New Zealand College of Midwives (INC)

JOURNAL

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

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NEW ZEALAND COLLEGE OF MIDWIVES (INC)

Contributing to the New Zealand College of Midwives Journal

Gillian White, Editor

Since taking over as the Editor of the *New Zealand College of Midwives Journal* I have undergone a steep learning curve, predominantly in relation to design and publication. The position of Editor has hidden challenges and can be stressful but in the main is very rewarding. All of us learning a new job want to improve, we certainly want to get it better next time, and I am no exception. This edition of the NZCOM Journal is the result of trying out new ideas, seeking the advice and expertise of others and putting into practice what I have learned. It is also my last production as Editor. My current work commitments have increased and it is important that I focus on the objectives that I have set.

An editorial team, in Dunedin, will manage the next edition, due in October. The team from Otago Polytechnic have already begun their planning with enthusiasm and we can look forward to another phase in the development of the *New Zealand College of Midwives Journal.*

An important issue for getting a publication out on time is that the proofs are camera ready. In other words, it saves time if articles are submitted to the design and printing agent in the format appropriate for the Journal. Otherwise papers are sent backward and forward until the edition is finally (almost) flawless.

It is also important to submit articles to be considered for publication with a good lead-in time if they are to be peer reviewed (which is the aim of this Journal), sent back to the author for amendments or editorial changes, and re-submitted in time for inclusion in the forthcoming Journal.

Naturally, the Journal depends on its authors. The small band of authors who have supported the Journal through their submissions has impressed me. In this edition you will find a wide-ranging sample of such authors.

Professor MaryAnne Levine is currently spending time in New Zealand sharing her expertise with Victoria and Massey Universities as well as midwives throughout the country. Her guest article raises awareness of issues for childbearing women and young children in the developing world who continue to exist within a life cycle of poverty. While MaryAnne's experiences derive from countries with extensive poverty her plea for recognising and valuing new mothers and their young children is an important message for all societies.

Sally Pairman continues the international theme in her paper on international trends and partnerships in midwifery education by exploring the concept of partnership through a variety of relationships underpinning educational programmes.

The midwife-woman relationship is further examined by Stephanie Vague who pursues a dimension of quality in practice identified as "warmth." The qualities of warmth and emotional availability are privately felt rather than publicly audited and evaluated. There are, however, aspects of midwifery practice that are open to evaluation according to nationally derived guidelines.

Anne Barlow has determined aspects of the NZCOM Standard Review Process that work well and those that need improvement. Using a case study approach Anne evaluates the educational aspects and cultural adequacy of the current review process.

While women in developing countries seek to have their basic needs met many women in industrialised countries are facing a modern phenomenon of caesarean section on demand. The implications of this rising international trend are discussed by Jeannie Douche in her position paper on caesarean section in the absence of clinical indicators.

Finally, a thought provoking article by Jack Heinemann has been included in which he debates contentious issues concerning alternative vs conventional medicines. In this paper Jack raises a serious issue about societal need for certainty.

From poverty, where women live in a world of uncertainty and have no freedom to choose, to societies where women demand certainty and are privileged to have the freedom to choose, this edition of the NZCOM Journal weaves a challenging path for its readers. I hope you will enjoy this edition and you will continue to support the new editorial team as you have supported me.

Together, let's endeavour to achieve a reputation to match other high quality professional midwifery journals.

Childbearing women and poverty in the developing world

Mary Anne Levine MSN, RN, SCM
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Introduction

In working with childbearing families in the developing world for more than thirty years and despite the emergence of a so called global community, the web of poverty for the majority of women and their children has not changed. For many, the cycle of poverty has even intensified and is manifested as a downward spiral that is difficult to evade (Beneria & Bisnath, 1996; Filmer and Pritchett, 1997; Levine, 2000a, 1993; Prakasamme, 1998; Solimano 1999; Williams, Baumslag & Jelliffe, 1994). As the state and status of poor childbearing women and their young children continues to deteriorate pregnancy, labor and delivery, and the puerperium are fraught with multiple risks to both mother and baby. This paper will address numerous influencing factors that contribute to the complex issues of childbearing women and their children in the developing world, and the invisibility of their struggle.

Social Milieu

In any given society each person is the end product of his/her socialisation process. This is greatly influenced by the five basic institutions of all cultures: government, education, economics, family and religion. Families have a great influence on all individuals, especially girls. In the developing world, as in the industrialized world, girls are socialized to model their mothers' behaviors. This means that girls at a very young age are caring for their younger siblings, the family home and the food garden. Girls in the developing world learn to become domestic engineers, and even more important learn to be pliable, adaptable, and acquiescent in their life. For women of the developing world, marriage and childbearing are the two biggest developmental milestones to which they must aspire in order to survive. The family/extended family unit is the essence of life for these women (Beneria & Bisnath, 1996; Levine, 2000b,c; Filmer & Pritchett, 1997; Solimano, 1999; Williams, Baumslag & Jelliffe, 1994).

Deprivation and Poverty

Poverty is pervasive for the majority of these women. Education is scarce, access to health care sporadic or inadequate, housing substandard, potable water is difficult to obtain, and food intake is limited to what is cultivated by the family and/or available for purchase on a very limited income. Life is a daily struggle for survival with insufficient resource options. The constructs of poverty are all encompassing and affect every facet of existence.

The lives of women in this milieu are predicated on their gender, family structure, financial status, and educational level. Female gender implies marriage, motherhood, home and subservience. Family structure is such that males are the decision-makers and leaders; women the followers. Finances are the domain of the males of the family and education is not considered a necessity for females. Job opportunities that directly relate to the number of years of formal education relate to economic opportunities and thus family lifestyles. Religious beliefs, and its prescriptions and proscriptions also impact roles, family values, and even educational opportunities (Beneria & Bisnath, 1996; Filmer & Pritchett, 1997; Levine, 2000a,b; Solimano, 1994).

Girls may be viewed as a financial burden as the time they spend with their families of origin is short. There is a reluctance to make an investment in female children, as there will be no future collective family gain. Most girls are married between the ages of fourteen and nineteen and then belong to their husbands' families. Sons remain an integral part of the family, in this gender-based structure, and their wives are completely absorbed into the marital family; permission may even be needed for a wife to make a visit to her biological family.

Status is determined upon the ability of women to bear children, which confers higher social status and also promotes feelings of self worth; one must literally (re)produce. To have any major cultural or formal value fertility is further enhanced with the importance placed on male children versus female. In some cultures it is the number of children that count. Men are considered 'real men' as the number of children they biologically father accrues; women are valued by their producing offspring.

Meeting Basic Needs

Substandard housing, whether in a temperate or tropical climate, implies a lack of amenities: dampness, mildew, earthen floors, lack of proper ventilation, cooking on a wood fire, no near water source, potable or other, no drains and no adequate receptacle for human waste. There are no ways to keep food fresh, overcrowding is common, farm animals share family living space; a common way of life.

Poor families do not have access to the foods that families with higher incomes take for granted. This puts poor childbearing women and their young children at grave risk for malnutrition, and increases the morbidity/mortality related to perinatal status. The issue of nutrition is a very vital one for childbearing women. If as an infant, young girl and adolescent the pregnant woman (girl) has been chronically malnourished the potential for alterations in bone growth and density may have occurred. This can have a profound effect on the outcome of labor and delivery due to the decrease in pelvic diameters as well as other mitigating factors (Dutta, 1998; Enkin, Kierse, Renfrew, & Neilson, 1995; Williams, Baumslag & Jelliffe, 1994).

Some cultures have taboos surrounding foods ingested during pregnancy and thus potentially nutritious sustenance may be denied to the pregnant woman. Also, local custom may dictate fewer calories in order to prevent the fetus from growing too big and causing a difficult birth. The impact of these practices for already compromised women can lead to further difficulties for both mother and baby.

Usually young boys are given nutritional priority over young girls, because males represent the future security of their parent(s) in their old age, and when acute diarrhea presents a mother must make a decision related to health care intervention. Disparity exists in the disproportionate rate of boys to girls taken for treatment. An infant girl may be weaned from the breast when a mother realizes that she is once again pregnant as she is ever hopeful of producing a male child, yet another example of gender preference (Beneria & Bisnath, 1996; Pelletier, Frongillo, Schroder & Habicht, 1994, Solimano, 1999).

Culture

Equally important to the concept of poverty is the concept of culture. The milieu, in which we live and have been socialized into, is formidable, affecting one's entire way of life. Culture is the sum total of who we are. It is the knowledge, beliefs, customs and mores, our learned patterns of behaviors and values that we communicate through generations of a family, community and society. The way cultures operate are predicated on the milieu into which one has been socialized; this acts as a guide to life long thinking, decision making, and actions (Leininger, 1994; Levine, 2001,2000a,b; Ramsden, 1991; Talabere, 1996). In some cultures women's work is deemed less of a contribution to the family as their lives are predominately centered on their homes and children, and thus women and children even eat after the men and older working boys have consumed their meal. Perhaps this has evolved as a protective mechanism for the males would not be able to perform strenuous menial labor every single day for years and years without enough calories, and therefore there would not be enough food for any family member. These customs are not usually perpetrated with malice but as the result of beliefs and value that have been in place for centuries.

Cultures communicate their values through their practices and so further consequences for women may include no right of property ownership nor the right of inheritance. Upon the death of the husband women may soon be remarried to another member of the husband's family, or sent back to their biological family as they are viewed as a burden. The scenario changes when the woman dies; the husband remarries and the young children of the former union are disenfranchised and manifest a greater chance of dying as the new family begins its function of procreation. The new wife is busy with her own children and trying to ensure their survival.

In some agrarian societies women work alongside their men in the fields and still must do all that is necessary to maintain a functioning household. There are places where women work the small family plot and grow local food products; the excess of which can be sold at the local market to augment the family's income. These women must still perform all of their functions including gathering fuel for cooking, meal preparation, hauling water for household use, looking after children and elders, washing clothes, maintaining a tidy home, and perhaps caring for the family's few chickens. The activities of daily living consume an inordinate amount of time without modern appliances to ease the burden.

Family Unit Disintegration

Maladaptive responses to poverty have also produced the phenomenon of single parent families (female). Rural families are fleeing their lives of subsistence farming and relocating to the environs of cities. This has severely impacted childbearing families. The everyday stresses of city living often become overwhelming; no work for the men means there is no money to provide for basic necessities. In addition, the extended family that has been left behind can no longer provide the psychological and social support readily available in the village. Local community is lost. Men often abandon their families and take up short-lived casual liaisons, producing more children and more need. This phenomenon is quite common in Central and South America and the locales are termed "pueblos jovenes" (new towns), known for substandard housing, rampant crime, unwanted children, and social disorganization. These women suddenly become the heads of the households and face innumerable stresses. With this continuing increase many new stresses are placed upon women as they contend with survival for themselves and their children (Levine, 1990).

Limited Employment Opportunities

Employment opportunities for women who manage a household, and also must work outside of their home environment, are those occupations that are traditionally filled by the uneducated: domestic help, street vendors, field hands, unskilled labor in small factories, and prostitution (when necessary for family survival). Wage discrimination is common as women receive less pay than their male counterparts for performing the same tasks. Job security, work benefits, and holidays are virtually unknown. If one is unable to work, for any reason, there is usually no compensation. Jobs can be quickly claimed by others, desperate for employment, should the position be vacated.

Health and safety standards do not exist as known in the developed world. Women, and children, working in small factories with little or no ventilation may be constantly exposed to toxic chemicals as found in herbicides and pesticides. Working daily with paints, solvents, lead, and iron, such as in a glass factory or pottery factory is commonplace. The impact of work on health is not addressed. The baby that is still being breastfed, in a sling across her mother's back or chest, may potentially suffer effects across the life span in terms of intellectual and physiological development due to the baby's physical presence in unsafe work sites.

Childcare is also a problem. Supervision is sporadic and trauma is common. Children are left on their own for many hours each day. Young children with few skills are raising their younger siblings in a continuing cycle of deprivation. Siblings can be responsible for the care and feeding of two or three of their younger siblings, an awesome task at the age of seven or eight. This also severely limits the future of these children, as they will not be able to attend school. (Levine, 2000 a,b,c, 1993).

Overall Effects on Reproduction

Pregnancy outcomes related to socio-economic status have been well documented for many years. Studies have consistently demonstrated the relationship between low socioeconomic class and high maternal and/or infant morbidity and mortality. The maternal/fetal unit is affected by maternal status pre-conceptually and during the pregnancy itself; thus females of lower socio-economic status are at a much greater risk for poor outcomes.

Women deliver at home and even when using their local health facility there are few hospitals able to cope with the problems associated with pathophysiology and/or birth defects. The technological equipment rarely exists nor are there personnel to utilize it appropriately.

Impediments to Use of Maternity Services

Available health services may be viewed as alien when health care personnel do not truly understand the culture or practices of their client population. This causes alienation of the potential health consumer. Women out of their usual social milieu feel uncomfortable with care providers because the health care provider is often viewed as belittling to patients and talking about them in

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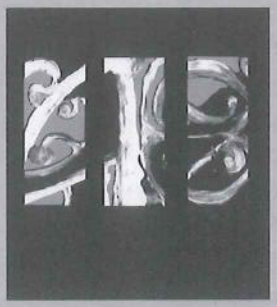

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a foreign language (figuratively and/or literally). This lack of reciprocal communication is one of the factors that deter women from seeking maternity health services and reinforces the gap between provider and potential consumer of health care (Baldonado, 1996; Levine, 1977; Samovar & Porter, 1988).

