal*. 21, 6-12.
Bryar, R.M. (1995). *Theory for midwifery practice*. London: Macmillan Press.

