



NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

JOURNAL

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Post-traumatic stress disorder
and childbirth

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Equal rights in the
birth chamber

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midwifery lecturers

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Legal Comment

Jackie Pearse



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Promote women's health issues as they relate to childbearing women and their families.

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Views and opinions expressed in this Journal are not necessarily those of the New Zealand College of Midwives.

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Survey aims to discover Midwives' understanding and use of genetics and embryology

In these times of increasing antenatal testing, in order to give women information that enables them to make an informed choice about having those tests, midwives need to have an understanding of the reasons for these tests as well as an understanding of the basis of those tests.

Are you presently working with women and their families as a core midwife or LMC midwife?

Interested in participating in a survey that looks at midwives' perception of their knowledge of genetics and embryology and its use in their practice?

Your participation will involve a 20-minute anonymous questionnaire, which has received ethical approval from Massey University Wellington, Ethics committee.

If you are interested please contact:

Ann Noseworthy or Marion Cooper

School of Health Sciences, Massey University at Wellington

801-2794 ext 6873 or 6714 or e-mail D.A.Noseworthy@massey.ac.nz or M.Cooper@massey.ac.nz

EDITORIAL BOARD COMMENT

We welcome you to this issue of the New Zealand College of Midwives Journal which offers some international and national perspectives on midwifery issues. The diversity of midwives' practice is something to celebrate in the profession and it is evident throughout this issue. The upcoming New Zealand College of Midwives Conference in Dunedin will provide further opportunities for such celebration and networking between colleagues. In the meantime read on.....

Marie O'Connor's article provides insights about maternity care in Ireland which might provoke us to take a moment and think about the opportunities that exist in New Zealand. In contrast to an international view, Frances Sutton, Marion McLauchlan and Carey Virtue report a piece of original research which adds to the growing body of published material about New Zealand midwifery practice in their comparative study of midwife-led and general practitioner-led maternity care. Focusing on national issues, Ann Noseworthy reports a nationwide research study.

The findings challenge midwifery educators and tertiary institutions to consider ways of developing faculty practice to both strengthen education and the profession. The abstract from Christina Engel's master's thesis offers further thoughts on the nature of New Zealand midwifery practice. With regard to one aspect of midwifery practice Judy Crompton, who offered workshops in New Zealand in 2001, writes about post-traumatic stress disorder and the implications for midwives. Jackie Pearse approaches practice from another perspective offering legal comment on "Lead Maternity Carer Response to Intra-Cardiac Echogenic Foci". In keeping with maintaining currency in practice, Sarah Stewart's regular column "Surfing the net" identifies resources for midwives to access evidence and resources to inform current practice.

There is an upsurge in the amount and range of midwifery research being undertaken in New Zealand. Publishing such research is an important way of developing our midwifery knowledge base.

In the context of increasing intervention during childbirth midwifery needs to develop more strategies to promote a midwifery model of care. Publishing research or articles about practice which can then be read and debated by other midwives is a vital process in the development of the profession. We are always keen to receive articles, book reviews, research abstracts and letters to the editor. In particular, we are keen to have a regular space to publish the abstracts of research undertaken as part of masters or doctoral study. Similarly, we have recently been contacted by several midwives commenting on the quality of stories which midwives are including in their portfolios as part of professional development programmes and preparation for competency based practising certificates. We would be very keen to receive any stories about practice and would urge you to sharpen your pencils or keyboards.

The notes for contributors were published in the October 2001 Journal and will be in the October 2002 Journal.

GUEST EDITORIAL

Sally Tracy *RM, RGN, BNURS (NZ), MA (UK)*

Prof. Doc. in Midwifery Cand., UTS, Sydney 2002.

Sally is a research midwife based at the Centre for Family Health and Midwifery, Sydney. She is also teaching in M502.1 Clinical Inquiry paper in Otago Polytechnic's Master of Midwifery and she wrote this editorial following some of the discussions in one of the seminars. Contact: stracy@ozemail.com.au

Thank you for the privilege to write on research matters in this journal. I recently spent time with a group of wonderful South Island midwives who with me, in the course of our study into clinical inquiry, struggled with the concept of the "null hypothesis". This is a research convention that always appeared to be one of those obtuse and confusing things that people who appear familiar with research just took in their stride. It seemed to be a sort of code to confuse anyone trying to come to grips with anything mildly 'scientific'. I have spent hours struggling over research questions that set out to say 'that X will not influence the outcome of Y', when really what I want to know is a seemingly straight forward 'does the influence of X affect the outcome of Y'?

Now I'm telling you this because it has finally dawned on me why we persist with this apparent obscurity.

"Let me take you for a minute into the world of scientific thought, where in political and social theory, and in economics and much of modern science, the principles of subjective interpretation and indeterminate causality have been strongly challenged. Mechanistic thought, which applied the laws of determinism to human affairs for three centuries has finally been contested in the twenty first century by studies of biological systems that are characterized by the 'sovereignty of chance, luck, and contingency' (Burztajn, Feinbloom, Hamm, & Brodsky, 1990, p. 56). Einstein's famous epithet, "Gott wurfelt nicht", suggests that because 'God does not play dice', there would always be a possibility that in the future, when scientists had a deeper theoretical understanding and more sophisticated computing methods, the hidden determinism for apparently random phenomena would be easily understood (Ekeland, 1990). "What Einstein resisted and what quantum physicists such as Neils Bohr and Werner Heisenberg accepted, was that chance and cause were not mutually exclusive categories (Burztajn et al., 1990, p. 29).

The Newtonian scientific method, relying solely on the observation of cause and effect reduced the modern scientist to a mere spectator. However, Einstein's special and general theories of relativity did away with the concept of "an absolute and universal notion of space and time" (Greene, 2000, p. 377).

So the suggestion is, that if we give up trying to predict an exact and reproducible outcome for every individual cause, it will enable us to begin to understand patterns that may be predicted through statistical methods that recognize a 'probabilistic pattern' (Ekeland, 1990). The theories of probability claim that causal relationships cannot be known with certainty. They claim that small causes can have a great effect and the same effects may not have the same causes (Burztajn et al., 1990). Although the science of probability was well known among early French mathematicians such as Pascal, Laplace, Fermat and Poisson (Goodman, 1999), it was strictly ignored from the clinical sciences and had little relevance to clinical medicine until the early nineteenth century.

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Guest editorial

So, the paradigm 'shift' that is looming, involves abandoning the thinking and practice of reductionism, where causes are believed to be linear, objective and quantifiable, and replacing these with measures of multifactorial influences expressed in terms of probabilities. In short, knowledge, including midwifery and obstetric knowledge that was once thought to be exact or absolute, is now perceived as 'probabilistic', even, 'provisional'.

Unhappily, more often than not, in our practice we reject the element of chance or probability and prefer to rely on the "theory of errors". For example, very often when a research result is not expected or explainable it will be put down to the fact that women are imperfect, the body is imperfect, the machine used to measure the particular outcome is not big, or strong, or sophisticated enough. The unrealistic expectation is that certainty and perfection will be achieved eventually.

What appears to be emerging though, is a common understanding of the need to move from 'uncontrolled experimentation' in obstetric care, to a practice that acknowledges women as the centre of care and research. In addition a greater recognition of uncertainty and mutually recognised anxieties may facilitate stronger co-operation and better use of finite resources. This new movement has claimed the mantle of 'evidence based practice' (Sackett, Richardson, Rosenberg & Haynes, 1998) and in its endeavour to minimise error, both systematic and random, two major constructs become pivotal; the use of comparison groups and the derivation of a random sample.

According to Ann Oakley, once uncertainty and the play of chance are acknowledged, obstetric and midwifery knowledge can never be the same again (Oakley, 2000). A realisation that in acknowledging uncertainty in the way things are practiced, opens the way to discovery and a new vision. Feminist scientists such as Evelyn Fox Keller and Margaret Wertheim claim that women will see and interpret things differently in a scientific sense simply because of our different enculturation (Wertheim, 1997). Maybe even mathematics may be unseated from its pedestal of objectivity and the language of reduction, by the embrace of chance and probability.

So coming back to my discovery about the null hypothesis. It all makes a little more sense now.

The new paradigm deems certainty is unattainable not only in fact but also in principle, that is, certainty is a delusion – only uncertainty is definite (Logan, 1996, p.397). You see Karl Popper, (the father of the 'null hypothesis'), claimed that where one increases the *truth content* of an argument at the same time the *falsity content* is increased – that is to say, the *exception* (italics added) to the rule is also more likely to occur (Popper, 1972). Although researchers spend most of their time trying to demonstrate that a relationship between variables is true, for example 'that we should avoid the influence of X because it will affect the outcome of Y', the problem is that it is almost impossible to know such a thing absolutely. We would have to do an infinite number of experiments to prove a relationship true (without any exceptions), but only one experiment to prove it false. It is much easier to demonstrate that the relationship is *unlikely* to exist and that the hypothesis or statement is false. There's our dilemma, in order to show that something is true – we are better to set out to show something else is false!

As one of the post grad midwives pointed out – it's a useful tool if you are questioning accepted practice. Rather than having everyone feel challenged and 'shutting down' when you ask a direct question; to pose a question using the null hypothesis allows everyone to stop and take another

look – from a distance. It feels far less confrontational to question and find out what we believed to be true is in fact not true if we ask the question with a measure of creative uncertainty. Now that calls for a null hypothesis!