There are other reasons cited by women for avoiding formalised health care; these include long waiting times in clinics, financing the visit and the transportation, distances to travel, lack of courtesy of the staff, perhaps the need for granted permission from one's husband, and/or time lost from employment and family and household tasks. The impact of history can also be seen. Because home births are common, and formalised health care perceived as less than satisfactory, it reinforces the status quo.

Conclusion

In newly emerging nations the perinatal mortality rate, the number of stillbirths added to the number of neonatal deaths per 1,000 live births is ninety-one as opposed to five to nine in the industrialized world (depending upon the resource consulted). The maternal mortality rate, the number of maternal deaths resulting from pregnancy, labor, delivery, the puerperium, and up to a year after birth can be as high as 737 versus the statistic for the industrialized world which is thirty-four (again this depends on the resource consulted). (Central Intelligence Agency, 1998; Filmer & Pritchett, 1997; United Nations Statistical Division, a, b). Many births and neonatal/infant deaths are never recorded. Except for the grief of the family, it is as if the neonate that lived a few minutes, hours or days had never existed.

For childbearing women this life cycle of poverty extols a grim toll. The totality of these conditions for women and children will continue until the status, education of, and roles of women and young children are valued. The thinking processes of societies need to change so that childbearing women and their young become valued members of society. The veil of invisibility needs to be lifted.

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International trends and partnerships in midwifery education

Adapted from a paper presented at the International Confederation of Midwives Asia-Pacific Region Conference - Bali, October 20

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Introduction

Midwifery practice and midwifery education are inextricably intertwined. To prepare the midwife of the future it is necessary to offer her an education that provides her with the knowledge and skills necessary to practice safely and effectively. To do this it is essential that the student midwife can work alongside more experienced midwives who work in the model that she is being taught. Practising midwives are the most influential role models for students, and thus must understand and believe in the model of midwifery that the student is being taught. Changes can be made to maternity systems in countries through legislation, but the most significant change comes from socialisation of midwives and women to a new way of looking at maternity systems. When women and midwives start to do things differently, society as a whole begins to change and the dominant values of the maternity services can begin to change.

In this paper I intend to explore several strategies for ensuring congruence between pre-registration midwifery education and midwifery practice with reference to New Zealand and Ontario, Canada. Both countries have experienced resurgence in autonomous midwifery over the last ten years and have developed midwifery education programmes that reflect this midwifery autonomy. Interestingly, both New Zealand and Canada offer models of midwifery practice and education that differ significantly from their nearest neighbours, Australia and America respectively. And both countries offer models of midwifery that are highly successful with good outcomes for mothers and babies, and cost effective maternity services. I believe that the models of midwifery practice and midwifery education that operate in New Zealand and Canada contribute significantly to the midwifery success each has experienced. The international midwifery community can learn from their experiences.

Setting the scene: New Zealand

New Zealand has had a regulated midwifery workforce since 1904 but over the last 100 years the scope of practice of these midwives changed significantly as a result of increasing hospitalisation and medicalisation of childbirth. From autonomous practitioners working within the full scope of practice in the early 1900's, midwives gradually become 'assistants' to doctors. From working in the community midwives began working mostly in hospitals and within specific areas such as antenatal clinic, labour ward or the postnatal ward, as pregnancy and childbirth became fragmented into specialised and separate parts of the whole. In this process midwives lost their understanding of childbirth as a normal life event and of themselves as 'guardians' of the normal. Instead they experienced highly interventionist and medicalised maternity care where the doctor and the hospital directed the process (Donley, 1986).

This is a model that will be familiar to many midwives. It was this model, dominant through the 1920's to the 1980's that was imposed by Western counties such as New Zealand, Australia, Britain and America on our neighbours in the Pacific, Asia, Africa and the Americas, in our attempts to help 'improve' and westernise the maternity services in many countries and to decrease maternal and infant mortality and morbidity. Some countries have been left with this legacy and for many it has not been a successful strategy.

In New Zealand, however, it was women who rebelled against this model of childbirth and demanded the return of the 'traditional' midwife – one who would be alongside them throughout the whole experience from pregnancy through to six weeks after the birth of the baby. They wanted midwives who would believe in their abilities to give birth without medical intervention and who would support them to reclaim childbirth as a normal life event. New Zealand women wanted to take back the control of their birthing experiences and take their rightful place at the centre of events instead of the central control of medicine (Donley, 1989).

In the1980s midwives joined with women in this campaign to reinstate midwifery autonomy and together, in partnership, they carried out a very successful political strategy that culminated with legislation that secured the professional autonomy of midwives. The model of midwifery that has developed in the decade since that legislation is one of partnership between the midwife and the woman. The majority of New Zealand midwives now choose to work as independent practitioners carrying their own caseload of clients with responsibility for all their care within the normal scope of practice.

Over the last ten years the maternity services have changed dramatically. For example, 86% of women received care from a midwife throughout pregnancy, birth and the postnatal period in 1999, whereas previously continuity of care was only available in a limited way for those few women who chose homebirths. Now, instead of doctor-led care being the only option, some 71% of women choose midwifery-led care and this figure is still increasing rapidly [New Zealand Health Information Service, 2000]. Now, instead of doctor controlled maternity services, women expect, and are legally entitled to, information and the right to make informed decisions about their care. Now, instead of hospitals serving the needs of the health professionals there is an expectation of women-centered maternity services. New Zealand society is regaining its understanding of childbirth as a normal life event and the midwife is once again being seen as the primary practitioner in normal childbirth services.

Midwifery Partnership

The midwifery model that underpins the New Zealand maternity services is one of partnership between the midwife and the woman (Guilliland & Pairman, 1995). This is a relationship of equity to which both make equally valuable contributions. The midwife brings her knowledge, skills and experience and the woman brings her knowledge of herself and her family and her needs and wishes for her pregnancy and birth. Fundamental to partnership is communication and negotiation (Pairman, 1998). Over the period of the pregnancy the woman and the midwife get to know each other and to trust each other. They talk about their expectations of each other, they talk about how the pregnancy is progressing, they talk about options for care and decisions the woman will need to make. The midwife offers information and the woman is supported to make informed decisions about her care. Nothing is done to the woman without her permission and without having discussed it first. The woman remains in control of her birthing experience, making decisions about how she wants it to be. The midwife stands alongside the woman in a supportive role. She guides

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the woman and supports her decisions but does not take control. The power balance between them is equal and they share responsibility for what happens and for the decisions they make. The midwife aims to help each woman to reach her full potential and to have a positive, safe and fulfilling experience. Midwives believe that if women have this kind of positive birthing experience, that they will have more confidence in themselves as mothers and that this, in turn, will have a positive effect on children, on families and on society at large. For both the woman and the midwife the notion of partnership assumes their autonomy, their ability and their right to make decisions together, and their ability and right to take responsibility for those decisions (Pairman, 1998). Partnership involves a shift of power from the doctor or midwife to the woman and the midwife's allegiance moves from the doctor to the woman as she supports her and stands alongside her.

This midwife: woman partnership is now the basis for midwifery services in New Zealand. However, this partnership model extends beyond the individual midwife: woman relationship to the professional organisation that works in partnership with consumer groups at a political and professional level. It also extends into education where this partnership model underpins the pre-registration midwifery education programmes in New Zealand. For New Zealand midwives partnership with women defines their professional status (Guilliland & Pairman, 1995). I will come back to partnership but first I want to turn to Canada.

Setting the scene: Ontario, Canada

Ontario was the first province in Canada to regulate midwifery after a long history of illegal midwifery that had led to an increase in lay midwives and underground midwifery practice. Like New Zealand it was women who demanded a change and a strong consumer movement brought about legislation that legalised midwifery and created a new midwifery profession. Unlike New Zealand, Ontario had the opportunity to develop a midwifery profession from scratch and they drew on the experiences of Holland and Britain for this new midwifery model.

The model of midwifery that has developed in Ontario is based on the ICM definition of a midwife as an autonomous practitioner within the realms of normal childbirth. Midwives are based in the community in group practices and one or two midwives, who work together, care for each woman. Midwives have access to maternity hospitals and women have the choice of homebirth or hospital birth (Kaufman, 1991).

Ontario does not claim 'partnership' as a concept that is central to midwifery practice although a number of concepts are shared between the two models. For example both New Zealand and Ontario offer a one-to-one midwife: woman relationship, continuity of care, informed choice and consent, autonomous midwifery practice and a focus on the normalcy of pregnancy and childbirth (Interim Regulatory Council on Midwifery, 1991). Likewise the model of pre-registration midwifery education offered in Canada is very similar to that in New Zealand and draws on several aspects of the partnership model.

Midwifery education: partnership in action

In developing a new midwifery profession both New Zealand and Ontario have developed a new system for preparing midwives for registration. Both started with deciding what it was that midwives needed to do within their maternity services and claiming this scope of practice as unique to midwives. For both, as I have explained, the scope of midwifery practice is in line with the ICM definition. That is, midwives work autonomously within the scope of normal childbirth or primary maternity services. Midwives work in consultation with an obstetrician when complications arise and the woman or her baby requires assistance from secondary maternity services. Midwives in both countries care for women at home and in maternity hospitals and are able to access the facilities without necessarily being employed by hospitals.

Direct-entry midwifery

Both New Zealand and Ontario chose three-year direct-entry midwifery programmes to prepare new midwives. New Zealand had a history of nurse-midwifery where registered nurses could complete further education to become midwives but Ontario did not. However, in both countries women were concerned that to successfully prepare midwives who could work autonomously and who would support women to take control of childbirth, it was necessary to educate women who had not previously been socialised in a health system that places power and control with medicine. Thus, while nurses could still undertake midwifery education programmes, it was considered important that the majority of midwives be direct-entry. Any nurses who were accepted into midwifery completed the same education programme as direct entry midwifery students, although they may obtain credits for some aspects of the programme.

Combining theoretical learning with apprenticeship learning

Both education models deliberately take the best of other international education models. Significant teaching occurs in the classroom within an educational institution. This focuses on ensuring a sound theoretical base that seeks to produce midwives who can articulate their own philosophy of practice, utilise research in their practice and think critically about practice. Linked with this theoretical learning is apprenticeship learning where students work alongside a practising midwife on a one-to-one basis for long periods of time. The midwife provides an important role model for the student's learning. Unlike traditional apprenticeship models, however, the student works with more than one midwife through the programme and in this way is exposed to several ways of practising. Students learn, not only from the positive practice they see, but also from the practice they choose not to emulate in the future.

Partnerships in action

Within these education programmes a variety of partnership relationships exist, through which the student learns about how to practice in partnership with a woman. These partnerships all involve continuity of care so that the relationships have time to develop trust and understanding for each partner. These partnerships include the following:

Woman: Student Midwife partnership

Each student is allocated a number of women to 'follow-though' over the course of the three-year programme. The student is expected to get to know the woman, to accompany her through her pregnancy and birth experience from early pregnancy to six weeks postpartum. The amount of 'hands on' involvement the student will have depends on her stage in the programme and has to be negotiated with the woman as well as the other providers such as the midwife. In this way the student and the woman develop their own partnership relationship and have to negotiate how the student will be involved in the process. The student is able to learn about childbirth from the perspective of the woman as well as her own, and to begin to understand the importance of communication, trust, time, power sharing and negotiation to the partnership relationship. The learning that students achieve from women is most

powerful and stays with them throughout their careers.

Student Midwife: Midwife partnership

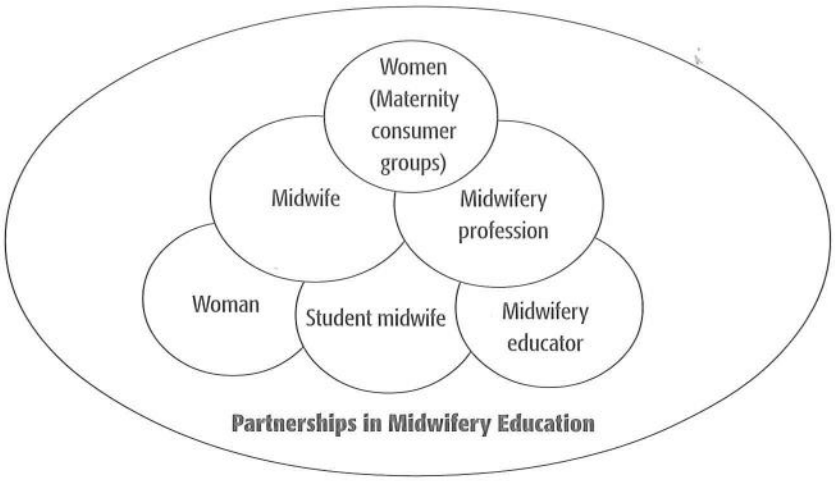
As well as having 'follow-through' experiences with women, midwifery students are also allocated to work with midwives on a one-to-one basis throughout the course. The length of time of these placements increases as the student goes through the programme, so that by the third year the student has the opportunity to really demonstrate her competence and developing confidence as an autonomous midwife. The midwife provides a really important role model for the student in integrating the knowledge and skills gained in the classroom with real practice. She supports and guides the student, allowing her to practise and develop her own style while keeping the woman safe and ensuring that high practice standards are maintained. The midwife needs to be open to student questioning and able to explain clearly about her practice and why she has done what she has done. Again the learning students experience with midwives is powerful and 'real'. The more congruence there can be between the classroom teaching and this real world of practice, the more influential the midwife's teaching will be.

Student Midwife: Midwife-Teacher partnership

Within the classroom it is also important that students are exposed to positive midwife role models. Midwifery teachers need to have high levels of knowledge and be able to share knowledge with students that is up to date, research based, challenging and relevant to practice. Midwifery teachers need to be credible with their professional colleagues as well as students and should maintain some level of midwifery practice alongside their teaching. Ontario has formalised this aspect, and requires all midwifery teachers to carry a small caseload of clients for whom they provide independent midwifery care throughout the year. Thus teachers can work alongside students in practice as well as in the classroom, reinforcing practice and providing a safe environment for students to debrief and question. Midwifery teachers have an important function as resource people for students, guiding the students learning and challenging their thinking.

Midwife-Teacher: Midwife partnership

The success of any midwifery education programme relies on the integration of theoretical teaching with practice. By developing strategies that require students to have long placements with midwives in practice as well as requiring midwifery teachers to maintain current practice, these education programmes acknowledge the fundamental partnership between the educators and the practitioners. Neither can provide enough on their own and it is the alliance of the two that will determine how successful the programme is. Both midwives and educators must be involved in the development of curricula and the planning of the programmes. Both must be aware of the objectives of the various aspects of the programme and the expected achievement of the student. Both must be involved in assessment of the student. In both New Zealand and Ontario this partnership has meant ongoing professional development programmes to help support registered midwives to update their knowledge and skills necessary for this new scope of practice. It has also meant developing programmes to help midwives learn the skills of mentoring and teaching so that they can work effectively with students.



Midwifery Programme: Midwifery Profession partnership

As stated earlier, the midwifery education programme of a country must reflect the kind of midwife the midwifery profession wants to produce. An important partnership exists between the profession and the providers of the midwifery education programme to ensure that the programme meets the standards and aims of the profession. The profession defines the scope of practice and the expected standards for midwives and should be involved in curricula development and the ongoing monitoring of the programmes.

Midwifery Programme: Women partnership

In the end it is the kind of midwife that women want and need that is most important. This can occur through involvement of maternity consumer groups in the development of curricula, in the ongoing monitoring of the programme and in the assessment of students so that they can influence the kind of midwife that is produced through the midwifery education programme.

Thus you can see that the model of midwifery education chosen by New Zealand and by Ontario is inextricably linked to the maternity service it is part of. A series of intertwined circles represent the various partnerships that are integral to the development and maintenance of these programmes. These partnerships keep the programme grounded in what is its primary aim – to produce midwives who are capable of working autonomously as primary maternity care providers within their countries, and within this – to produce midwives who can work in partnership with women.

New Zealand and Ontario midwives have succeeded in revitalising midwifery in both their countries, raising both the status of midwifery and the status of women. The congruence between the midwifery education programmes and the scope of practice of the midwives is an important part of this success.

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In pursuit of 'warmth' in practice

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Introduction

Giving birth is a powerful experience. Women retain vivid memories of their labour and birth, sometimes decades later (Simkin, 1992). The midwife's part in the birth story is important because she is the health professional who spends a significant amount of time with a labouring woman. Her actions or words can have a profound effect on whether or not the experience is a positive one. Some midwives stand out by virtue of their ability to establish a real rapport with most women in their care. What is it about the kind of relationship established with a woman that sets some practitioners apart from their colleagues? How do some midwives appear to develop an extra level of intimacy with women? We can call to mind midwives who would fit this description. Identifying what qualities they possess, or maybe what personality traits they display, is more difficult. The added dimension that these midwives bring to their midwifery relationships, however, is apparent to midwives and women alike.

Background

One study has identified 'warmth' as the defining characteristic that appears to allow some midwives to establish a genuine affinity with women (McCrea, Wright & Murphy-Black, 1998). The absence of this 'warmth' was identified in the 'cold professional': a midwife who met the physical needs of women, but failed to engage with them in any real sense of empathy, compassion or partnership. The 'warm professional', by contrast, adopted a more holistic approach, providing care in a professional manner and also acting as a 'friend'.

I was intrigued by the notion of 'warmth' and wondered if this is an attribute that could be recognised in practice. Would 'warmth' be visible to midwives and women in the same way? I suspected that women would see 'warmth' in the manner in which the midwife aligned herself with the woman as a positive and supportive companion. I was less sure, however, about the way in which midwives would categorise 'warmth'.

Approach

In an attempt to understand more about 'warmth', I approached three midwives who seem to me to manifest the values of a 'warm professional'. One midwife is employed by a hospital, one carries a caseload and provides continuity of care through a Know Your Midwife (KYM) team approach and the other is a self-employed independent midwife. I talked with them about their philosophical approach to midwifery care and what they actually do in providing labour support. I focused on labour support because McCrea, Wright and Murphy-Black's study concentrated on this area of practice. By doing this, I hoped to see examples of 'warmth' in their stories and so have a better understanding of how their practice might differ from that of other practitioners.

I also listened to tales of labour from three women, each of whom had been cared for in labour by one of the midwives previously mentioned. I was interested in occasions where 'warmth' was evident through their eyes. The names of all those I spoke with have been changed to honour confidentiality.

Common Qualities and Threads

Before I looked closely at the stories there seemed to be a sameness about the way in which the women described the qualities of 'their' midwife. They identified qualities, which they thought might be necessary in order to exhibit 'warmth'. The women spoke to me of a sense of humour, teamed with an aura of confidence in their midwifery skills, which they found immensely reassuring. There seems to be a reflective side to the midwives' practice that is evidenced by their willingness to seek feedback from women about their experience of labour.

Three common threads emerged from the midwives' stories about their practice. They all talked of demonstrating caring and understanding; promoting a sense of security and trust and, ultimately, a feeling of control in women for whom they cared.

Caring and Understanding

Communication

Effective communication seems to form the core of the caring model that good midwives foster in order to establish a rapport with women. Communication is a reciprocal process of sharing information and encompasses not only the verbal message, but also non-verbal cues such as body language, tone of voice and touch (Ralston, 1998). The midwives I talked with placed considerable emphasis on spending time to impart information about labour. Clearly, time is the commodity that the midwives providing continuity of care enjoy over the hospital-based midwife meeting the woman for the first time when she is in labour. The hospital midwife is like a one-stop shop. She must work quickly to forge a relationship with a stranger in labour and attempt to provide the type of environment where the woman feels able to voice any worries. Her use of superior communication skills can achieve similar results to those of a midwife who has the luxury of time on her side. The midwives offering continuity of care have often had several months in which to prepare their client for labour and allow her the opportunity to ask questions and express concerns:

"...you have that relationship where they can say the things that worry them. The silly things like, am I going to do poos? I always tell them about that feeling because most women will say afterwards 'Oh, that was just the worst feeling I've ever had in my life!' and you can see them clenching bottoms. I always talk to them about that's what it feels like. That's normal, that's your baby."
(Chris, KYM midwife).

This midwife seems to not only encourage women to articulate their innermost fears, but may even facilitate the opportunity by anticipating likely sources of concern and raising them before labour. She is then able to reassure and support her client during labour by reiterating previously discussed information. This knowledge is likely to be more easily understood by a woman distracted by the pain of labour because it is familiar. Could this forearming with knowledge augment a woman's armoury of coping strategies? Is this an example of a midwife displaying evidence of 'warmth' in conveying a sense of the normal progression of labour through excellent communication?

Presence

The midwives I spoke with knew the value of 'presence' in helping to allay fear and promote a feeling of caring and understanding. They see that there are times when an active presence is required to coach, to encourage, to maintain eye contact or to help rub a back.

One midwife describes it in the following way:
"Your presence can help lots. You don't do it for everyone, but for some, like the woman the other day, I massaged her back for just about the whole of her labour. She commented afterwards how fantastic it was. She really, really felt that that got her through."
(Sue, independent midwife).

The women, too, talked of times during their labour when they felt more needy and wanted the midwife beside them. This woman seems to speaking of just such a time:

"She was there all the time with me. She was really good. When the contractions were coming on, I really wanted to push and she was talking to me and trying to get me to not push, to focus and breathe it out. Actually, she wears this badge with her name on it and a [motif], and I was focusing on that."
(Millie).

Could this be an example of 'warmth' in action? Millie describes the presence of the midwife in an engaged role, but also seems to speak of a preparedness to be emotionally available to her. This openness of spirit may be a glimpse of the way in which some midwives are able to 'put themselves out there' to support and encourage in whatever way they are required to.

The midwives also speak of times when the woman and her support person, or people, are working as a unit and merely require the promise of presence if needed. The midwives recognise these moments as intimate times in the woman's birth experience when unnecessary intrusion is undesirable. They may even see these times as evidence of the empowering nature of a positive relationship that supports a woman to 'be in her body' (Tinkler & Quinney, 1998). But the absence of the midwife does not mean a lack of watchfulness. It seems that there is a knowing around the way a midwife can leave a woman to labour and rely on the sounds emanating from the room to provide her with sufficient information to monitor a situation. This midwife trusts her instinctual knowing, born of experience, to judge the times that she returns to 'check in' with a woman in labour:

"But I think I know what's going on in there all the time, even when I'm out of the room, and I'm very conscious that there's something which clicks in my mind when I've been out of the room for how ever many minutes and I must go back and at least look, show my face."
(Mary, hospital midwife).

The midwives all emphasised their commitment to fostering an atmosphere of caring and understanding through their communication of information about labour and its progress. They were careful to demonstrate their desire to listen and explain in an appropriate manner. They provided emotional support and knew when to stay close. In describing her perception of what makes a "good" midwife, one talked of making the woman feel special by conveying a willingness to *'be there'* for her. Another midwife stressed the importance of the woman never feeling hesitant to ask for something, be it information or support. There seems to be a forthright and honest approach to the midwifery partnership revealed in the stories of these two groups. The emphasis appears to be on the midwife demonstrating a flexible and mutually amenable attitude to the needs of the woman.

Security and trust

A product of the rapport that builds over the establishment of caring and understanding, is a sense of security. With this security come feelings of trust in the midwife. Some women, and some midwives, view this as a friendship (Pairman, 1998). Labour is a testing time for many women and the relationship with their midwife may determine how well they cope with its challenges. The 'warm' midwife appears to show no expectation of compliance in her approach to pain relief but seems to assume that she will work in partnership. Her emphasis is on portraying pain in a positive way and clearly stating that she is there to support and encourage. She endeavours to make a woman feel special by concentrating solely on her needs.

Coping with pain

The midwives I spoke with appear to articulate similar approaches. The midwife's own attitude to being with women in pain is a factor in her ability to truly support someone in labour. This midwife paints a picture for me of someone who is going to be there talking and encouraging and reassuring when the going gets tough. There are glimpses of 'warmth' behind these words:

"There's different types of noises that women make in labour. If someone's making a noise which you think is a good noise, that's actually nearly there, then you can give them the reassurance that it's not long. I don't suggest pain relief at that stage and I tell them antenatally that I will not ask them if they want pain relief. They have to ask me. Some people need permission to have pain relief and we talk a lot about, what you do, will depend on what stage you're at."
(Chris, KYM midwife).

Chris relies on the antenatal discussions about labour and pain relief to give women time to prepare themselves for what labour may bring. She empowers them to initiate pain relief, if and when it is necessary for that individual. This is a measure of the trust built between them.

The way a woman copes with pain during labour seems to lie, in part, with the degree of trust that she enjoys with her partner and the midwife. Here, the woman Chris cared for in labour describes just such a situation:

"Chris said, I really don't think you need the gas any more. I thought, you're right, I don't really need it. I

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think it was just having the mouthpiece to bite on. So, I was a bit taken aback, but had the confidence to say, if Chris doesn't think I need it, OK, I can always ask for it back. I know she wouldn't deny me. So that's what we did and it was fine."

(Jenny).

The decision to relinquish that mouthpiece was not easy. But Jenny had trust in Chris's judgement at that time, and the sure knowledge that if she wanted the gas again, Chris would respect her wishes. This example of trust in practice serves to illustrate the depth of certainty that Jenny felt for Chris's reliability, even in the face of such vulnerability.

Friendship

The 'warm professional' acts as a friend to the women in her care. Among the midwives I spoke with, there was general agreement that a sort of friendship does frequently occur. For those midwives who are involved in providing continuity of care, time is a big factor in the establishment of a sense of familiarity. These midwives will get to know the woman and her family over the months of antenatal visiting.

"I think it's a time factor. It's a trust thing. It's a friendly face, non-threatening environment. Each visit gets better, easier. By the time you're seeing them for the fourth or fifth time, it's more of a social thing. You do the urine and the blood pressure, listen to the baby and the rest is how are the kids and how's the husband and have you moved house yet."

(Sue, independent midwife).