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Primary maternity care outcomes in New Zealand: a comparison of midwife and medical practitioner care

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Frances Sutton is an independent economist and statistician specialising in health services research (off-print requests to FS). At the time this research was undertaken Marion McLauchlan was a Lecturer in Midwifery at Wellington Polytechnic (now Massey University) and Carey Virtue was an independent midwife and Director of Domino Midwives, Wellington. Set up in 1989 Domino Midwives, Wellington was New Zealand's first independent group midwifery practice.

Abstract

Objective: To compare the outcomes of primary maternity care delivered by two types of provider: independent midwife and general practitioner.

Design: A retrospective cohort study. A regression analysis of two groups of providers on eight indicators of obstetric intervention and adverse outcome using routinely collected data.

Setting and participants: Wellington, New Zealand. Primary maternity practitioners and women giving birth between 1 January 1993 and 31 December 1997.

Measurements and findings: The eight indicators used were induction, epidural analgesia, instrumental birth, caesarean section, postpartum blood loss, low apgar at 5 minutes, admission to neonatal intensive care unit, and stillborn. Logistic regression was used to estimate the odds ratios of outcomes, controlling for risk. The study showed that rates of maternal interventions tend to be lower or the same for midwife-led maternity care compared with general practitioner led care.

Conclusions and implications for practice: This study supports midwife-led care as a valid choice for women.

Introduction

The effectiveness and safety of midwifery led care has been debated worldwide and the focus of this article is the New Zealand setting. In the context of this article midwife-led care means primary maternity care (antenatal, intrapartum and postnatal) provided by a midwife.

Randomised controlled trials of the effectiveness of midwife-led care have supported the move to midwife-led care. In the United Kingdom midwife-led care was found to be clinically effective, resulting in intervention rates similar to or less than those for shared care (care divided among midwives, hospital doctors, and general practitioners) (Turnbull, Holmes, & Shields, 1996). In Australia, continuity of care from a midwife team was found to produce fewer adverse maternal and fetal outcomes than routine care (Rowley, Hensley, Brinsmead & Włodarczyk, 1995). A Canadian study found that women in the nurse-midwife group experienced fewer interventions; in particular the caesarean section rate was significantly lower for the nurse-midwife group than for the physician group (Harvey, Jarrell Brant, Stainton & Rach, 1996). While such studies have been conducted in tertiary units the recommendation is for further evaluative studies in other clinical settings (Turnbull et al., 1996).

In the United States a meta-analysis of six controlled observational studies of low risk women in home and hospital birth setting concluded that home birth is as safe as hospital birth for low risk women. The home birth practitioners were midwives or lay midwives in all six studies with general practitioners also being involved in three of the studies (Olsen, 1997). A retrospective survey of planned home birth by certified nurse-midwives, also in the United States of America, found support for the safety of home birth with such care providers. A retrospective cohort study of home birth by midwives and a probability sample of the United States of America National Natality/Fetal Mortality Survey data concluded that home birth with the midwives was as safe as hospital birth (Anderson & Murphy, 1995; Durand, 1992).

A United States study found that in a primary-care clinic, prenatal care of low income women by certified nurse-midwives can reduce the caesarean rate without compromising infant outcomes (Blanchette, 1995). The author found no significant differences in apgar scores or birth weights for the two groups in his study.

Little New Zealand research on maternity outcomes is available. A recent study examined trends in caesarean section rates and reported that the caesarean section rate in New Zealand rose from 9.6% in 1983/84 to 15.3% in 1994/95. The authors noted that over half the caesarean sections in New Zealand might be medically unnecessary and that cost savings could be achieved if the rates were reduced (Bulger, Chapman & Stone, 1998). A factor influencing the caesarean rate is the use of epidural analgesia in labour. A comprehensive review of articles on this subject concludes that epidural analgesia is safe and effective in relieving pain in labour, but results in longer labour, more operative intervention, and increases in cost (Thorpe & Breedlove, 1996).

Between 1973 and 1990 New Zealand law required medical supervision of all births, effectively preventing independent midwifery practice. The Nurses Amendment Act (an act to amend the Nurses Act of 1977) in 1990 restored the right of midwives in New Zealand to practise independently of medical supervision. Since then increasing numbers of independent midwives have elected to provide continuity of maternity care, and both home and hospital birth care. Midwives provide maternity care as Lead Maternity Carers (LMC) in home births, small rural units and major city hospitals. The Lead Maternity Carer (LMC) is the midwife, general practitioner or obstetric specialist who has been selected by the eligible woman to provide her comprehensive maternity care, including the management of her labour and birth, and who holds an access agreement (Section 51 of the Health and Disability Act, 1993). General practitioner led care (GP-led) is when the general practitioner is the LMC. In this case the antenatal care is led by the GP; a midwife is also involved. The midwife provides the labour care in consultation with the GP (who may visit during labour), and the GP and midwife both attend the birth. In most cases where complications occur, an obstetrician is also involved.

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Primary maternity care outcomes in New Zealand: a comparison of midwife and medical practitioner care

The midwife undertakes the postnatal care and the GP may undertake some of the visits and will perform the six-week exit examination. Midwives working as LMCs carry out all care and consult with an obstetrician as required. In many cases the midwives provide care for both home and hospital birth, and are guided by a midwifery philosophy. In GP-led care most births are in hospital and the approach to care is primarily a medical one.

This study uses routinely collected maternity data to compare the outcomes of primary maternity care provided by two types of provider: midwife-led maternity care and GP-led maternity care. The midwife-led care was provided by the Wellington Domino Midwives Group, which was established in 1989 and provides full maternity care in home and hospital settings ("Domino" stands for "domiciliary in and out of hospital"). The midwives are guided by a philosophy of birth as a normal event for most women and an appreciation that good midwifery care minimises interventions. Comprehensive data collection is a feature of the practice.

Methods

Ethical Considerations

In 1996 the Wellington Polytechnic Research & Ethics Committee approved a study titled "Profile of a Midwifery Practice, A Retrospective Analysis of 1,000 Births". A decision was made to extend the study by obtaining a cohort set of GP-led care data from the regional hospital database for a comparative study. In 1997, approval for obtaining an anonymous set of data from the Perinatal Information Management System (PIMS) at the regional hospital was granted by the Wellington Regional Health Authority Ethics Committee.

Data

The study group involved women booked under a primary-care provider, defined on an intention-to-treat basis. Thus, women booked under a primary care provider but transferring to specialist care for medical or any other reasons were included. Only singleton births of gestation 38 weeks or more were included to avoid introducing a bias of unknown origin, as the independent midwives data had a lower proportion of records with gestation under 38 weeks.

The GP-led group consisted of all women who gave birth at Wellington Women's Hospital (WWH) between 1 July 1994 and 30 June 1997 and who had a GP as LMC. Data were obtained from the PIMS database and the sample constructed in this way consisted of 3840 women.

Table 1: Variables used in the study

Explanatory variables relating to provider group
Provider: Domino or GP-led care

Other explanatory variables

Age group outside 20-34
Parity (primipara, multipara)
Ethnicity: European or Other
Deprivation score quintiles

Maternal outcomes (binary variables)

Induction
Epidural for labour
Caesarean section (elective or emergency)
Instrumental (forceps or ventouse) birth
Post-partum haemorrhage (PPH) > 600 ml

Infant outcomes (binary variables)

Apgar at 5 min < 7
Admission to Neonatal intensive care unit
Outcome: Stillborn

The Domino Midwives Group consisted of all women giving birth between 1 January 1993 and 31 December 1997 in WWH, Kenepuru Hospital (a smaller hospital in the region) or at home, and for whom the LMC was a Domino midwife. Data were extracted from the Domino database, and the sample consisted of 642 women.

The difference in sample sizes reflects the greater number of general practitioners providing GP-led care than Domino Midwives. The Domino data collection period is from 1 January 1993 to 31 December 1997 and the GP-led group from 1 July 1994 to 30 June 1997. The longer period of the Domino data allows a larger data set; the GP-led data were not available earlier than July 1994.

Socioeconomic status

Socioeconomic status for our analysis was measured by NZDEP96, the New Zealand index of

deprivation based on 1996 census data (Crampton, Salmond & Sutton, 1997). There was no significant difference between the two provider groups ($\chi^2 = 4.49$, $df=4$, $p=0.34$).

Ethnicity

The number of Maori and Pacific Islands women in the sample was not large enough for separate statistical analysis. The sample was therefore split into "European/Pakeha" (the New Zealand term for people of European descent) and "Other" ethnicity. This is not ideal in the New Zealand context.

Statistical analysis

The main method of analysis was stepwise logistic regression; a technique that allows some control of confounders such as age and ethnicity. Table 1 lists the variables used in the study. Episiotomy was not included because usable data on it were not available. All the variables except deprivation were defined as binary (yes/no) variables. The stepwise process forced the provider variables to remain in each model, but other explanatory variables (e.g. age group - see Table 1) remained only if they had significant explanatory power. Calculations were done in SAS (statistical software package). (*Editor's note. A comment on the meaning of OR and CI, which are presented in subsequent tables is provided by Richard Nyhof at the end of this article.*)

Findings

Table 2 shows the ethnicity of the sample.