Another midwife who provides continuity of care appears to view the friendship as a professional alliance that has clear boundaries. She talks of the advantages of working in a small team because:

"You can share women that are more difficult, that you haven't bonded with, because you're not going to bond with everybody. You need to keep a degree of distance because if you're too interconnected, you can't sometimes step back and say that's not good. For me, it's that finite time for your birth. Some of the women think it will go on and on. But it's not like that."

(Chris, KYM midwife).

The perception of friendship appears to be viewed differently by midwives. The closeness, while pleasurable and real, is nonetheless part of the job. At the conclusion of the midwifery partnership, often about six weeks postpartum, there seems to be a sense of closure for the midwife as her caseload continues.

The opportunity also exists for a friendship to develop between a woman and a hospital midwife during the course of a labour.

"I can think of half a dozen people who still send me Xmas cards with whom I developed friendships. I see people today rushing into the women and cuddling them and kissing them before they go off shift. Now I just don't happen to be that sort of person, but I still think could look after them adequately without hugging and kissing them."

(Mary, hospital midwife).

This raises some interesting questions about the nature of a friendship that could develop within a time of labour only. It would seem that personality plays a big part in the kind of the rapport that develops. Midwives with more reserve may still display 'warmth' in their interactions and develop an excellent bond. As Mary is a midwife in middle age, it may be that the age difference between the two influences this relationship as much as personality traits.

Control

Feeling in control appears to be closely linked to a positive birth experience for women. There are two parts to this sense of control. Firstly, there is a sense of self control which is reliant on the woman's perception of the pain of labour, the strategies and /or medications used to combat the pain and, crucially, the level of caring and support that the midwife is able to provide (Halldorsdottir & Karlsdottir, 1996). Emotional support is clearly of great importance to labouring women and forms a substantial part of the midwife's role during this time. This support should empower the woman during labour rather than undermine her resolve by causing her to relinquish mastery of her situation. The willingness, even the ease with which some midwives are able to align themselves emotionally with women and to demonstrate real empathy, appears to be another facet of 'warmth'. Positive reinforcement from these midwives helps to maximise the coping strategies employed by women.

"People don't want to be out of control. They don't like it. We talk about transition antenatally. That feeling of the last little bit is where you really need your reserves and this is what it feels like and that's the time when you will feel frightened and that's OK. I'll be there with you."

(Chris, KYM midwife).

Closely intertwined with personal control is a sense of control revolving around a woman's autonomy in labour. Being involved actively in decision making seems to correlate with increased satisfaction and sense of control for some women (McCrea & Wright, 1999; Hall & Holloway, 1998). Information is important at every stage of the birth process. Excellent communication skills, whereby information can be imparted in sufficient detail to allow informed consent and promote a partnership model, is therefore essential. Simply being reassured that all is progressing normally and that the baby is doing well can be sufficient to enhance that sense of control.

It has to be acknowledged, however, that a certain ambiguity exists over issues of control and decision making for some women. Bluff & Holloway (1994) suggested that some women expressed a need for someone to take charge of what happened during their labour. In spite of this trust in the midwife as the perceived expert who 'knows best', they also wanted to feel in control of events.

Tensions around partnership

In New Zealand, the midwifery partnership model, as articulated by Guilliland and Pairman in 1994, is presumed to underpin most relationships. In practice, some women do not appear to accept that the interaction with the midwife is an equal one of shared knowledge, power and responsibility. One midwife told me that she believed partnership is more easily achieved within a similar cultural and educational grouping to herself. Her experience of clients from a different cultural background suggests that their expectations do not allow for a sense of partnership, despite her best efforts to promote this:

"I would certainly find that most Pacific Island women want to have that direction and advice - it's a cultural thing."

(Chris, KYM midwife).

Some women may be more comfortable in a role of 'patient' because their cultural background or self-image has conditioned them to seek a more passive role in relationships. For these women, the power imbalance feels great, particularly when interacting with predominantly white, middle class health professionals such as midwives.

Another midwife reflected that she didn't think the vast majority of women look on it as a partnership, even though she advocates this philosophy and tries to promote partnership.

"They look on you as a health professional, a friend to some extent - you are there to help them. If things go well they are probably prepared to take 50% of the responsibility. But if it doesn't, then they don't want to have that responsibility for looking after themselves or making the decisions."

(Sue, independent midwife).

It seems that Sue recognises a tension around partnership, especially when there are complex issues to confront and the need to make a decision about care. Skinner (1999), in her critique of the Guilliland and Pairman model, echoes Sue's comments in challenging the assumption that all women seek control and partnership.

Environmental factors

Another factor in the woman's perception of control over her environment is the environment. It can be argued that the physical appearance of a hospital setting and the degree of midwifery centred care that is practised, will have an influence on perception of control for some women. The medicalised power bases flourishing in some hospitals may threaten those who strive for a normal experience. A high obstetric intervention rate is likely to produce feelings of disempowerment in some women who are anticipating an uncomplicated outcome (Lavender, Walkinshaw & Walton, 1999).

These environments also pose a threat to midwives working within them. The woman-centred approach to midwifery care can be difficult to maintain in the face of a more dominant discourse from those in positions of authority who often hold a more medicalised world view. Midwives such as those I spoke with already face obstacles to the provision of labour care in a way, which will encourage the most satisfactory outcome for all parties in the midwifery partnership. The commitment they show to the women they care for, by their unstinting efforts to advocate and 'work' the system, are perhaps further evidence of a 'warm' midwife's attributes.

Conclusion

My pursuit of 'warmth' has shown me that it reveals itself in tantalisingly brief images, or echoes. Whilst its manifestations may be numerous in practice, 'warmth' shuns the light and forces those seeking it to be satisfied with shadowy approximations of its likeness. I glimpsed it in the excellent communication skills employed by some midwives to engender a sense of caring and understanding in a labouring woman. These small accumulations of 'warmth' coalesce into a sense of security from the woman's point of view. This goes some way towards explaining the importance of presence, not only in a physical sense, but also the implied meaning. Embedded in this meaning is the certain knowledge that the midwife is willing to align herself with the woman during labour and to support her come what may.

This preparedness to be emotionally available seems to lie at the heart of 'warmth' in practice and is visible to women and to other midwives. It is clear from the depth of the feelings some women have for 'their' midwife, that the ability to impart a sense of emotional availability is greatly valued. It is not something that can be offered half-heartedly, but necessitates true commitment in terms of 'being with' a woman.

With feelings of security comes a development of trust, which is essential in any relationship. During labour, when a woman is most vulnerable due to pain and uncertainty as to what lies ahead, trust is vital. Midwives, and women, value the bond that trust creates and that 'warmth' cements. Women have identified a sense of control as a most important factor in contributing to a positive birth experience. This includes a sense of self control which is realised by a woman's ability to gain a feeling of mastery over pain by employing useful strategies and relying on emotional support from significant others in the midwifery relationship. Again, it seems that the depth of the rapport established correlates with the degree of 'warmth' that the midwife generates.

A sense of control is also achieved by feeling some autonomy over decision-making and her environment. 'Warmth' seems to be apparent in the empathy shown to the women during their labour. It appears to empower these women to trust in the process.

Further, it seems that, in attempting to embrace the partnership model, the midwives I spoke with have accepted their responsibility to acknowledge the political reality of midwifery practice today. As guardians of the normal childbirth experience, these midwives are aware of the need to be vigilant in the face of threats from other health professionals, especially those in positions of power. The willingness of these midwives to defend women-centred midwifery care could be evidence of 'warmth' originating within the midwifery partnership and embracing the wider political scene.

In the end, the relationship between a woman and a midwife lies at the heart of the birth process. Where a midwife is able to bring 'warmth' to this occasion, the experience is more profound, not only for the woman and her family, but also for the midwife herself.

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Evaluation of educational aspects of the New Zealand College of Midwives Standard Review Process

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Executive Report

A case study evaluation of educational aspects of the New Zealand College of Midwives (NZCOM) Midwifery Standards Review Process[1] was undertaken in 1999 in the Auckland NZCOM region. This summary outlines the key findings. A full report is available from the writer.

The Review Process is nationally and regionally coordinated by midwives and women (consumers) who evaluate the quality of independent midwifery practice according to nationally derived standards for practice.

This research determined the aspects of the current Review Process in Auckland that were working well and those that needed improvement. Criteria for evaluation included the relevance, adequacy, progress, effectiveness, impact, efficiency and sustainability of the Review process.

Any evaluation process is based on a philosophy. The philosophy underpinning the Review Process is the partnership/midwifery model articulated by Guilliland and Pairman (1995)[2]. The Process has evolved over time and the Review teams have developed their approaches in response to feedback from midwives. The need to remain relevant for stakeholders is ongoing and requires constant reflection and monitoring by the Review committee and midwives.

Despite the implementation difficulties, this research shows that the Review Process in Auckland is relevant, adequate, well organised, effective and efficient. A longer time frame for the research would have been useful to determine more fully the impact of the Review.

The Review worked well to provide quality assurance and audit of practice. It further provided public accountability within a partnership model, support for midwives, and an 'educative' evaluation including reflection and professional development. Recommendations have been provided for stakeholders including the Auckland Midwifery Standards Review Committee. These focus on the importance of continuing dialogue between all those interested in the process, a need to improve the cultural adequacy of the Review, the need for continuing an 'educative' evaluation process that includes support for midwives and a need for reflection in any midwifery quality assurance process.

There has been an emphasis on the educative aspects of the Review Process throughout this study. Participants identified aspects of the Review that encouraged reflection and changes in practice. The limitations of the Review Process and factors in the midwifery context that limited the effectiveness or impact of the Review were also explored.

There are supporting professional and political processes to ensure that the Review will be sustained. The implications of the proposed Health Professionals Competency Assurance Bill and the relationships between the New Zealand College of Midwives and the Nursing Council of New Zealand for determining competencies for practice support the Review Process. There is, however, a risk that removal of the voluntary aspect of the Review could detrimentally alter the nature of the Review. Credentialling is also under consideration as an alternative, employer controlled evaluation of health services provision. Credentialling threatens midwifery autonomy and may not be effective in reducing 'patient risk.' Evidence to support the practicalities of this approach for midwifery is needed.

This study will be useful for those involved with the Review Process. Although there are limitations in generalising this study to other locations, there may be opportunities for 'naturalistic generalisations' (Stake, 1995)[3] where the descriptions fit other situations or contexts. For example, the framework used for this analysis could be used for evaluating the process in other NZCOM regions or in hospitals where the NZCOM Review Process is increasingly being used to evaluate 'continuity-of-care.' It would also be useful to investigate more fully reasons for some midwives' non-participation in the Review.

Midwifery practice is continually challenged and changing. The Review Process is dynamic and constantly evolving. It is important that the gains made in achieving midwifery autonomy and partnership maintain currency amidst the discourses of the medical model, market economies and individualism. Professional standards for practice need to be evaluated and maintained within a midwifery and consumer perspective. Finally, it is essential that methods of evaluating midwifery practice are based on both midwifery and educational philosophies.

Acknowledgements

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1 An outline of this process is in Appendices A-D of the report.

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Cultural Adequacy: aspects of a case study

Introduction

The New Zealand College of Midwives Standards Review Process[1] was evaluated from an educational perspective and this included examining the adequacy of the Review process for Maori midwives and midwives from cultures other than Pakeha/European New Zealand. In particular, the adequacy for Maori midwives, women and their families/whanau are reported in this paper which considers the structure of Reviews, what Reviews meant for Maori participants in the study and how the social and cultural context of midwifery influenced their thoughts about evaluation of practice. This paper presents aspects of a case study, which provides valuable insights into the relationship between midwifery practice, and how midwifery practice is evaluated.

Review structure

The Maori section of the College of Midwives, Nga Maia o Aotearoa me te Waipounamu, nominate representatives to NZCOM at Maori hui. Maori midwives have been considering an alternative Review Process because it was felt that the existing Process was inadequate for their cultural needs. As Nga Maia is currently a parallel development with the College any alternative process would need to be tabled to the College, not for 'approval' but to illustrate to others what is available. To date there have been some differences between Nga Maia members about the best way of developing and implementing this process, however no documentation has been provided in support of another 'tool.' Little progress has been made in this regard and other numerous concerns, such as the lack of clarity regarding the actual structure and function of Nga Maia within the College, have taken the attention of the group. The future requirements for Competency Based Practising Certificates[2] may make the need for clearer definitions more urgent. This concern has been signalled as worthy of current exploration (Donley, 1999).

Review process for Maori midwives

A Maori midwife explained that at Reviews Maori bring a "mate" to "keep them safe" in a difference sense from a Pakeha/European perspective. It might be "really dangerous" to reveal too much of tradition (or what was sacred).

"When we go in pairs we keep each other safe and that sort of stuff, and it's like - hey, you're giving away too much, shut up." (Maori Midwife)

Sometimes Maori midwives bring their whanau (family) and there have been endeavours by the Auckland Midwifery Standards Review Committee to have Maori midwives on the Review teams.

A Maori midwife described two Reviews she had undertaken. For her, the first Review Process began with her filling out the documentation and she felt that this validated her practice – mainly because there were very few "ticks in the boxes"[3] (That is, her practice was non-interventionist). She specially requested her next Review because she'd had a baby die and she needed support of a different kind. She felt it was "really *really* important" that the Review take place on the Marae and said this was her best Review.

"When a baby dies, for me, being a Maori midwife I'm always answerable to my tipuna which are my ancestors. So having that review in the Marae, kept me totally accountable to my tipuna. What was of value was reviewing that stuff in the environment where I knew my tipuna were present as well. We can't see them, but for me it was a real healing, clearing process. So after that process I chose to no longer be a part of the Review process as we know it." (Midwife O)

At her Review a Standards Review team went to the Marae, yet were not fully equipped in Maori traditional birth knowledge to appreciate some aspects of her practice. For example, she felt the Standards in the *Handbook for Practice* (1993) were not explicit in detailing the culturally important aspects of practice and when she stated to the Review team that her most important achievement for the year was successfully returning 100% whenua (placenta) to papatuanuku (mother Earth), they hadn't known what whenua was or why this had importance. (I didn't ask if Maori language terms only were used.)

Burying the placenta was significant for her because the Native Health Act (I believe this refers to the Tohunga Suppression Act 1908) forbade this traditional practice. She said that when she had become a midwife her elders laid down ground rules for her. In turn she outlined these 'choices' to her clients when they chose her for their midwife.

"Because that protects me in a spiritual sense, that I'm doing things, what we call tika right. And, like recently I had a baby that's died of SIDS. Now if that placenta hadn't been returned to Papatuanuku and I hadn't done all the things Tika, that if I hadn't kept myself safe, I'd still be sitting here in a dilemma today, wondering whether my breach of Tikanga contributed to the death of that child. And that was what was explained to me." (Midwife O)

This midwife had it explained to her that because she chose to work in a Maori world and her mission statement was to "reclaim traditional birthing practices" she had to make sure that she "walked that walk'. Care had to be taken that placenta did not go into ice-cream containers and care was needed when the pito (umbilical/cord) dropped away from the baby's umbilicus. She found that "there's a lot of educating whanau about that." In fact, she found that when she explained and enlightened families about the Tohunga Suppression Act (1908) and how Maori midwifery and breastfeeding were outlawed, people "really started to care to the point that I've had families steal placentas and dash off in the middle of the night to bury it. Like it might be the grandmothers." According to Maori tradition, fighting over placentas is similar to fighting over the urupaa (burial places) of loved ones and "it's a sign that people care. It confirms to me that I'm on the right track when I see those arguments happening as much as that." Therefore, evaluation of practice had cultural meaning for this midwife and having a Review in a place where the culture was understood was important because Standards could then be viewed within the cultural context.

Consumer feedback

The context of practice evaluation for Maori midwives is not just with the mother but with the baby's father and family. A more communal evaluation is more likely to happen on a Marae, where Maori values are supported. 'Looking at practice' can include aspects such as whether the karakia (prayer, incantation or blessing) is from the right iwi. Parents grateful at the time of birth may not mention these things if incorrect, however the Marae presents an opportunity for the midwife to develop more fully. By contrast, the usual NZCOM Review seemed inadequate to this Maori midwife.

"I never came out of the College Review Process thinking there was anything I had to change, but my clients would challenge me all the time around different things that I could do better." (Midwife O)

An oral language tradition places greater value on verbal feedback than written consumer forms. The

continued over...

Cultural Adequacy: aspects of a case study

structured language used in most English questionnaires may limit expression – particularly for Pacific Island and Maori clients. NZCOM do have an evaluation form for non-English language clients. One Maori midwife described how a few of her clients have ignored the standard consumer evaluation forms, preferring to give her written birth stories as a part of evaluation. In other instances consumer feedback forms seemed inadequate to convey women's feelings about their midwives. For example:

Client: *Why do I need to fill this out, if you were doing a rat-shit job I'd tell you, and anyway, we've told you you're doing a wonderful job and you want us to write it down, do you want a fat head?*
Midwife: *Just send it to the college, they need to know I'm doing a good job.*
Client: *Why do you care what the College thinks about you? Shouldn't it only matter what we feel?*

A hui was therefore thought to be a better option for Maori midwives. Midwife O made the following comments. At a hui "people stand up and speak their truth. If there's something they're not happy about, you're going to hear it on that forum." A Marae group is more likely come up with suggestions and recommendations that clients on their own would be unable to make. She also commented that Maori tended to be harder on Maori midwives than their European/New Zealander counterparts. However, such suggestions for the Review would not necessarily suit all Maori midwives. Some may not be open to a Marae Review, some might feel far too exposed and some "may not have evolved into themselves as Maori women". For example, some may be born Maori and not have had the nurturing or knowledge in their lifetime. These Maori midwives would feel just as uncomfortable as a non-Maori midwife who's never been on the Marae. However, reclaiming lost knowledge is not easy and the choice can not be 'no choice.' It was felt that little could be done with midwives who "go through the process like a Claytons Review."[4]

Ownership of material

The Review process of assessing statistics has cultural implications for Maori midwives. Accountability was about being accountable to Hapu (family) and Iwi (tribe) for practice and the Review statistics belonged to them.

"Yeah the knowledge. I mean you can't challenge me on Tikanga if you don't know what it is, whereas they (Maori) can. And just that whole responsibility back again, back to your own Iwi and Hapu. In terms of stats, the Homebirth Association's never had the privilege of my stats, because I firmly believe they belong to the Iwi, not to the homebirth association and the same with the College. You know, that they're not something that I can just give away because they don't belong to me in the first place. As much as it's a reflection of my practice, the ownership isn't totally with me." (Midwife O)

Social and cultural context of midwifery for Maori
For the Review to be culturally adequate, the wider aspects of context need examination. Cultural norms and values influence outcomes and many institutions and hospitals do not support traditional birth practices. This midwife speaks of her experiences:

"(Maori) midwives are exposed to racism, every time they walk through that (hospital) door and the ***institutions*** *are not reviewed. The law LAW has overridden our law LORE and those were the things that kept us safe."* (Midwife O)

Changes to maternity services funding have resulted in many women, especially in South Auckland where there are large Pacific Island, Maori, Asian and Indian women, receiving inadequate postnatal care from hospital services. Standards of health for Maori have been historically influenced by poor social and education policies in New Zealand that tended to blame the victim. Large family size is the cultural norm for many Maori and Pacific Island families and is often a focus of criticism by European New Zealand health professionals. Traditionally, education in most New Zealand schools has been based on a British curriculum that has favoured the knowledge of the 'privileged' classes (Codd, Harker & Nash, 1985; Smith, 1990). The practices of 'streaming' classes and 'grading' results for school certificate, until the last decade, for example, have clearly disadvantaged Maori pupils (McNaughton, 1987).

Some midwives do not understand the effects of the general education system in New Zealand. Determining 'excellence' for a Maori midwife (or midwife caring for Maori women) may mean assessing their ability to build people's self-esteem and self-confidence. As Midwife O says:

"You can always find one good thing, even if it is a Jake Heke[5] household and there's crap everywhere. And you can find one thing in that whanau that you can help them capitalise on and build from. And it may be that one thing is that baby. But I use it, to motivate them, to strengthen them. I use my life story, I use other client's life stories, bring them together for hui. So our stronger ones, who have achieved, because they did believe in themselves, can share that with those that haven't had that privilege, that haven't had anybody that ever believes in them. And that for me is - what I believe is - the bottom line - what's wrong with my people. We lost our belief in ourselves, and we bought into this 'we're dumb Maori' mentality. And, so, you know, maybe I should go into psychology, but I think it's around changing those underlying belief systems, that you don't buy into it. And part of that is re-educating people - what our real history was." (Midwife O)

For these reasons the Maori midwife's 'scope of practice' extends beyond the physical into the region of spiritual and psychological safety, yet exploration of these factors is often constrained by the time available in a 'standard' Review. Some of these principles apply equally to the determination at Reviews of culturally safe and appropriate care provided by **all** midwives.

The meaning of being safe for Maori

Culturally appropriate and safe practice is more than being culturally sensitive. According to Midwife O it means making a commitment to learn about everything that is a "spiritual projection" around birth. Hand washing is vital and food should not be eaten in the birth environment. Care about breaching tapu is not only for the midwife's protection. It also protects the child. Recently midwifery practice has been concerned about policies or protocols that have foundations in the scientific medical model at the expense of other paradigms of knowledge. For example, the common practice of artificial rupture of the membranes (ARM) for hastening 'normal' birth has been questioned. Maori philosophy provides a challenge to the medical model from a cultural perspective. Despite the devaluation of 'superstition' by the medical (scientific) model, personal experience can validate the spiritual. Maori spiritual belief considers ARM not only unnecessary but positively dangerous. For example, one midwife reported the following interchange at a birth that illustrates these concepts:

Kaumatua/elder (at birth): *Are you in a hurry? Is there a reason why you want the baby to be born fast? Why do you do that Midwife? Why do you want to break the baby's waters? Is there something that's telling you that the baby's not well and you want it*

to be born quickly? Do you have somewhere you have to be?
Midwife: *No, it's just what we do. Sometimes, if it's not done you can suffer a whole lot longer.*
Kaumatua: *OK, so you're interfering with the life path of that child.*
Midwife: *I want to see if the baby has done a tiko (meconium). The mother has been at 8 cms for three hours.*
Kaumatua: *No, Midwife. You have no faith. You have no trust. Is the baby's heartbeat fine?*
Midwife: *Yes, the baby's heart beats fine.*
Kaumatua: *Does she look like she can't handle it?*
Midwife: *No, she is, she's handling it beautifully, but you know I'm concerned that she's going to get tired and we're going to...*
Kaumatua: *Midwife, you have no faith.*
Midwife: *But I'm trained, I know what I'm doing.*
Kaumatua: *But you have no faith. Are you scared? Should we have this baby in hospital if you're scared?*
Midwife: *No that's not what I'm saying. I'm just offering that I can break the waters.*
Kaumatua: *But if the waters wanted to break Midwife, wouldn't they break?*
Midwife: *Well, not always.*
Kaumatua: *You don't have the faith but I have enough for you and I today, so I give you my gift of faith and I want you to sit and wait.*

-And then the baby's born inside the membranes-

Kaumatua: *If you'd broken those membranes, you would have deprived my mokopuna from the taonga that it came in and that korowai gives it the protection of tangaroa for all it's life.*[6]

The midwife believed that the kaumatua was checking to see if she was "tuned in" to the baby or "just doing her job." There was a long line of navigators in his family and he wanted to see if she "knew." This provides another example of how cultural aspects of midwifery care are more readily understood and evaluated within that culture. The reflection and learning by this midwife was culturally as well as contextually bound.

Comment

The Review Process in its current form, while generally adequate for European/New Zealand midwives and consumers, has some limitations that have been outlined for assessing and evaluating *Maori* needs and midwifery care.

The changes needed to make the Review Process adequate for Maori have been widely debated at hui amongst Maori midwives and with the NZCOM National MSRC Coordinator. This debate has included looking at ways of using the Review structure/tools with a Maori cultural perspective. Within Nga Maia about six midwives have had hui Reviews, using the College 'tools.' The development of Maori Review teams is complicated by needs to accommodate tribal tikanga at hapu and iwi level, so there has been a reluctance to arrive at one national 'Maori Review Team' (Midwife O). Recently a web site has been established to inform people of Nga Maia and its representatives. It gives information to women about Maori midwives and local Midwifery Standards Review committees (NZCOM 2000) www.maori.org.nz/nav.htm provides an email address for gaining this information.

Ongoing dialogue between all the stakeholders in the Review Process is essential to ensure that the Review can be fully adequate for cultural safety needs.

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SITUATIONS VACANT

MIDWIFE

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1 The Midwifery Standards Review process is a formal voluntary process whereby an independent midwife evaluates her previous years work with a small group of midwives and consumers who are elected representatives on the New Zealand College of Midwives (NZCOM) Midwifery Standards Review Committees.

2 The proposed Health Professionals Competency Assurance Bill will require professionals to maintain competency based practising certificates. Independent midwives will need to show evidence of Review or other similar process 'recognised' by Nursing Council.

3 The statistics required for each Review are charted and include rates of processes such as artificial rupture of the membranes intrapartum and administration of ecbolics (active management) in the third stage of labour.

4 Claytons is a New Zealand non-alcoholic drink that was marketed as a substitute for the 'real' alcoholic drink – Having a Claytons became a euphemism for substituting something for the 'real' thing.

5 Jake Heke: Character in Alan Duff's Once Were Warriors. 'Tough' and abusive (also a victim).

6 Transl: If you'd broken those membranes you would have deprived my grandchild of the precious 'caul' (membranes) that it came in and that cloak gives it protection from the sea for all its life. There is also a belief with some Westerners that a child born within the membranes will not die or drown at sea.

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Caesarean section in the absence of clinical indications

The first cut is the deepest?