The statistical analysis involved logistic regressions on models that included all the explanatory variables in Table 1. Deprivation (as measured by NZDEP96) was eliminated in the stepwise process. The results reported here (Table 3) omitted deprivation, thus giving a larger sample size. The analysis considered each intervention independently of the others. A woman could have more than one intervention. These results show that the incidence of interventions in labour and birth

Table 2: Ethnicity of the samples

	GP-led		Domino	
	N	%	N	%
European/Pakeha	2,578	67.1	521	81.2
Other ethnicity				
• Maori	309	8.0	74	11.5
• Pacific Islands	352	9.2	21	3.3
• Other	514	13.4	26	4.0
Total Other ethnicity	1,175	30.6	121	18.8
Missing	87	2.3	0	
Total	3,840	100.0	642	100.0

Table 3: Intervention rates (unadjusted for explanatory variables) and results of logistic regressions.

OR is the odds ratio. CI is the confidence interval. * indicates significance at the 95% confidence level.

Intervention	N in sample and % with intervention		Regression results		
	GP	Domino	OR	95 % CI	
Induction	3840 22.1%	638 7.1%	0.25	(0.18, 0.34) *	
Epidural	3840 50.1%	642 19.3%	0.20	(0.16, 0.24) *	
Instrumental birth	3840 15.1%	642 5.5%	0.31	(0.21, 0.44) *	
Caesarean	3840 15.6%	642 10.4%	0.65	(0.49, 0.84) *	
PPH	3768 8.4%	636 5.2%	0.62	(0.42, 0.88) *	
NNU admission	3836 3.1%	641 3.1%	1.06	(0.63, 1.68)	

tended to be lower for the midwife group. For some outcomes, the numbers of cases with adverse outcomes were too small to use logistic regression. For these outcomes the percentage of cases was calculated where the outcome was adverse (Table 4). There were no significant differences between the provider groups in the incidence of the adverse outcomes, but sample sizes were too small to detect small differences.

For all women, the logistic regressions suggested that ethnicity may influence intervention rates. Table 5 shows that women of European/Pakeha ethnicity were more likely to have epidural analgesia, induction and instrumental birth, and less likely to have caesarean section and PPH.

For both groups, women who had an epidural for labour were significantly more likely to have an instrumental birth than women who did not have an epidural (OR=10.0, 95% CI =7.9,12.8).

Discussion

Limitations

Compared with research designs using random allocation, a retrospective analysis does not permit selection bias to be fully eliminated. The possibility of such bias therefore limits the generalisability of this study. Further, the difference in data collection periods between the two data sets creates a further limitation.

Maternal outcomes

When compared with the GP-led group, the Domino Midwives group had lower rates of epidural use in labour, instrumental birth, induction, caesarean section and postpartum haemorrhage. The findings of this study are thus consistent with

previous studies of midwifery-managed care where the incidence of interventions in labour and birth for the midwife group is lower than or the same as the medically managed group (Turnbull et al., 1996; Rowley et al., 1995; Harvey et al., 1996). Availability may affect the epidural rate. In this study all women in the GP-led group were exposed to a 24-hour on site anaesthetic service. For the Domino Midwives group, this was true for all women except those who, on an intention-to-treat basis, chose birth at home (173 women), or at Kenepuru Hospital (19 women).

Regardless of provider group, those women who had an epidural for labour were significantly more likely to have an instrumental birth than women who did not have an epidural. An epidural was also associated with higher rates of caesarean section, although the effect was weaker than for instrumental births. This is consistent with Thorp and Breedlove's (1996) literature review on epidural analgesia, which found that this is associated with increases in duration of labour, instrumental vaginal births and caesarean birth.

Neonatal outcomes

There were no significant differences between the provider groups in terms of stillbirth rates; the sample size was too small to detect small differences.

Neonatal morbidity was measured by 5-minute apgar scores and neonatal unit admission rates. For the apgars, no significant differences were found. However, in this study low apgar scores were rare, and the sample size was too small to detect small differences.

There was no significant difference between provider groups in neonatal unit admission rates and small sample size was less of a problem. Neonatal unit admission rates are a debatable measure of infant outcome as there is no national or universal admission policy or criteria. However, within the same maternity unit used by both midwives and general practitioners in this study, admission policies could be expected to be consistent across provider groups.

Conclusions

This study showed that rates of maternal interventions tended to be lower for midwife-led maternity care compared with GP-led care. The differences appear not to be explained by uncontrolled selection bias in socioeconomic status, ethnicity, parity or maternal age. It appears rather that style of care is a major influence on intervention rates. The most important differences between intervention rates for midwife-led and GP-led care were for epidural analgesia and induction. The study was consistent with findings in published literature that epidural analgesia increases the probability of operative birth.

The lower rates of intervention by the midwife-led groups appear to be consistent with good infant outcomes, but sample sizes in the study were

continued over...

Table 4: Incidence of adverse outcomes.

For the apgar scores, only live births with non-missing apgar data are included. The last column gives 95% confidence intervals on the difference in the percentages for the two provider groups.

Provider group	N women	N adverse outcome	% adverse outcome	Diff % 95% C.I
Stillborn				
• GP	3840	4	0.1	
• Domino	642	1	0.2	(-0.3, 0.4)
Apgar at 5 min < 7				
• GP	3825	27	0.7	
• Domino	641	2	0.3	(-0.9, 0.1)

Primary maternity care outcomes in New Zealand: a comparison of midwife and medical practitioner care

Table 5: The influence of ethnicity on outcomes: intervention rates (unadjusted for explanatory variables) and results of logistic regressions.

OR is the odds ratio. CI is the confidence interval. * indicates significance at the 95% confidence level.

	N in sample and % with intervention		Regression results	
	European/Pakeha	Other ethnicity	OR	95 % CI
Induction	3439 21.2%	1403 17.2%	1.39	(1.18, 1.65) *
Epidural	3443 45.5%	1403 43.7%	1.18	(1.02, 1.36) *
Instrumental birth	3443 13.7%	1403 11.4%	1.34	(1.09, 1.65) *
Caesarean	3443 14.1%	1403 16.7%	0.78	(0.65, 0.93) *
PPH	3385 7.4%	1376 9.9%	0.73	(0.58, 0.92) *

too small for fine discrimination between the provider groups in this respect.

This study supports midwife-led care as a valid choice for women.

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A COMMENT ON RATIOS

A comment on Odds Ratios and Confidence Intervals.

Richard Nyhof is a Lecturer at Otago Polytechnic. He is involved in teaching a range of programmes including statistics for health professionals.

An odds ratio (OR) gives information about the likelihood of a particular outcome for two different groups. This means that when looking at an odds ratio there will be:

- A specific outcome (e.g. having influenza)
- Two specific groups (e.g. people who were vaccinated and people who weren't vaccinated)

If the odds ratio is 1 (written as OR = 1.0) it means that the outcome is equally likely in both groups. If the odds ratio differs from 1 it means the event is more likely to occur in one group than the other. Hence an OR = 1.5 means that one group is 1.5 times more likely to have the outcome than the comparison group. The way the research has been designed and analysed will determine which group

is more likely to experience the outcome - this should be obvious from the context and data.

To get an exact value for an odds ratio it would be necessary to look at every individual in both groups. This is generally not possible and so a sample is taken from the target population. This means that the calculated odds ratio is not exact, instead it is a "best guess". Crudely put, the bigger the sample taken the better the "guess". This is reflected in a confidence interval (CI). The confidence interval is the range, centred on the "best guess", that the odds ratio is likely to be within. For example, CI=0.7, 4.8 indicates that the range is between the two stated values. With a 95% confidence interval there is a 95% chance that the exact value for the odds ratio (that would be produced if every individual were included in the study) is somewhere within the range.

When looking at a confidence interval for an odds ratio the key question becomes "is 1 within the interval?" If 1 is in the confidence interval then the statistics are reporting that:

- Possibly the outcome is more likely in one of the groups (the portion of the CI with the OR < 1), or
- Possibly the outcome is more likely in the other group (the portion of the CI with the OR > 1). Not very conclusive really!

So, if 1 is contained within the confidence interval then there is no clear evidence of differences between the groups. If, on the other hand, the entire confidence interval is on one side of 1 then this is a significant result - it can be said that the outcome is more likely in one of the groups.

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Equal rights in the birth chamber: the need for a midwife-based system of maternity care in Europe

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Note from the Editors

This article has been reprinted with permission from MIDIRS Midwifery Digest 2001; 11 (1); 129-132. The article provides an overview of the current state of maternity care in Europe and Ireland in particular. By way of background for readers Marie O'Connor has provided some general information about Ireland and its maternity services. We asked Karen Guilliland to provide some comments about the article in order to identify similarities and differences for midwifery and maternity services in the New Zealand context. Karen's comments follow the article.

Background to Ireland

Ireland is an island with a population of 5.3m., of whom 3.6m live in the Republic. The remainder live in Northern Ireland, which is part of the United Kingdom. All references to 'the state' denote the Irish Republic, as does 'Ireland' and, by extension, 'Irish'. Health care and midwifery in the North is organised from within the United Kingdom (UK), and all UK references cover Northern Ireland.

The island as a whole is about half the size of New Zealand. The Irish health care system is a mix of public and private, generally on the same site. Health care in the Republic is free but queues for hospital beds ensure a growing market for private health insurers. The public subsidises the private, with publicly employed medical consultants given access to hospital facilities free of charge for their private practice.

Nineteen of the State's 22 maternity units are public. The system is highly centralised. The three major Dublin hospitals are among the largest in Europe. As 'public voluntary' hospitals, they are privately owned, but publicly maintained. Between them, they deliver 40 per cent of the Republic's babies. Recently, the largest of the three units warned that, due to the midwife shortage, quota systems limiting admissions might have to be introduced. The midwife-to-birth

ratio in the major Dublin hospitals is approximately 250 births per midwife per annum.