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Introduction

Childbirth is a major life event for women and their families. Women's memories of satisfaction with their birth experience remain constant over many years and can have a lasting impact on their self-image (Simpkin, 1992; Kitzinger, 1992). Of particular concern is the rise in caesarean section rates (National Health committee [NHC] 1999). The committee identified a wide variation in the rates of caesarean births within ethnic groups, socio-economic status, providers and regions, suggesting that the driving force behind this development could in part be attributed to an interplay between women's and obstetrician's preferences (NHC, 1999). Moreover the lowest rates were found to be among women who have been represented as having the greatest risk for birth complications. These findings parallel overseas trends (Francombe & Savage, 1993; Ministry of Health, 1999) and are interesting in the light of the new section 51 notice of the Health and Disabilities Services Act, 1993 and the Code of Health and Disability services consumer Rights, 1996, both of which have affirmed the right of women to make choices in pregnancy and childbirth. The experience of a caesarean birth not only has consequences for a woman's satisfaction but also may impact on her future childbearing choices.

Traditionally caesarean section has been viewed as a surgical intervention, medically indicated when the wellbeing of women and their babies were at risk. Attitudes are changing, with the growing perception that women have the right to elect to have a caesarean section in the absence of clinical indications. While the NHC identified implications concerning quality assurance, equity of health services and cost savings, the trend also has salient implications for midwifery practice in that midwives are both supporters of both women's choice and normalcy of childbirth.

This article is based on a paper entitled 'Caesarean Section On Request' presented at the Bi-annual Conference of the New Zealand College of Midwives (NZCOM) held in Cambridge in September 2000. It is not intended to be a comprehensive analysis of the topic, rather an overview of trends in New Zealand over the last decade and includes a background of international literature from a variety of sources. The subtitle of this paper, 'The first cut is the deepest', is a symbolic representation of how caesarean birth has evolved in just over a decade from a major abdominal operation with profound negative consequences for women, to become an increasingly acceptable choice of birth method. Indications for caesarean birth will be discussed along with factors extending beyond biophysical reasons, which are thought to be linked to the rise in caesarean section rates. The topic is represented in the literature as being contentious, complex and contradictory, so for that reason, pertinent themes embedded in the debate will be identified and discussed along with implications for midwifery practice. For the purposes of this article the terms caesarean section and caesarean birth will be used synonymously.

New Zealand trends

In New Zealand the caesarean rates have been steadily rising over the last two decades. Broadhead and James (1999) identified a rate of 5.2 % in 1976. Burger Howden-Chapman & Stone (1998) reported that between 1988 and 1995 the national caesarean section rate had increased from 11.7% to 15.3%. A further increase to 18.2% was reported in 1998 by the Ministry of Health (1999). Wide variations between hospitals are known to exist (Johnson & Ansell, 1995; Burger et al, 1998). Over the last decade increases in induction of labour and epidural anaesthetic rates have become apparent (Ministry of Health, 1999). Recently evidence has emerged to implicate induction of labour as a risk factor for caesarean section (Buist, 1999b; Maslow & Sweeny, 2000).

Indications for caesarean section

Indications for caesarean section are classified as medical and non-medical (Broadhead & James, 1995). Francome and Savage (1993) further categorize medical indications as absolute and relative. For example, absolute indications refer to those events that preclude a vaginal birth such as is the case with placenta previa. Relative indications are those where decisions are based on individual assessments and the experience of the attending practitioner. Of these categories, the four major medical indications for caesarean section most frequently identified in the literature (Keeler & Brodie, 1993; Francome & Savage, 1993; Broadhead & James, 1995; Sachs, 1995; Enkin, Keirse, Renfrew & Neilson; 1995; Churchill, 1997; Bulger, et al, 1998; Dickinson, 1999) include repeat caesarean, dystocia, foetal distress and breech presentation. In New Zealand these are thought to account for 67% of all caesarean sections (Bulger, et al, 1998). In recent times, variations in caesarean section rates, have drawn attention to factors beyond bio-physical reasons that are thought to be behind the increase in caesarean births.

Beyond biology

In their study 'A Cut Above: the rising caesarean section rate in New Zealand', Bulger, Howden-Chapman and Stone (1998) identified wide variations in caesarean section rates within regions, ethnic groups, socio-economic status, providers and regions. These variations parallel overseas trends and cannot be explained by biophysical factors alone (Francome & Savage, 1993). The increasing age of women; day of the week (Curtain & Kozak, 1998), regional differences; hospitals (Johnson & Ansell, 1995), fear of litigation; birth attendant (Francome & Savage, 1993; MacDorman & Singh, 1998), private versus public providers (Bertollini, Dilalla, Spadea & Peerucci, 1992; Price & Broomberg, 1990; Roberts, Tracy & Peat, 2000) are other commonly cited factors thought to be behind the rising caesarean section rates. These variations tend to reflect differences in obstetric practices rather than differences in the population of women they serve

(Francome & Savage, 1993; Enkin, Keirse, Renfrew & Neilson, 1995).

The issue of repeat elective caesarean section as an indication is debatable given that vaginal birth after caesarean (VABC) is considered a safe alternative (Buist, 1999a; Enkin et al, 2000). Repeat elective caesarean section has its origins around the turn of the 20th century when classical incisions were dominant. The age old dictum 'once a caesarean always a caesarean' was a judicious announcement by Craigin (1916) because classical incisions at that time had a high rate of uterine rupture in subsequent pregnancies (cited in Buist, 1999a; Churchill, 1997; Enkin et al, 2000). Craigin recommended caution when performing a primary caesarean section, as this would subject women to a caesarean birth for all ensuing pregnancies. In the majority of cases the classical incisions have been displaced by lower uterine segment caesarean section (LUSCS) forerunner to a vaginal birth after caesarean (VBAC) (Churchill, 1997). Yet despite evidence that shows VBAC to be a safe alternative to elective repeat caesarean sections (Enkin et al, 2000) the number of repeat caesareans continues to dominate the literature as a major indication for, and contributor to, the overall caesarean rate (Broadhead et al, 1995; Churchill, 1997; Wilkinson, McIlwain, Boulton-Jones & Cole, 1998; Dickinson, 1999).

The issue of consumer choice in childbirth has now extended into the realm of maternal preference for elective caesarean section as a choice of birth method (Atiba, Adeghe, Murphy, Felimingham & Scott, 1993; Ryding, 1993; Mould, Chong, Spencer, & Gallivan, 1996; Amu, Rejendran & Bolagi, 1998; Young, 1999; Wagner, 2000). Many writers view maternal requests to be a significant factor behind the rise in the caesarean section rates (Churchill, 1997; Bulger et al, 1998; Ministry of Health, 1999; Jackson & Irvine, 1998). The convenience of scheduling birth around other life events is often cited as a reason for such requests (Kirby & Hanlon-Lindberg, 1999; Al Mufti, McCarthy & Fisk, 1996). The allure to remain 'honeymoon fresh,' an idiom coined from the United States of America by Kitzinger (1998) is beginning to surface and is gaining appeal. One might be forgiven for pondering as to whose interest this genitocentricity may serve? Moreover parental expectations for a perfect baby is rapidly being received as justification for promoting caesarean section as a panacea to the risks of vaginal birth (Steer, 1996; Paterson-Brown, 1998). Extracting the actual reasons for maternal requests for caesarean birth from the national maternity data can be problematic because of short-comings the integration of the information (Health Funding Authority, 1999) and the tendency for individual categorization biases in reporting. However in the context of New Zealand Bulger et al (1998) suggest that over half of the caesarean sections in this country may be viewed as medically unnecessary. Importantly a number of issues emanate from this supposition and include the following questions: Do half the women in New Zealand who have had a caesarean birth appreciate that their caesareans may be needless? Are women choosing caesareans gratuitously under the banner of individual autonomy, a sign of things to come in the 21st century (Saunders, 1997) or have women simply lost confidence in their bodies to give birth naturally? The latter implies that some women may believe their bodies to be faulty. This construction is entirely likely. Drawing on the work of Foucault (1975), Rebecca Aubury (1999) surmises that the social processes of pregnancy and childbirth have become so medicalised 'that it is hard to think of these processes outside medical language and practice, what is called, following Foucault, "medical discourse" '(p. 41).

Women's faulty biology

Within medical discourse, the construction of birth as a medical event implies that women's bodies cannot be trusted to give birth without the aid of technological intervention (Kitzinger, 1992; Young, 1999). Feminist literature alludes to medical discourse as viewing birth as a mechanical process in which the female body is akin to a machine, capable of breaking down (Ehrenreich & English, 1978; Kent, 2000; Kitzinger, 1998; Oakley, 1993; Vosler & Burst 1993). Within medical ideology, women's knowledge about their bodies becomes devalued. Green (1970) illustrates this unequivocally in his medical text when he outlines the use of Haase's rule for calculating the estimated date of delivery:

'many variations can be expected, and because women's memories are notoriously unreliable , the patient should be warned that the date of delivery is only approximate.' (p. 30)

This text was used extensively by midwifery schools throughout New Zealand in the 60s and 70s. More recently Schwarts (1990) proposes that obstetrics has transformed from having a mechanical emphasis, designed to overcome problems as they occurred, to an engineering conceptualisation.

'The obstetrical engineer has to master and control normal physiology in order to prevent the abnormal from happening' (p.55).

The emergence of the term 'prophylactic' caesarean section proposed by Feldman & Freiman, (1985) in response to a litigation case in the USA, exemplifies this shift in conceptualization. Caesarean section, once designed to overcome problems as they occurred, has now been transformed to prevent 'the abnormal from happening'. Exactly whom prophylactic caesarean birth privileges remains to be seen.

Steer (1998) reinforces an ideology of women's faulty biology, by heralding elective caesarian section as a technological way to improve upon nature. Using the theory of evolution to give credence to his thesis, he puts forward the idea that competition 'between the need to think and the need to run' (p.1053) has resulted in *Homo sapiens* selecting for cranial enlargement and a narrow pelvis (Steer, 1998). He argues that a caesarean birth provides a technological solution to the conflict between the size of the baby's head and the mother's pelvis (Steer, 1998). Steer discounts the widely held view that labour is a harmonious interaction between a woman and her baby on the grounds of their genetic differences. One cannot help but muse over the fact that Homo sapiens have survived for so long prior to the invention of the procedure. Within the context of evolutionary time it has only been relatively recently

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that the procedure has been considered safe. In tracing the historical roots of caesarean birth, Churchill (1997) reports mortality rates between 71% and 92% in the 1880s. Others it seems have been pondering too. Kitzinger (1999) believes that Steer's thesis places women and their babies in a competitive alliance. She suspects that Steer's hypothesis is an avenue for the promotion of the widespread use of elective caesarean section. She also reasons that marketing caesarean section in this manner serves to further undermine women's abilities to give birth naturally. Wagner (2000) could find no evidence that babies were getting bigger or women's pelves were smaller. Upadhay and Buist (1999) are cautious about adopting Steer's hypothesis warning of the increasing evidence implicating previous caesarean section with an increase in placenta previa and placenta accreta. They conclude that a considerable amount of evolution will need to take place both in the species and in the procedure before caesarean births can be regarded as absolute for the safety of both women and babies.

Paradigm Posturing?

Traditionally midwifery and obstetrics are represented in the literature as competing paradigms with diametrically opposed views of childbirth (Donley, 1994; Wagner, 1994; Oakley, 1993; Bryar, 1995; Rooks, 1999; Kent, 2000). Midwifery conceptualizes childbirth as a normal physiological process while obstetrics conceptualizes childbirth as a potentially pathological process that can only be normal in retrospect. Inherent in these differing perspectives is what appears to be paradigm posturing, capable of shaping women's perceptions of childbirth. For example, a woman carrying a singleton pregnancy, vertex presentation at term is considered in midwifery discourse as *normal* while in medical discourse (Morton et al, 1999) the label *standard obstetrical risk* is ascribed. While these philosophies remain in contention, both are faced with the vexing question of what constitutes *normal* and what constitutes *risk* as both these constructs are open to interpretation (Downe, 1997; Davies, 2000; Page, 2000). If 'normal' is interpreted as common or average then as inferred by Page (2000a) it seems logical to view the rising rates of caesarean birth as a 'normal' occurrence. Likewise interpretations of risk can be nebulous as is evident when women considered as low risk have higher rates of caesarean births than women who are considered high risk (Nutthall, 1999; Saxell, 2000). However, the tendency to view these two perspectives as diametrically opposed may embody an oversimplification of reality, given that there are wide variations between individual practitioners. Recent works (Bryar 1995; Rooks, 1999; Kent 2000) propose that rather than view them as mutually exclusive these ideologies would be better placed along a continuum to take into account similarities and differences of each. Furthermore these 'competing paradigms' share in common the goal of a healthy mother and infant. It is evident from the literature that writers from both sides of the divide have expressed their concerns about the lost knowledge of normal labour (Young, 1999; Francome & Savage, 1993; Clark, 1994; Nutthall, 1999; Rosser & Anderson 2000). These concerns have legitimacy in the light of the evidence surrounding safety issues associated with caesarean birth.