The number of midwives on the "active register" is around 13,000, and it is estimated that 15 per cent work as midwives. The term 'midwife' has all but disappeared from the language, and this is partly attributed to the 1985 Nurses' Act, which made it legal to refer to midwives as 'nurses', and to "active management". Turnover in midwifery is running at 1:3 over the past two years.

Women in Ireland have little choice in maternity care. Choice of midwife provider is unavailable, except in home birth. The national home birth rate is 0.3 per cent. No hospital in the Republic provides waterbirth, and there are no midwife-run birth centres.

Irish maternity care, which is obstetrics-based and consultant-driven, is highly interventionist in character. Caesarean rates range from 13 to 27, and the national rate in 1998 was 19 per cent. As many as 37 per cent of all women have their babies by scalpel, forceps delivery or vacuum extraction. About the same number - mainly those with private health insurance - choose private obstetric care. Breastfeeding rates, at 30 per cent, are 30 per cent below the second lowest in the European Union.

Almost all midwives are employed in hospitals. There is no hospital caseload midwifery and little team midwifery, except in two units providing an outreach service. Hospital midwives cannot accept individual clients, and self-employed midwives are denied hospital privileges. Publicly employed midwives usually deliver the babies of obstetricians' private patients where the birth is uncomplicated, and obstetric fees are unaffected by midwife delivery. With 53, 000 births per annum, the private obstetric market is worth at least £25 million, and this is divided among less than 100 obstetricians.

The growing demand for home birth is met mainly by self-employed midwives, often in the face of non-cooperation from maternity units and obstructionism from health boards. There are only seventeen self-employed midwives in the Republic. All are in private practice. They tend to work as sole practitioners, carrying caseloads of fewer than 40 per year. All provide pregnant women with continuity of care from the antenatal through to the postnatal period.

Community midwifery fees now equal or exceed private obstetric fees. £1,500 is now the norm in Dub-

lin, where fees are highest; this charge includes all antenatal, labour and postnatal care. Health boards give parents a grant of up to £1,200, although this amount is variable. One of the most salient differences between Ireland and the UK is that, in the Republic, all women are entitled to a home birth service from the State under the 1970 Health Act - irrespective of income.

Introduction

Maternity care is in crisis throughout Europe. In some maternity hospitals, standards of service provision have been compromised to an unprecedented degree due to increasing demand, an escalating shortage of scarce resources, and in particular, a growing shortage of midwives. Such are the current shortfalls in hospital care, both in Western and Eastern Europe, that the physical and, indeed, mental health of women in childbirth, and their babies, may be at risk.

Maternal and infant mortality

Maternal mortality in European hospitals continues to be a matter for concern. In Ireland, maternal deaths accounted for 8 per cent of all maternal negligence claims taken against obstetrician/gynaecologists from 1978-1998 (The MDU Ireland, 1998). There is some evidence that shortfalls in standards of service provision may result in perinatal fatalities. In 1995, the British Confidential Inquiry into Stillbirths and Deaths in Infancy analysed the deaths of 873 normal term babies who died in labour. In over half of these cases, it was estimated that better care would reasonably have been expected to have made a difference to the outcome (Department of Health, 1998).

Centralisation, discrimination and rural women

Many European national health and insurance systems favour specialist obstetric care for all pregnant women. Such policies, in requiring the centralisation of the birth services, discriminate against rural women. Centralising birth results in unplanned out-of-hospital births. In Ireland, for example, a national study shows that the rate of unplanned out-of-hospital delivery to planned home birth is 1:1 (O'Connor, 1992, pp.10-11). Unplanned out-of-hospital births carry very high mortality rates. Centralising birth also results in the targeting of rural women for induction. Local obstetric protocols underpin national health

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Equal rights in the birth chamber: the need for a midwife-based system of maternity care in Europe

policies: many women in rural areas have their labour induced for geographical rather than medical indications.

The recent EU Directive, adopted in June 2000 (2000/34/EC), will reduce the working time of doctors in training by 2009 to 48 hours per week. This Directive is widely expected to result in the closure of obstetric units throughout Europe, thereby exacerbating the established trend towards centralisation of maternity care throughout the Member States. In Britain, for example, plans for the closure of almost 200 obstetric units are "well advanced", to quote Dr Richard Porter, Director of Maternity Services for Wiltshire Health Care NHS Trust (Porter, 2000). Despite the anticipated closures, however, maternity care policies in the vast majority of countries are still being framed within the traditional, obstetric hospital care model.

The Caesarean epidemic

Within the specialised, hospital or tertiary care model, birth is treated as a medical problem. This has led to huge amounts of unnecessary and costly medical intervention. Rapidly rising caesarean section and instrumental delivery rates have become the norm throughout Europe. Since 1980, national caesarean rates in some countries have doubled, and in some hospitals, they have gone up four-fold. The combined operative and instrumental delivery rate in Spain is 40 per cent (Wagner, 2000).

Despite the considerable variation in local and national caesarean rates, neither local nor national surveillance systems have been implemented in Europe. Moreover, in many Member States, the collection and publication of data on operative and instrumental deliveries, both in publicly funded and privately owned hospitals, is discretionary.

Active management of women in labour

The acceleration of labour is a cornerstone of the 'active' or aggressive management of women in labour so prevalent in many Member States. *Active management* is a set of obstetric protocols standardising the medicalisation of first births. It comprises early amniotomy, high-dose oxytocin (Frigoletto, 1995) and one-to-one 'nursing', the term it uses to denote midwifery. At the National Maternity Hospital, Holles Street, a leading Dublin hospital dedicated to active management, 50 per cent of all first-time mothers (Cuidiu, 1999, p.35) have their labours artificially accelerated for 'failure to progress'. Staff at the hospital are indemnified against *cephalo-pelvic disproportion, uterine rupture, and injury to the child* (O'Driscoll, 1993, p.56).

Oxytocin increases the demand for epidural anaesthesia, as women under active management strive to make labour more tolerable. Epidural anaesthesia, however, is estimated to multiply by four a low-risk woman's chances of having a caesarean section (Frigoletto, 1994). This form of anaesthesia is often accompanied by continuous electronic fetal monitoring, thereby compounding the risk of caesarean section in uncomplicated labour.

Iatrogenic damage

In any speciality, medical intervention inevitably leads to a proportion of iatrogenic damage. The use of obstetric technology in birth, for example, is associated with postnatal depression (Oakley, 1992, pp.277-279).

Caesarean, widely presented as being safe by obstetricians, is not without hazards. National surveys on maternal deaths in the United Kingdom (Hall & Bewley, 1999) show that while the mortality rate for all caesareans is six times that of vaginal birth, the fatality rate in elective caesareans is three times that of spontaneous or unassisted birth.

Widely used both to accelerate and to induce labour, oxytocin features strongly in obstetric negligence claims (The MDU Ireland, 1998). Oxytocin has been identified as a salient factor in infant brain damage (Taylor, 1998, p.7) and in intrapartum fetal deaths (Department of Health, Britain, 1995, pp.36-37). Maternal deaths have also been reported in connection with its use by its American manufacturers (Parke-Davis, 1993, p.1813).

At the National Maternity Hospital, where active management was developed, more than one newborn baby in seven - over half of whom weigh 2,500g or over - is admitted to intensive care following birth. Overall, from 1995 to 1996, the number of term admissions rose by 15 per cent. With a 37.5 per cent increase in ventilated newborns from 1994 to 1996, the number of babies requiring full intensive care at the National Maternity Hospital is rising steadily, but this trend remains unexplained. (National Maternity Hospital, 1996, pp.49-50)

The waltz of obstetrics with litigation

Over 70 per cent of all British and American obstetricians have been sued (Wagner, 1998). In Britain, obstetric claims cost the National Health Service over £150 million every year (Cumberlege,

cited in House of Lords Debate concerning the Maternity Services, 2000). Litigation increases the cost of professional indemnity or malpractice insurance. In Ireland, malpractice insurance for obstetrician/gynaecologists increased by 88 per cent (*Irish Medical Times*, 1999, p.1) last year, and this was more than seven times the percentage increase levied on other medical consultants in the State. Within the spiral of intervention, with its pain-epidural-monitoring-caesarean dynamic, the waltz of obstetrics with litigation goes on: the more obstetricians intervene in birth, the more birth injuries occur: the more obstetricians get sued, the more actively they manage women's bodies in labour (O'Connor, 1995, p.287). Fear of litigation has been identified by British obstetricians as one

of the main factors in the growth of caesarean rates, outranked, in their view, only by electronic fetal monitoring (Francome & Savage, 1993).

Public costs and private profits

Dutch health insurance data on the cost of birth shows that, in 1997 a caesarean rate of 9.5 per cent accounted for 44 per cent of the total cost of maternity care in Amsterdam, while home birth, at 26 per cent, made up only 5 per cent of the total bill for birth in that city (Klinkert, 1999). British figures show that an increase of 1 per cent in the caesarean rate adds £5 million to maternity care costs. This, as Baroness Cumberlege has observed, is the equivalent of 167 midwives in full-time employment for one year (Cumberlege, cited in House of Lords Debate concerning the Maternity Services, 2000, p. 16).

Obstetrics can be a lucrative business, as the Irish experience demonstrates. Public and private care operates side by side, often on the same site. Within this system, state-employed midwives care for obstetricians' private patients. Midwives are paid approximately 8 per cent of what obstetricians earn, but this may be an over-estimation. The market for private maternity care (Republic only) is worth at least £20 million per annum. Obstetric incomes average £275,000 annually, but this may be an under-estimation.

The benefits of midwifery care

The recognition (ten Hoope-Bender, 1997) that midwifery care can result in shorter labour, less medication, and fewer interventions such as surgical or operative deliveries is growing. In 1996, WHO concluded that midwives are the most appropriate, and cost-effective caregivers in normal pregnancy and birth (WHO, 1996).

Since 1980, national caesarean rates in some countries have doubled, and in some hospitals, they have gone up four-fold.

Midwifery care has been shown to be as safe, or safer, than care provided by doctors. A recent American study of 4 million low-risk births (MacDorman & Singh, 1998) showed that the outcomes of midwife-attended births were significantly better than those of medically-conducted deliveries. The risk of having a neonatal death was 33 per cent lower with a certified nurse midwife than with a doctor, while the risk of infant death was 19 per cent lower in midwifery births than it was in physician deliveries.

Discrimination against midwives

Whatever the benefits of midwifery care, laws and regulations discriminating against midwives are widespread throughout Europe. National health and insurance systems sustain medical monopolies, even at primary health care level, in areas of midwifery expertise such as antenatal care. In many countries, official health care policies prevent midwives - the specialists in normal birth - from assuming responsibility from the care of healthy women in childbirth.

Structural and legal barriers to midwives' equality in the workplace are common. Many midwives are forced to work as obstetric nurses, and births become deliveries conducted according to obstetric protocols. In many Member States, midwives are hindered from practising their profession to the full. European Directives on midwifery, adopted 20 years ago, have yet to be fully transposed into national law. In some States, for example, midwives do not have prescribing rights, although such rights are to be inferred from a 1980 European Directive on midwifery (80/155/EC).

Many hospital midwives do not have the right to discharge healthy women and their babies after birth. Most midwives who work at primary health care level do not have hospital 'privileges', that is, the right to admit a client to hospital, and to assume responsibility for her care in labour. Many do not even have referral rights, that is, the right to refer a midwifery client to another professional practitioner. Nor are midwives commonly allowed to certify a woman's unfitness to work in pregnancy, or after the birth of her baby. While midwives are generally permitted to notify births, they are usually precluded from signing perinatal death certificates.

In some countries, there is a growing midwifery shortage. In Britain, for example, only 34 per cent of registered midwives are currently in practice (Emerton, cited in House of Lords Debate concerning the Maternity Services, 2000, p.19). Working conditions are poor for many midwives, and unequal pay structures persist in many countries. National health and insurance systems con-

tinue to discriminate against midwives - equal pay with doctors for equal work, or for work of equal value, introduced in New Zealand in the 1990s at primary health care level, is virtually unknown in Europe. There is further evidence to suggest that European midwifery is lagging behind midwifery in other parts of the world. Most European midwives, with the exception of The Netherlands, have yet to be given equal powers and responsibilities with general medical practitioners in maternity care. In Ontario, Canadian midwives were given such powers as far back as in 1994 (Shroff, 1997, pp.205-239).

Working conditions in Europe

European midwifery, in contrast, is distinguished by discriminatory short-term, temporary, and part-time work contracts; non-recognition of years spent working in the home, or abroad by public service superannuation schemes; lack of parity with other health professionals in areas such as pension entitlements; lack of career development and inequitable promotional opportunities. In England, in recent years, the proportion of midwives working part-time has increased to 40 per cent (Sandall, 1995). Pervasive discrimination in the workplace is leading to increasing discontent. Hospital midwives frequently complain of bullying in the work place (Commission on Nursing, 1998, p.181), a command and obey model of management, a preoccupation with hierarchy and bureaucracy, and a tendency towards information control (ibid, pp.123-125), within an overall culture which can no longer distinguish between midwifery and nursing. All of this has led to low morale among midwives, and high migration from the profession.

In 1999, in a break with tradition, Dutch midwives, in an endeavour to secure better pay and working conditions, marked the advent of the third millennium with a midnight strike (de By, 2000). Overworked, and underpaid, midwives in The Netherlands point out that there has been an increasing shortage of new midwives in recent years. With an annual caseload of 155 clients (Klinkert, 1999), many are suffering from burnout.

The overshadowing of midwifery by nursing

WHO has recently described midwives' lack of influence on national health care policies as an 'anomaly' to be corrected (WHO, 2000). Invisibility is a major difficulty for midwives, and for midwifery. In many countries, educational requirements underpin and reinforce the overshadowing of midwifery by nursing. Despite the fact that nursing and midwifery are two separate and distinct professions, entry into midwifery is often

restricted to qualified nurses. In some countries, midwifery is officially classified as a medical profession. In Ireland, the term *nurse* may legally refer to a midwife (Nurses' Act, 1985).

Midwifery is often 'represented' by nursing, the WHO Health21 Conference on Nursing and Midwifery in Munich, June 1999, being a recent example. Equality of midwifery representation with nursing and medical interests is rare. Throughout most of Europe, midwives are excluded from policy-making, overshadowed by adjacent professions such as nursing, and obstetrics. This overshadowing is evident in regulatory bodies, professional associations, government ministries, maternity hospitals, university faculties, and in health and other agencies.

Gender mainstreaming and the democratic deficit

The non-representation of midwifery in elected and appointed bodies at local, national, and international levels has serious implications for the development of woman-centred maternity care. In some Member States, both midwifery and consumer representation in maternity care policy structures are virtually unknown.

The dominance of midwifery by medicine has vitiated the capacity of midwifery to develop its potential as a separate and autonomous profession, and to contribute to the shaping of maternity care structures. Services for birth have historically reflected medical rather than midwifery or client needs. Midwifery is an almost exclusively female profession, one which has historically been dominated by adjacent professions, such as obstetrics, a largely male profession.

Maternity care clients are solely female: their need for these services derives solely from a uniquely female competence, namely, the ability to bear a child. Most women lack control over the services they receive for birth. Some women face additional barriers in birth because of poverty, ethnicity, language, religion, sexual orientation, disability, migrant, or refugee status. These barriers reinforce their fundamental exclusion as full and equal participants with providers in maternity care. Some are still denied choice and freedom in birth, finding themselves excluded from the decision-making process by midwives who themselves may be powerless to offer alternatives to medical management. This exclusion from decision-making of both service providers and service users, reproduces, and is reproduced by, their joint exclusion at higher levels, in a process of mutually reinforcing

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ing circles of powerlessness. Gender equity, it appears, has yet to be brought into the birth chamber.

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COMMENT FROM KAREN GUILLILAND

The New Zealand context: similarities and differences

Karen Guilliland

Director, New Zealand College of Midwives (invited comment at 31/8/01)

New Zealand has some similarities to Ireland in terms of health structures. The private/public obstetric picture is similar as are our increasingly interventionist maternity practises.

However there are some significant differences in choices and outcomes for both women and midwives. We have fewer midwives in number (4,000) but more (2,000) in active practice, with nearly half of all midwives carrying caseloads. New Zealand midwives, employed and self employed, are entitled to individual clients and hospital "privileges".

Having said that, the majority of women in New Zealand, like Ireland, have an obstetric consulta-

tion at some point. This is because of hospital obstetric protocols and national specialist referral guidelines that require midwives and general practitioners to tell women they should have a consultation with an obstetrician. Indicators for consultation are broad and cover most possible scenarios and this has the effect of heavily medicalising childbirth despite midwives being Lead Maternity Carers (LMCs).

Like Ireland, political restructuring has leaned heavily on the side of centralised maternity services and many small birthing units have been closed. In the new District Health Board (DHB) restructuring, the small birthing units that remain are threatened once again with closure if DHBs fail to recognise the essential nature of primary birth facilities.

The lessons for New Zealand midwives in this article are that the politics of gender, institutionalisation, medicalisation and fear are all encompassing and have the same effect whether or not midwives are the lead maternity caregiver. Global anxiety around childbirth is at epidemic proportions. What New Zealand midwives have been able to do is contain the anxiety better and in doing so positively influence the choices and outcomes for women and babies. More women birth at home and significantly more breastfeed. Fewer women and fewer babies die and fewer babies require admission to neonatal intensive care. New Zealand midwives also enjoy more status, higher pay, have more control over their working lives and practise longer.

Caseload management and midwifery lecturers: recommendations for practice using a modified Delphi technique

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Abstract

Clinical practice is becoming a reality for lecturers in midwifery in New Zealand. The future introduction of legislation that requires proof of competency will make the requirement more pressing. This paper presents the findings of a research project aimed at developing a set of guidelines for midwifery lecturers who take on a continuity caseload as a way of maintaining practice. The purpose of these guidelines is to help managers and lecturers combine practice and academic duties in order to benefit from the practice and avoid the pitfalls. A modified Delphi technique involving midwifery lecturers and school managers in New Zealand was used. The end result was a set of guidelines that contained 25 suggested recommendations.