Safety of caesarean birth

While today's caesarean birth is considered as safe as it can ever be, given the high mortality rates of the 1800s, it is still a major operation and carries greater risk than a normal vaginal birth (Enkin, Keirse, Neilson, Crowther, Duley, Hodnett & Hofmeyr, 2000; Hillan, 2000). When compared to a normal vaginal birth the maternal mortality rate with caesarean birth is considerably higher (Enkin et al, 2000). These authors along with others (Bulger, 1998; Wagner, 2000) report respiratory problems in infants born by caesarean birth. Furthermore links to increased risk of placenta previa and placenta accreta in subsequent pregnancies are beginning to surface in the medical literature (Amu, Rajendran & Bolaji, 1998; Upadhay & Buist, 1999). These authors also alert the reader to the complications and the long term consequences of caesarean birth such as bladder adhesions or injury, uterine rupture and ectopic pregnancy. Some writers have found an association with voluntary and involuntary infertility (Jolly, Walker & Bhabra, 1999). These factors raise doubts as to whether caesarean births in the absence of medical indications, can be justified when there is little scientific evidence in the literature to support it. Notwithstanding the biophysical implications there is a dearth of literature on the psychosocial implications of caesarean birth (Murtyn, 1994; Hillan, 1999; Churchill, 1997). Given the negative sequelae of the operation it comes as no surprise that Enkin et al (2000) advise that these risks can be minimised by restricting the procedure to situations when it is clinically indicated.

Promotion of caesarean birth as an alternative option

Despite these cautionary accounts about the hazards of caesarean birth some obstetricians are promoting the offer of caesarean section routinely for all pregnant women (Al Mufti et al, 1996). Their justification comes under the mantle of consumer choice. Al Mufti et al., surveyed female obstetrician's personal preference regarding mode of delivery for their first baby if it was an 'uncomplicated singleton cephalic presentation at term' (p. 544). Thirty-one percent of female obstetricians said they would choose caesarean section. The reasons for their choice included convenience and avoidance of the risks of vaginal birth. Their survey has received much attention in both professional and popular press and no doubt will serve to titillate those easily seduced by state of the art technology. Already there has been reference made in the literature to celebrity caesareans (Lancet, 2000).

Since the publication of Al Mufti et al's (1996) article there has been an eagerness to hear about midwives attitudes toward an elective caesarean birth in the absence of clinical indications given that midwives are a large group of informed women (Robinson, 1998; Dickinson & Willett, 1999). These authors are concerted in acknowledging that as an informed group of women, midwives are in an excellent position to make an informed choice about their preference with regard to mode of birth. Dickinson & Willett approached 135 female midwives working in Ireland and found that 129 (96%) would aim to have a vaginal birth. Likewise in Ireland, McGurgan, Littler and O'Donovan (1999) compared obstetrician and midwives preferences as to mode of delivery using the same criteria as Al Mufti et al's survey and found that, after controlling for gender and in contrast to their English counterparts, 7.3% of obstetricians would elect to have a caesarean birth. Similarly, for midwives in their survey, 7.5% reported a caesarean as their preferred mode of birth.

Whose choice?

While there is much rhetoric on the topic of elective caesarean birth in the absence of clinical indications, the literature is both contradictory and

confusing as to who is leading the charge. Both women and obstetricians are being castigated. In admonishing obstetricians for implicating maternal requests for the rise in the caesarean birth rate, Robinson (1999) believes women are being unfairly blamed. She views it rather as a subtle ploy by obstetricians attempting to trigger a demand. Selection bias (Flamm, 1995) may confound Robinson's argument in that women who request a non-clinical caesarean birth select to have obstetricians for their maternity care. As Kirby and Hanlon-Lundberg (1999) so graphically put it 'only the obstetrician wields the knife' (p.260). Few studies however have examined the experiences of women who have demanded caesarean section for non-clinical reasons. Studies that have observed maternal requests for a caesarean option reveal that for the majority of women their requests were for 'relative' indications such as previous caesarean, breech presentation or previous difficult births (Jackson & Irvine, 1998; Wilkinson, McIlwaine, Boulton-Jones & Cole, 1998) or justifiable reasons such as a history of a previous traumatic experience and a debilitating fear of pain associated with childbirth (Ryding, 1993; Churchill, 1997). There is limited hard evidence that women requested caesarean sections for matters such as convenience.

Informed choice: real or cliche?

The literature about women's requests for a ceasarean birth in the absence of clinical indications unfolds a complex issue that is shrouded with contention and contradiction. On one side of the divide, there are those that question whether women are being fully informed about the procedure (Phelan, 1995; Churchill, 1997; Hillan, 2000). On the other side, there are those who argue high levels of satisfaction with both decision making and the procedure (Mould et al, 1996). Both Churchill (1997) and Wagner (2000) argue that women are not being appropriately informed about the realities of a major abdominal operation such as increased pain post partum, longer recovery times, complications along with mortality and morbidity factors when compared with vaginal births. Simultaneously legal opinion is focusing on the right of women to choose an elective caesarean birth regardless of indication (Flamm, 1995). Beguiling pronouncements calling for the need to respect women's autonomy in relation to the choice of a caesarean birth are beginning to surface in medical journals (Drife, 1998; Lancet, 1997). In campaigning for women's choice Drife (1998) contends, where cost effectiveness and women's views are in conflict 'obstetricians should support the women, not the auditors' (p. 844). Likewise, The Lancet (1997) proclaimed that 'The trend for use of caesarean section, coupled with a greater emphasis on individual autonomy in medical decision making, has clearly progressed too far for a return to paternalistic directions to women on how they should give birth' (p. 815). In a similar manner Paterson-Brown et al (1998) deemed that women should be able to have the choice of a caesarean birth provided they are fully informed. This presumption of women as autonomous individuals who can make rational decisions after receiving all the information is commendable, but is somewhat hollow when held up against Hemminki's (1997) argument, more recently endorsed by Wagner (2000) as to whether women can make an informed choice about caesarean section in the absence of clinical indications as there is no scientific base for it. Moreover the growing emphasis on shared-decision making in medical and midwifery encounters, does not guarantee real choice, as the manner in which information is presented can be framed to fit the practitioners penchant (Harding, 2000). Indeed some would argue that a shared decision is a euphemism for an informed decision managed according to the practitioner's preference (Gwyn & Elwyn; 1999). Whichever side of the debate one takes, the inevitable outcome of the discord will be to mask the evidence upon which women are expected to make informed decisions about their choice of birth method and as Lewison (1996) and Gwyn and Elwyn (1999) point out unless there is real choice between two viable options, then choice is meaningless.

Implications for midwifery

Midwives face a tremendous challenge endeavoring to keep birth normal. In the context of New Zealand they have an ethical responsibility to uphold each woman's right to free and informed choice throughout her childbearing experience (New Zealand College of Midwives [NZCOM] 1993). They also have a responsibility not to interfere with the normal process of pregnancy and childbirth and to ensure that no actions on their part places women at risk. *The increasing regularity of caesarean section has the potential to normalise this mode of birth while creating a population of women who are expected to cope with the recovery from major abdominal surgery, together with the demands of caring for a new baby. Both have new meaning for the practice of midwifery. Juxtaposed to this notion is the tension of positioning healthy childbearing women in the sick role.* Pathologising of women in this way is akin to what Taylor (1979) refers to as 'patientising the population,' the tendency to convert 'the entire population of the industrialised countries into patients' (p. 173). Will an unintended consequence of upholding women's choice for a caesarean birth in the absence of clinical indications be the unwitting complicity toward patientising the population of child bearing women? Down (1996) reminds us 'If midwives are to become the experts in normality they must also learn to defend the definitions of the normal in order to protect mothers and babies and promote optimum health gain' (p.106). Down's assertion is a pertinent point as the upshot of an increase in the primary caesarean birth rate will, in effect, lead to a less healthy population of childbearing women in the future. Midwives for that reason have a critical role to play when informing women of their choices.

Conclusion

While the topic of caesarean section has been extensively researched, the evidence for maternal requests for this choice of birth method in the absence of clinical indications is unconvincing. Nonetheless, the arguments both for and against women's choice for a caesarean birth are compelling. The trend is part of an international drift, which may have implications for midwifery practice. Midwives have a role as facilitators of women's choice and the promotion of birth as a normal life event. Implicit are two competing values. The first cut may no longer be the deepest, but is it the kindest?

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Alternative vs. conventional medicines: a clash of culture or of science?

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Entire communities of health care practitioners are squatting in encampments demarcated by their position on the use and efficacy of what are often called 'alternative' and sometimes 'traditional' medicines (Iwu & Gbodossou, 2000). Of course these camps are symbolic of only the strongest opinions polarising the debate. Still, the tone of the debate is sufficiently extreme as to make it impossible to forge a coherent and universally accepted definition of alternative medicine (Fulder, 1996). From my academic's viewpoint, the borders defining these camps appear to be political, derived from ingrained differences in their cultures, rather than inherent differences in the medicines.

These political differences are not advancing the debate. The same arguments are being made now as years ago. As a researcher with interests in drug discovery and testing, I often encounter polar opinions from the health care community about drugs. Not uncharacteristic is this quote from the Lancet 'There might be a few pearls that I do not know about among the countless alternative therapies available. However, I still believe that, in general, alternative treatments do not work' (Knipschild, 2000). Meanwhile other health care providers will leap to equally broad conclusions about the efficacy and safety of drugs that have not been through sufficiently stringent masked randomised clinical trials.

Are the political divisions just maintaining a false dichotomy between the medicines? Certainly there are rewards (such as having papers published in visible journals) that protagonists of both camps receive as long as the issues of contest are the issues they are good at contesting. That might be reason enough to keep the debate where it has always been. Here I hope to change a single aspect of the debate, perchance to advance its resolution.

In this article I will review evidence that the difference between medical establishment pharmaceuticals (or what are variously called 'mainstream', 'evidence-based' and 'conventional') and alternative agents is not what the conventional or alternative health care provider may think. Indeed, the objectivity and rigour associated with the approval process of conventional drugs may be, in some cases, overrated by the conventional health practitioner, and the superior quality of alternative drugs, in most cases, does not exist. So I will attempt to re-assert a functional definition of alternative and conventional medicinal drugs, based on rigour of evaluation. This definition may not be new, but if invoked universally it could cause some conventional drugs to be re-classified as alternative.

All drugs dispensed by all practitioners have some evidence supporting the conclusions that they both work and are safe. However, evidence can be gathered using widely different standards. The surprise is that those standards can be objectively low for drugs that are either conventional or alternative. This is what I perceive to be the false premise of the debate between the cultures. The evidence for the effectiveness of alternative agents is often criticised by conventional practitioners, but they fail to recognise when conventional drugs are worthy of the same criticisms. Conversely, alternative practitioners may substitute alternative agents because their natural origin confers upon them fewer undesirable characteristics or superior curative properties, conclusions that could all too often also be valid for the conventional drug if it had been subject to an equally casual test. This article is not about vindicating the viewpoints of either symbolic camp of medicine, but reinforcing the need for consistent application of standards for gathering evidence.

How conventional and traditional drugs are alike
What do conventional pharmaceuticals - those produced by drug companies, approved by various government authorities and endorsed by 'proper' Western medical school graduates - have in common with alternatives? Importantly, most come from the same place. That is, most drugs used in conventional medicine are extracted from natural sources, for example bacteria, fungi, and plants, just like alternative agents, for example *Allium sativum* (garlic), pine bark and *Echinacea purpurea* (eg, Murphy Cowan, 1999).

Conventional drugs are more stringently purified, may be chemically modified, and in the extreme, can be completely synthetic (Aldrige, 1993). However, purification, modification or synthesis do not automatically make conventional drugs different from alternative agents in their effect, usefulness, or safety. Chemical bonds are the same length and strength whether they are synthesised in a laboratory or synthesised by an enzyme in faecal bacteria (Sears, 1995).

continued over...

Waitemata District Health Board
Te Wai Awhina

North Shore Hospital's Maternity Service invites you to our two Midwifery Open Days in May.

North Shore Hospital provides Level 1 Maternity Services to families throughout Auckland, mainly in the Rodney and North Shore districts. Our open days in May are an exciting opportunity for health professionals to come and see our service first hand and to meet the staff who work here.
The programme includes exciting and informative displays of our current maternity service as well as innovative redevelopment plans including a Special Care Baby Unit.
The SBCU is a progressive approach to the changing needs of the community. The redevelopment will provide exciting opportunities for health professionals to learn more about our expanding services within North Shore Hospital. Come and see it for yourself!
Programme for the Open Days includes:

- Displays
- One-to-ones with maternity staff and managers
- Tours of the Maternity unit
- Opportunities to meet our Clinical Leaders
- Light refreshments, tea and coffee
- Lucky door prize

Where: Conference Room 2, North Shore Hospital, Shakespeare Rd, Takapuna, Auckland.
When: Friday 4th May, 3pm - 7pm & Saturday 5th May 10-3pm
For further information contact Jan Henderson, Ph 358 0825 and dial 1297 or email: Hendersj@whl.co.nz

Indeed, the beneficial, as well as the deleterious, effects are likely to be more systematically examined for conventional than for alternative drug preparations. The greater purity and more consistent composition of conventional drugs reduces, but does not eliminate, the likelihood of unanticipated effects in those treated with the drug (Sears, 1995; Knipschild, 2000). Unfortunately, all medicines have in common their ability to cause undesirable side-effects.

Aversion to the use of antibiotics is a classic example where natural alternative agents are mistakenly considered superior to conventional drugs. In response to the increase of infections caused by antibiotic resistant bacteria, for example, I have heard health care providers recommend 'natural' remedies because they are not as dangerous as antibiotics. Such conclusions can only be reached when two forms of misinformation are combined simultaneously: the idea that antibiotics are not natural and that the alternative agent has been demonstrated to be less dangerous in comparable situations (especially the situation where they are recommended without a confirmed identification of the infectious agent).

Antibiotics are, by definition, *natural* products produced by organisms all around us and in our food (eg, Hancock & Diamond, 2000). They work by killing, or inhibiting, the reproduction of disease-causing bacteria. They are not fundamentally different from other phytotherapies.

Like, I suppose, a microbial Rogernomics, antibiotics have produced a global redistribution of bacterial wealth, concentrating it for use by the bacteria that cause disease. Antibiotics tend to kill many bacteria, not just those that cause disease. So whereas these 'magic bullets' are considerably more dangerous to them than to us, they are not discriminatory among the bacteria. Through the use of antibiotics, we have rewarded those bacteria that become resistant to antibiotics with the resources that would have otherwise been consumed by the non-disease causing bacteria also killed by antibiotics. Thus, the world has become re-populated with newly antibiotic resistant strains of bacteria (Levy, 1998).

Some would claim that we should use alternative agents in place of conventional antibiotics. But unless the alternative agent does not involve killing or inhibiting bacteria (or stimulate the immune response which kills bacteria), then the 'alternative' agent is just, in effect, a crude reconstruction of the conventional antibiotic, and may have the same potential to select resistant bacteria (Heinemann, 1999; Heinemann et al., 2000).

Thus, the idea that alternative agents are natural and conventional drugs are not is largely a cultural perception with little or no relevance to their safety or success. A practical, but again cultural, distinction between the two is their availability to patients. The patient is wont to suffer if a suitable drug from one culture is not made available because the health care provider is of a different culture (Iwu & Gbodossou, 2000).

How could they differ?

What, then, is the significant difference between conventional and alternative drugs? An alternative agent can become conventional if properly produced, tested and dispensed. Therefore, alternative agents are not inherently different from conventional. Indeed, alternative agents can be a source of conventional drugs. However, a conventional drug is, presumably, certified by a different standard of research than an alternative agent. The certification procedure for approving conventional drugs legitimises claims of their efficacy. That is, the process of evaluating conventional drugs, most notably the double blind random clinical trial, should make it impossible to conjure with our imaginations an effect that does not really exist (Weijer & Elliot, 1996).

For example, the common perception that Echinacea possesses immunostimulatory compounds that protect against colds in particular (Sears, 1995; Knipschild, 2000) have made it a popular alternative agent. Its fame has developed and spread from anecdotal experience without controls for the placebo effects. No blind studies have been consistently able to vindicate the claims for Echinacea, even when the administered compound was prepared under defined conditions and batches were uniform (eg, Knipschild, 2000; Turner et al., 2000).

Tainted trials

Nevertheless, the alternative health care provider can have much in common with the conventional and Echinacea has much in common with some conventional drugs. What could be the meaningful difference between the conventional and the alternative is in actuality sometimes *not* the difference.

Clinical trials can be compromised by anecdote (Cohen, 1995) and data selection (Vines, 1995; Vines, 1997), the very sins for which alternative agents are routinely dismissed by the evidence-based medical establishment. 'Doctors are so convinced that they know what's best for their patients that many are tempted to cheat in clinical trials,' reports Philip Cohen in a New Scientist article (p. 10, 1995). The effect of cheating, even with the best of intentions, 'can even make a harmful treatment seem effective' (p. 10). Of 400 medical researchers and doctors interviewed over an eight year period, more than 200 admitted to cheating on trials (Cohen, 1995). No one is immune to the power of instinct and preconception.

Perhaps more subtle, but systematic, bias comes from data selection. The reasons for publishing the results of studies are not always related to the merits of the work. Negative results, those that do not show an effect, are generally more difficult to publish than positive results. Motivation to write a paper for publication is often proportional to how exciting the result is to the author (Vines, 1997). The best or most popular journals are not always the preferred journals for publishing data that contradicts accepted wisdom (Vines, 1995). 'Failure to publish every last scrap of available data may seem like a harmless oversight, but it's not. Some say it amounts to systematic scientific (sic) fraud' (Vines, 1995, p.14). A survey of trials funded by the US National Institutes of Health found that the results of as many as 7% 'were never published—more than enough to constitute a serious 'publication bias' in systematic reviews' (Vines, 1995, p.15). Interestingly, a tendency to ignore negative trials is one of the central criticisms conventional practitioners have of alternative practitioners (Knipschild, 2000)!

Human frailty in research

What is the relevant difference between alternative and conventional drugs then? The real differences are in the tests, not in the people who recommend, or what camp claims, them. More medicines are, in actuality, alternative than conventional practitioners admit. And more alternative medicines work the same old way as conventional than is recognised.

Both cultures suffer from the same stresses as my academic culture. We must serve a society that would prefer to invest in strategies (eg, technology, outcomes and products—like drugs) rather than in an informed and objective community of advisers. Society also wants certainty, perhaps motivating practitioners to too often make definitive statements in support of, or against, a type of medicine or drug. Academic and professional opinions are formed under a shroud that can limit research to problems that have immediate rel-

evance, profitability or greatest publishability. As the clinical trials demonstrate, even being motivated by the public, or clients', good can be a powerful prejudice (Heinemann, 2000; Taubes, 1998).

'Try this, it can't hurt.' 'It works for me and all my clients.' 'It's natural, so it must be good.' Would you trust this evidence? For me, the only useful definition of alternative agents and conventional drugs has to do with how they achieve acceptance by health practitioners. Whether the drug is ultimately patented by large companies for distribution via conventional medical practices, or produced as home remedies, are distracting issues. Anecdote, instinct, and inspiration are all legitimate clues to draw upon for identifying useful new drugs. They are, however, just clues, not evidence upon which to rest or recommend. The debate between cultures might progress if the energies devoted to arguing were channelled instead into quality research.

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LETTER TO THE EDITOR

In response to Irene Calvert's opinion: Midwives should nurture their young, not eat them

Mary Vella, 'Student' midwife

This is an open letter to all Midwives.

New Zealand Midwifery philosophy and standards are wonderful ideals to work and live by. However the reality is all too often something quite different.

The focus of New Zealand Midwifery philosophy is 'holistic by nature'... delivered in a manner that is flexible, creative, empowering and supportive. In the Standards of Midwifery Practice standard 10 requires midwives to 'give special recognition to student Midwives and shares her expertise in a supportive manner'. As Irene Calvert has pointed out in her article the reality for Midwifery students is often not supportive at all. All too many individual Midwives, including those trained under this new philosophy, are so busy protecting their own career and position that they have neither the time nor energy to focus on delivering this philosophy of care to women and supporting students and new graduates.

Because of the article I discovered about Ruth Lubic, Midwife and Author from New York City and would like to add some of her philosophy for the benefit of Midwives and students alike:

1 Begin with the needs of the people you serve.
2 Take care of all the people of the nation.
3 Trust your caring instincts.
4 Learn to tolerate uncertainty.
5 Choose your professional colleagues for their caring philosophy.
6 Be aware of the limits of the medical model.
7 Avoid anger (consumes energy).
8 Avoid bitterness against professional adversaries.
9 Base design for change on the best science possible.
10 Overcome the fear of leadership.

7 and 8 are the one's I use as a current focus as I attempted to deal with the adversaries placed in my path... *'Dreams can be such dangerous things. They smoulder on like a fire does and sometimes consume us completely.'* (Anon)

My great grandmother, Mary Skinner (nee O'Lone), came to this country as a 15-year-old in 1873. She had 8 children and ran a bakery with her husband, as well as being the local Midwife, even though she could not read or write. This work continued even though her husband deserted her. She was a 'family skeleton' until my mother and I discovered her in our local oral history and I feel very connected to Mary's spirit as I hang on to my dream of being a superb Midwife.

Anti-D in midwifery: panacea or paradox?

by Sara Wickham
Books for Midwives Press RRP: $82.95

Reviewed by Ann Noseworthy, Lecturer (Midwifery), School of Health Sciences, Massey University

Anti-D has been routinely given to Rh D negative women since the 1970's. In a time when women and midwives are questioning routine practices during the childbearing year, the routine use of anti-D is being put under scrutiny.

This book takes a detailed look at the history, use and current evidence surrounding Anti-D. In it Sara Wickham critiques the research on Anti-D and points out areas about which there is a lack of knowledge. She also explores the anti-D evidence within a midwifery framework.

The book raises questions about the routine use of the drug, its long-term effects, a safe effective dose, the risks associated with its use and the lack of unbiased information on which women can make a fully informed choice about receiving the drug.

A well-written book that covers all aspects of the Anti-D debate, raises questions about its routine use and points out areas needing further study.

It should appeal to Midwives, Midwifery students, Obstetric Health Care providers, and women who may be affected by the issue.

Midwifery, Mind & Spirit: Emerging issues of care

by Jennifer Hall
Oxford: Butterworth-Heinemann RRP: $62.36

Reviewed by Gillian White, PhD
Editor, NZCOM Journal, Associate Professor, School of Health Sciences, Massey University, Wellington

This small book (134 pages) was written by Hall, a freelance midwife, because she believed that debate concerning spiritual issues in midwifery needed to be initiated. She was also curious, as to whether midwives holding some form of spiritual belief, offered an enhanced special kind of care to women. In the book she questions whether current midwifery education is enabling students and midwives to meet the spiritual needs of mothers and their families. She notes that there is a paucity of academic writing concerning spiritual issues associated with midwifery practice. Each chapter contains reflective questions that can be used by individuals or small groups to explore spirituality in practice. Hall admits that the book is just a beginning, an attempt to raise awareness.

Spiritual care is an integral part of midwifery care. The sphere of midwifery practice includes meeting the physical, social, emotional, education and spiritual needs of women within the context of childbearing. The concepts of spirituality and spiritual care defy a definitive meaning as elements are identified that have relevance to existentialism, the search and meaning for life's purpose, belongingness, relationships, respect and value for others, self-awareness, cultural heritage and the awareness of personal beliefs and how they affect practice. In her first chapter Hall raises these issues, compares spirituality with religious beliefs, and alerts the reader to signs of spiritual distress and thus there is a promise of more to come. Unfortunately the rest of the book is haphazard, often repetitive and lacks the depth of debate anticipated.

The book does offer educationalists ideas for integrating spiritual concepts and issues into the midwifery curriculum and reminds us to use the 'teaching moment' in clinical practice. However, scholars wishing to pursue study about spirituality in midwifery will be disappointed, although the references are extensive and helpful.

Hall is calling for research to inform debate and the book serves that purpose. The problem is that the cost of the book is a major consideration.

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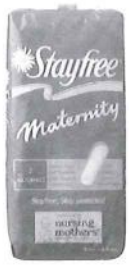

STAYFREE* Maternity Pads are very thick pads with extra length and cushioning that are designed specifically for the extra heavy flow and tenderness experienced at this time, particularly with episiotomy and stitches.

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Midwives - interested in exploring and developing your practice?

Why not try postgraduate study with Otago Polytechnic?

The Otago Polytechnic School of Midwifery has developed three new postgraduate programmes with the help of practising midwives. These programmes meet the needs of midwives by:

- Acknowledging the skills and knowledge that midwives already have
- Focusing on practice
- Delivering papers in a flexible way to work around midwives' busy lives
- Offering programmes that are incremental so midwives can complete components as desired rather than committing to a master's degree straight away

These postgraduate midwifery programmes commenced in 2000 and further papers are being offered in 2001 as well as a repeat of those offered last year. Current students have enjoyed the papers so far with positive feedback received about topics of discussion, networking with other midwives, supportive environment and lecturers and the fun they have had along the way as well as the obvious benefits to their practice.

The School of Midwifery offers the following programmes:

- The Postgraduate Certificate in Midwifery Practice (consists of two papers and is usually completed part-time over one year)
- The Postgraduate Diploma in Midwifery (consists of four papers and is usually completed part-time over two years)
- The Master of Midwifery (consists of eight papers and is usually completed part-time over four years)

Each academic year runs from February to November and papers run over half a year each. Papers are offered in both Dunedin and Christchurch each year. and we will consider coming to other centres if class numbers are sufficient.

Places are still available for second semester papers in both Dunedin and Christchurch, commencing in July.

For 2001 these are:

- Clinical Inquiry: Evidence for practice
- Midwifery Practice as a Continuity midwife in Aotearoa
- Midwifery Practice as a Core facility Midwife in Aotearoa
- Leadership and Change in Midwifery Practice.

For further inquiries please contact:
Sally Pairman, School of Midwifery, Otago Polytechnic,
Private Bag 1910, Dunedin
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- Current contact details where the author can be reached

Where there is more than one author please ensure that the letter accompanying the manuscript has been signed by each person.

References - American Psychological Association (APA)

In the text, cite the authors' names followed by the date of publication, e.g. Bowers (1996).

Where there are three or more authors, all authors' names should appear first and thereafter *et al.* will suffice. Where there are six or more authors *et al.* can be used throughout.

In the reference section only include those authors referenced in the text.

Please check references carefully.

Style as follows:

Pairman, S. (1999). Partnership revisited: Towards a midwifery theory. New Zealand College of Midwives Journal. 21, 6-12.

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