Introduction

Midwifery lecturers in New Zealand will in the future need to demonstrate their competence to practice. The framework for Competency-based Practising Certificates has been developed by the Nursing Council of New Zealand and is waiting to be implemented. These certificates are a quality assurance requirement of the Health Professionals Competency Assurance Bill (currently being referred to as Health Practitioners' Competence Assurance Bill), which is forecast to be enacted in law in the near future. However, this is not the only impetus for midwifery lecturers to practice, although in New Zealand it may be what provides midwifery in academia with the opportunity to address the issues around faculty practice. Midwifery is a science as well as an art and as educators in midwifery our role is to help students blend both these forms of knowledge. Historically those who taught also practiced. However, the move of midwifery education to tertiary education institutions means that most lecturers are outside the clinical sphere (Dickinson, 1994; Wilson, 1996). This has raised concern among the profession that lecturers are losing touch with the realities of practice and that in turn affects the education of students and the practice ability of graduates.

As a university midwife lecturer in a Bachelor of Midwifery programme I have taken on a small independent midwifery practice. I have found it benefits my teaching and maintains my credibility with students and practitioners. My practice has continued over three years and is managed largely outside the forty-hour working week. During the three years I have provided continuity of midwifery care to between 8-10 women a year. In that time I have postponed only one class and missed the birth of two women, neither of which occurred because of my commitments to the university. I have also on two occasions taken a student into my practice. I have found that these roles have enhanced my teaching as well as my practice.

Personal knowledge indicates that other lecturers in New Zealand, as well as elsewhere, practice continuity of care in addition to their academic duties. In New Zealand Schools of Midwifery, we teach continuity of care to students as it reflects the philosophy held by the New Zealand College of Midwives (NZCOM, 1993) and the Nursing Council of New Zealand (1999). Continuity is also what is happening in New Zealand for 70-80% of women, who receive their pregnancy care from the same midwife (NZCOM & Nga Maia, 1999). Continuity of care should therefore be one of the practice options available to academic faculty members in schools of midwifery, as it reflects the New Zealand context.

Midwifery faculty practice has its advantages as well as disadvantages and barriers. In order for midwife/lecturers and midwifery education to avoid the difficulties and gain from faculty practice, care must be taken when considering such a project.

The purpose of my research was to develop a set of recommendations for midwifery lecturers to help them set up caseload practice in addition to their academic roles. It is hoped these recommendations will enable midwifery lecturers and their managers to integrate caseload practice within the academic setting, thus benefiting the midwife lecturer, the institution and the profession.

Background to the study

This research is based on the belief that faculty practice should be an integral part of academic work. It is modelled on the work of Boyer (1990) and Langston, Cowling and McCain, (1999). In general tertiary education institutions do not reward or acknowledge faculty practice as a scholarly pursuit, with performance indicators being

research and the dissemination of research (Hutemyer & Donnelly, 1996; Langston, Cowling & McCain, 1999). In 1990 Ernest Boyer who proposed a new way of looking at scholarship challenged this prevailing view. He proposed four categories of scholarship. The scholarship of discovery refers to the need for academics to carry out research; the scholarship of integration is fitting research into a holistic multidisciplinary and social framework so it is not done in isolation. The third category Boyer (1990) describes is the scholarship of teaching, referring to the necessity for the knowledge gained to be passed on to others. The final category is the one that is most applicable in the case of faculty practice and which forms the basis of this study, is the scholarship of application. This category refers to the necessity of applying the scholar's knowledge for the service and betterment of society. Boyer emphasised, and it has been emphasised by others, that academics cannot keep themselves in isolation but must apply the knowledge they discover. Langston, Cowling and McCain (1999) added to Boyer's work by proposing that the work of the academy should be thought of as "knowledge work" rather than scholarship which is enmeshed in a long tradition of interpretation, and is activity and academic centred.

Langston, Cowling and McCain (1999) saw "knowledge work" as composed of all the categories Boyer writes about. However, they see it as being not just isolated activities but undertakings within a interconnected web. These undertakings are intimately connected parts of the work of an institution of higher learning, each part contributing to the other, leading on to, and supporting, the others. Langston et al. contend that recognition of the wholistic nature of "knowledge work" results in a faculty that is satisfied and productive and which provides an excellent education to students.

Practice as a part of midwifery lecturers' roles is "knowledge work"; it is an integral part of the scholarly pursuit of schools of midwifery. The benefits of faculty practice that have been investigated and discussed in the literature can attest to this. Practice has been found to benefit the lecturer, the student, and the institution. Research and anecdotal evidence have found faculty practice to be important in helping to bridge the practice-theory gap for students. It does this by enabling the lecturer to use realistic, current and

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relevant examples from practice which help the students reflect on their own practice experience (Dale, 1992; Driver & Campbell, 2000). Practice can also enhance learning by providing students with realistic up to date examples of current practice which can illustrate theoretical concepts (Parkin, 1998). Practising lecturers can help the students understand the differences between what they learn in practice and what they see experienced practitioners do in the clinical situation. In addition, practising lecturers provide role models for students and clinical colleagues as lecturer's practice and discuss their evidence-based work (Woodrow, 1994; Hindley, 1997).

A small study with student midwives and midwifery practitioners by Hindley (1997) has shown that clinical colleagues and students perceive lecturers who practice as having credibility, and that this improves the credibility of the educational institution in the eyes of the professional community. Faculty practice also enables the lecturer to network with clinical colleagues providing support in the form of research findings, support with preceptoring of students, and discussion of clinical concerns that may lead to research projects (David, 1999; Nobel, 1999). Lecturers who practice can integrate and evaluate research in the practice setting thus helping to develop the profession and support evidence based practice. In addition, familiarity with the practice setting and clinical colleagues can enhance the lines of communication between the educational institution, the clinical practitioners and health care institution (Nobel, 1999).

There are of course barriers and difficulties associated with faculty practice when it is not handled properly. The lack of recognition of clinical practice as a part of the "knowledge work" of academic faculty results in conflict and discontent within the profession (Oermann, 1998; Langston et al. 1999). The major concern regarding faculty practice is the expectation that the role is added to an already heavy workload. Lecturers do see practice as a necessary part of the roles they fulfil, and are concerned with the difficulty in achieving this (Crotty, 1993). However, without the support for practice, adding clinical work to an already busy workload can lead to burnout which a number of researchers found in their surveys with academic nursing faculty (Fong, 1990; Dick, 1992; Oermann, 1998). Burnout results in fatigue, loss of production and often, physical symptoms such as an inability to shake off an illness and frequent headaches (Freudenberger, 1974). Role stress and burnout is indirectly correlated to the amount of support and control people have in

their jobs and the roles they assume (Pearlin, 1989; Dick, 1992). It has been shown that increased demands lead to increased burnout but support from peers, management and family can decrease role stress and burnout (Dick, 1992; Stephens & Franks, 1995; Moen, Robison & Dempster-McClain; 1995; Oermann, 1998).

It was for the reasons discussed above that this project was carried out; it was felt that recommendations could assist in the management of faculty practice. What I learned from my own experience was that some guidelines might have provided me with a framework from which to work. My reading confirmed the lack of any concrete framework dealing with this issue and there was little evidence about what might work. In the light of the lack of evidence on which to build these guidelines it was necessary to choose a methodology that would enable their effective development and also give them credibility within the midwifery academic community. It was felt that a methodology that gave people experienced in faculty practice the opportunity to participate would meet these two criteria.

Method

A modified Delphi technique was chosen as the most appropriate technique to achieve the results. The Delphi technique is a non-interactive group process (Ziglio, 1996), that was developed by Dalkey and Helmer of the RAND corporation in the 1950's. It was used as a forecasting tool to estimate munition requirements during the cold war. "The technique involves sending out to a selected group of panel members a series of "questionnaires" the aim of which was to gain consensus on a particular issue. Panel members are carefully chosen on the basis of their expertise in the particular area of concern (Ziglio, 1996).

The panel members in this study were invited to participate because of their experience as lecturers who practice or because they were in a management position within a school of midwifery. The modified Delphi technique used in this research project involved posting out to the eight panel members a series of four "questionnaires". The first questionnaire presented background information on the issue and was accompanied by one open-ended question soliciting advice or ideas for such recommendations. The three rounds that followed were decision rounds. In rounds two and three the items developed from round one were sent to panellists so that consensus could be reached on which items would comprise the recommendations. Round two used a Likert scale where panellists ranked, on a scale of 1-5, the desirability of including each item in the recommendations (1 being "very desirable" and 5 being "very undesirable"). In rounds three and four panellists indicated "yes" or "no" to including the items in the recommendations. This change occurred because there was an undecided choice in the Likert scale, which it was realised would make consensus difficult to determine. Consensus was pre-determined as being when 50% or more of panellists in two decision rounds agreed to accept or reject an item as a recommendation item. The point of consensus is defined early in the research project to avoid the researcher arbitrarily choosing consensus based on the data. In each round panellists were asked for their rationale for decisions made and were invited to make comments. In proceeding rounds these comments and the results from the previous round were returned to panellists as feedback. This feedback is thought to help them clarify their decisions (Linstone & Turoff, 1975).

An information sheet giving instructions for, and inviting comment on, decisions made accompanied each round. The first information sheet covered the ethical issues of consent, confidentiality, withdrawal from the study and publication of findings. Ethical approval was required because it was a research project that involved human subjects, and so required a mechanism to protect the rights of the participants. This approval came from the ethics committee of the University at which the researcher was a student.

Results

The panel for the project consisted of eight people; three managers in schools/departments of midwifery and five lecturers who were currently, or recently, in practice. All participants worked in New Zealand. Initially thirteen prospective panel members were invited personally to participate; then letters and questionnaires were sent to all thirteen. Eight people returned the first questionnaire. These eight people comprised the panel throughout the research project. Not all panel members replied to each round, seven members returned round two, six returned round three and all eight returned round four. In the first round a selection of 36 items, were suggested by the panel members as ones that could be included in the recommendations. These items were then returned, in the second and third decision rounds, to gain consensus on which items should be included in the recommendations. At the end of the third round a total of twenty-two items had been accepted by consensus. A further five items were sent out for a fourth round as the decision to include them in or exclude them from the rec-

ommendations was not clear. In the fourth round the consensus resulted in a further three items being accepted and two being rejected. The final result was a set of guidelines that contained twenty-five recommendation items (Tables 1 & 2).

In each round, especially the first, panellists made extensive comment on lecturers practicing. On the whole the group supported the need for lecturers to practice continuity of care but expressed concern about the difficulties of work overload and how to fit it into an already busy schedule. There was also concern expressed about work done outside the education institution and how this is remunerated. A concern, which reinforces the belief, that practice is not a scholarly pursuit. The recommendations from this research may go some way to addressing these concerns.

Midwifery lecturers and caseload practice: recommendations for practice using a modified Delphi technique

Discussion

The recommendations developed deal with two broad areas; those of contractual issues and considerations about how to manage caseload practice so as to avoid role strain and burn-out. There are of course areas of overlap since addressing the administration or contractual side of faculty practice can contribute to the reduction of role overload. The recommendations allow a fair amount of flexibility when it comes to midwifery faculty caseload practice with the lecturer being able to exercise choice in some areas. These choices in-

Table 2: Lifestyle/support issues

- Teaching team support and understanding is required.
- The lecturer should be reasonable about the roles she/he fills and what she/he is able to do.
- Clinical workload should not be in addition to full time educational duties.
- The lecturer could involve students in her/his practice with the women's consent.
- The midwife/lecturer's caseload should be arranged during less busy times of the semester.
- The lecturer could consider teaching clinical papers so clinical expertise can be used.
- The lecturer should develop excellent time management skills.
- Consider teaching during blocks of time with no caseload, then blocks of time where caseload would be the major work.
- Family considerations need to be kept in mind.
- The women within the caseload should be able to contact the midwife lecturer easily.
- Support from a practicing midwife or midwifery team is important.
- Take time for holidays and rest periods.
- The lecturer should ensure she has time for herself and her family.
- Clients must be aware of the lecturer's way of working and given some guidelines regarding contact and cover.

clude when to practice, how many women to include in the caseload and how to practice, which go a long way towards dealing with one aspect of reducing burn-out, that of enabling workers to have control over aspects of their work (Pearlin, 1989). There was indication from the recommendations that these decisions need to be done in consultation with colleagues from teaching as well as management.

Other aspects such as recognition of caseload practice within the employment contract and the subsequent review of workload, which is an implication of the guidelines, fulfil two purposes. Firstly, the acknowledgment of faculty practice by management and secondly the ability for the midwife/

lecturer, and thus management, to meet the future requirement for competency-based practicing certificates. This acknowledgment of faculty practice in management terms and, as one item suggests, the ability to negotiate such things as remuneration can be done on an individual basis. This allows each institution and faculty member to work out what is appropriate for them, which can help to reduce the possibility of stress and burnout.

The practicalities of running a practice, such as the items about informing the women and being easy to contact, are outlined in the service specifications for Lead Maternity Carers as laid down by the Ministry of Health. However they are important points to include as they are issues that must be considered when taking on a faculty practice. These items are part of the boundaries around practice that help the midwife avoid becoming stressed and burned out.

The modified Delphi method chosen for this study proved to be an effective method of gaining the opinions of a group of stakeholders who were situated around the country. Although it took some time to collect all the data, it did enable all panel members to have a voice in the discussions with out the pressure of face-to-face confrontation and the investment of long periods of time. There were however more lecturer panel members than those in management which means the decisions may be weighted toward the lecturers' position. There is also the difficulty of determining if these guidelines truly represent the opinion of lecturers and managers country-wide as a comparative group was not included. However, this technique does not claim to give the truth, only

Table 1: Management/contractual issues

- Caseload practice should not be taken up within the first year of commencing the teaching position.
- Caseload practice should not be required during all years; the lecturer should be free to negotiate whatever she/he is comfortable with.
- Caseload practice should be recognised within the contract of employment with the institution.
- The lecturer's workload/contract should be adjusted downward to account for the midwifery work.
- Depending on the caseload taken then employment as a component of full time equivalent can be considered.
- Depending on the caseload taken, a joint appointment can be considered.
- The educational institution should provide equipment, especially if they are receiving the funds and require clinical practice to teach.
- Monetary reimbursement needs to be negotiated and should depend on the caseload and how this work is arranged.
- If the educational institution supports the lecturer's practice they should pay her/his practising certificate and indemnity insurance.
- Caseload practice should be recognised as professional development or practice leave.
- The institution could set up a midwifery faculty practice for midwife lecturers and other midwives.

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the best evidence based on the opinions of experienced people. A future study could investigate whether other practicing lecturers and managers agree with the recommendations developed here.

Conclusion

Faculty practice will be a reality for midwifery lecturers in the near future and there is a need to support it properly in order to avoid burn-out and disillusionment among academic faculty. These recommendations may not only form a framework on which to build such a practice but may be the basis for future discussions about practice within the midwifery academic community in New Zealand. It became apparent during this study that reaching agreement on this aspect of the issue was not easy and the comments made during the project brought to light some of the concerns about faculty practice. These concerns must be addressed in New Zealand and I suggest they need to be addressed elsewhere, since these same issues have been expressed in the literature from various countries.

The implication of these guidelines for educational institutions is that they will need to address the issue of faculty practice and assist lecturers in pursuing caseload practice. There needs to be more open discussion and the development of policy around the place of faculty practice within the midwifery schools/ departments. The recognition of practice as being part of the 'knowledge work' of the academy will necessitate a review of workloads so that practice is not **in addition** to a full academic load. This may mean that educational institutions will need to increase faculty numbers to enable lecturers to take up practice without resulting in overload. Whether this is feasible in an environment of financial constraint will remain to be seen. There is also a need to give some recognition of faculty practice when things such as promotion and tenure are considered.

For clinical midwives it will provide an opportunity for them to support a midwifery lecturer in their practice and may enable them to have closer ties with the educational institution. Building strong relationships with clinical colleagues can only be positive, and this may be a way to help address the workload issues as clinical colleagues may be able to join academic colleagues as teaching associates.

For students it means they will have midwifery lecturers who are current in practice and who may provide them with an effective and stimulating education. This will provide them with the tools to be reflective and adaptable graduates, and will

go toward addressing the concerns of students and the profession about the practice-theory gap. This can only enhance the standing of the educational institution in the eyes of the professional community and prospective students and employers.

For the lecturers the implications of the guidelines are that they will be able to maintain a midwifery practice and have it recognised as part of the work expectations; but there will be flexibility in when, and how, that is managed and in how the clinical work is recognised financially. This means there will be the opportunity to discuss such things as caseload numbers with managers and colleagues. It also means that practice will be out in the open rather than a clandestine undertaking.

There is further work to be done, both research and discussion, around the academic-practice interface. Discussion has the potential to shift the present thinking about what is scholarly work and lead to the recognition of academic work and practice as part of the web that Langston, et al. (1999) class as "knowledge work".

Further research in this area from a New Zealand perspective is needed. Keeping in mind the stress that can ensue from role overload, exploration into the stories of practicing lecturers should be undertaken. Some questions that have arisen from this research include the following. How do lecturers cope including practice with their academic work? There were the beginnings of stories in this study but there is more yet to uncover. What do students think of practicing lecturers? Does faculty practice help to bridge that practice-theory gap as Driver and Campbell (2000) contend? Does faculty practice provide a more relevant education for students and are lecturers more credible as Hindley (1997) suggests? These questions may be answered by future research.

This study begins to address the lack of guidelines for midwifery lecturers who wish to carry a midwifery continuity caseload as a means of maintaining competency to practice. Midwifery faculty practice is re-emerging and because of this there are many areas about which we do not have a full understanding. In order to achieve the best we can for the profession we need to understand and investigate more fully the issues around midwifery lecturers and caseload management. It is hoped that this study will provide the impetus for that process.

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Post-traumatic stress disorder and childbirth

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After having 5 children, all but the first born at home, I trained as a midwife. I became interested in women's differing birthing styles and realised that, sometimes, I was witnessing the symptoms of Post-traumatic Stress Disorder. Having subsequently trained as a trauma therapist, I specialise in Cognitive Behaviour Therapy and Eye Movement Desensitization and Reprocessing. I also write, teach, research, enjoy my grandchildren and love to travel.

Litigation is an ever present fact of life for those working in the area of women's obstetric and gynaecological health. Since 1980, when the American Psychiatric Association first described Post-traumatic Stress disorder (PTSD), it has been a compensatable diagnosis in litigation. As midwives, we have a duty of care to our clients and, as the causes and symptoms of PTSD have been in the public domain for twenty years, it may be that 'lack of knowledge' will be considered an inadequate response in the face of potential litigation. The issue of 'foreseeability of harm' is now examined by the courts (Jenkins, 1995). Medico-legal considerations have demanded a new precision in thinking, assisted by the new biological dimensions of the disorder, which are currently being explored.

This paper highlights some of the issues around trauma and childbirth and seeks to indicate experiences of both clients and midwives that can lead to psychopathology. It begins with the case history of Emma.

Case History:

Emma was a 28 year old married woman who had been sexually abused by her father in childhood. She now has no contact with her parents. A primigravida, she was admitted to hospital and had vaginismus throughout labour. She was in a lot of pain which worsened when given a syntocinon drip. She did not have an epidural. She shouted and screamed with pain and was told to be quiet. She felt that the doctor and midwife were hostile to her because she was shouting. She was told that if she shouted she would harm her baby. Eventually she had a forceps delivery. Her husband was excluded from the delivery room but several student doctors and midwives were present in the room. She shouted for them to leave but no notice was taken of her request.

She was subsequently delivered of a live healthy son but developed post-natal depression and feared that she might harm her baby. She complained to the hospital and received a letter agreeing that there should not have been so many people in the room at her delivery. The letter did not acknowledge that her request had been ignored. She feels angry about her treatment and mistrustful of health professionals. She scores positively for PTSD using the PTSD-1 questionnaire (Watson, Juba, Manifold, Kucala, & Anderson 1991). She has decided that she is not going to have any more children because of her experience.

Emma's experience is not unique, nor was her response. Creedy, Shocket and Horsfall (2000), contacted 500 Australian women 4 – 6 weeks after giving birth, and found that 5.6% of women met the diagnostic criteria for PTSD, and one in three reported a stressful birthing event with three or more trauma symptoms. Whilst the researchers did not question their population about previous trauma, other research over the last twenty years has indicated that one in five women will have been subjected to some form of sexual assault during their lifetime and one in seventeen will have experienced forced sexual intercourse (Bill C-127. Canadian Department of Justice). These figures are generally agreed to be under-reported and ignore the incidence of child sexual abuse. From these statistics it can be seen that many women approach childbirth with a pre-existing history of sexual trauma which may be exacerbated by the experience of genital pain and a sense of loss of control. As yet, there are few protocols which encourage health professionals to access and consider this type of experiential history.

PTSD: What is it?

Knowledge of the long term effects of trauma on psychological, physiological and social well-being is growing. PTSD is one of the most serious effects of trauma. It has a psychiatric diagnosis, yet can be **wholly environmentally** caused. This means that PTSD can happen to anyone at any time with no predisposing physical or psychological factors and thus can be seen as the outcome of stress responses which initially may have been adaptive, but continue after the threat has disappeared. The events which trigger PTSD may be natural or man-made disasters (hurricanes or wars) or as a result of torture, hostage taking, kidnap, child sexual abuse (CSA), assault, bullying, crime, rape, battering relationships, traffic accidents and childbirth.

It may seem strange that the 'normal' event of childbirth should be bracketed with these other events, but all of them can generate fear or horror.

The symptoms of PTSD have been written about for centuries and it has variously been described as 'Railway Spine', 'Irritable Heart', 'Shell Shock', and mistaken as cowardice (Healy, 1993). In 1980, with the emergence of large numbers of veterans of the Vietnam War, all showing similar symptoms and self-medicating on drugs and alcohol, the disorder was officially recognised as a separate diagnosis, named and described in DSM-111 (American Psychiatric Association) under the generalised heading of Anxiety Disorders. The definition in the American Psychiatric Association (1994) DSM-IV is,

The essential feature of Post-traumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic experience involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm or threat of death or serious injury experienced by a family member or other close associate. (p.424)

Diagnosis

Characteristic features of PTSD are expressed in three groups of symptoms (Crompton, 1996). The first set relates to reliving an aspect of the trauma, with nightmares, sudden actions, or feeling as if the event is taking place again. The second group comprises symptoms related to persistent avoidance of anything likely to remind the individual of the trauma. The third group includes symptoms indicative of heightened irritability, such as hyperarousal, sudden shock reactions, loss of libido and sleep disturbances, as well as sudden outbursts of anger.

PTSD can be **acute** (4 weeks to 3 months after the event), **chronic** (longer than 3 months) or **delayed onset** (showing first symptoms 6 months after the event). These are the present categories of DSM 1V (American Psychiatric Association, 1994) used in diagnosing primary PTSD, and it can be seen how traumatic childbirth would fit the type of experience needed for a diagnosis; for the mother, father or even the midwife. Others have suggested that these criteria may need to be relaxed even further in the future. There is

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Post-traumatic stress disorder and childbirth

anecdotal evidence that PTSD can be acquired by non-direct (i.e. secondary, vicarious) means by witnessing traumatic events on television (Mihill, 1994) or by listening to the accounts of traumatised others (Turnbull, 1994). Children are known to have developed PTSD from bullying at school, even if there is no physical contact with the aggressors.

Above all, it needs to be born in mind that it is the **person's** perception of the event which traumatises them, not another person's perceptions of whether an event should or should not be traumatic. This is a particularly important consideration for midwives as the working environment in which they are familiar and comfortable is alien territory for many women. Procedures which are regularly carried out as part of the ordinary working day (such as vaginal examination, suturing) may cause speechless terror to the client whose biography is unknown to us. Lying down with her clothes off when others are standing and clothed may contribute to a feeling of powerlessness (Crompton, 1996).

The two conditions most likely to predict the onset of PTSD are states of helplessness and hopelessness. This has been measured by the appearance of abnormally high levels of catecholamines in blood and urine samples under laboratory conditions (Yehuda et al., 1995)

What happens during a traumatic event?

When confronted with danger, humans have a similar repertoire of choices to that of animals; that is 'fight, flight or freeze'. The first two are mediated by hormonal events and the last has been postulated as a reversion to a primitive coping tactic of self-hypnosis. Stutman and Bliss (1985), suggest that self-hypnosis can generate a host of symptoms including depersonalisation, derealisation, hallucinations and amnesia which can, in turn, instigate and perpetuate the disabling post-traumatic syndrome. Others, (Henry et al., 1992; Zeitlin, McNally & Cassidy, 1993; Williams, Weir & Waldmann, 1994) suggest that the trauma of a critical life threat, in which the victim fails to regain safety or control causes the central nervous system to thrust all of its resources into the left cerebral hemisphere which dissociates to some extent from the right hemisphere. This is a condition called alexithymia and permits the sufferer to believe that he/she is still in control (despite the evidence to the contrary).

There is now evidence that traumatic events not only alter brain chemistry (Coleman, 1992) but the actual structure of the brain (Bremner et al.,

1995) and that, from a biological viewpoint, people who have suffered intense, prolonged trauma may never be the same again. The cycle of events, which is not completely understood, is believed to be such that the emotionally intense shock of extreme trauma causes the release of abnormally high levels of adrenalin and noradrenalin into the bloodstream which appear to inhibit the normal processing of memories (Turnbull, 1994). These toxic levels cause changes to occur in the locus coeruleus; an area of the brain which co-ordinates the secretion of these two hormones. 90% of the cells for the brain's noradrenalin controlling system are located in the locus coeruleus. In the face of extreme stress, it is as if it is unlocked and the key thrown away. The sufferer is left with altered brain metabolism, which is vulnerable to surges of noradrenalin; thus prompting alarm states.

In time, the sensation of an adrenalin surge (for whatever reason) acts as a memory and as a cognitive cue for the sufferer to relive the original trauma in intrusive recollections (known as 'flashbacks'). These are frequently so intensely distressing that the person will do anything to avoid a repetition of their trauma. There is, therefore, an avoidance of stimuli associated with the event or which may symbolise some aspect of the traumatic occurrence. This may take the shape of psychogenic amnesia or memory loss from psychological rather than physiological reasons (Crompton, 1996).

Childbirth and sexual trauma.

When talking about traumatic childbirth, women often use the language of sexual assault. *"I came away hurting and feeling violated", "My opinions were dismissed as irrelevant, although it was my body which was being invaded", "I felt assaulted and then abandoned"* (Menage, 1993, p.223 & p.226). In the absence of other relevant descriptions of the effects of childbirth trauma, that of sexual trauma is considered below. *"Sexual assault is a life crisis in which the ego is overwhelmed and the balance between internalised concepts of self and the environment is broken"* (Moscarello, 1990, p.25). Sexual assault is the violation of one human being by another of a fiercely protected, private aspect of oneself which breaches body boundaries and severely disrupts personal beliefs of invulnerability and belief in the world as a benign place. No one passes through life without experiencing some degree of distress, devastation or contact with a world that can suddenly be seen as cruel, grotesque and alien to their expectations. Psychic trauma results when an individual experiences an adverse event which causes undue stress, perceived to be beyond their control. When the event is un-

foreseen and happens quickly, such as obstetric emergency, it can be overwhelming.

Coping Strategies

Each person has a limit to the quantity and quality of stressful events they can experience before their capacity to cope begins to break down. The setting of this limit is not yet known but believed to have some genetic input but also to relate to early childhood experiences and the quality of social support experienced. Hans Selye (1956) called this limitation the general adaptation syndrome which established three stages of response to a noxious stimulus:-

Alarm Resistance Exhaustion

To understand the effects of psychic trauma one needs to understand the word 'self' which is as enigmatic as the concept that it represents, but can be described as a construct that develops over time and is the summation of a person's lifetime experiences... which have been edited by their personal beliefs and attributes. Trauma has a devastating effect upon a person's perception of the world and his/her self-image and identity. During psychic trauma the internal library of experiences is found to be empty of any useful response, which places the individual in an anxious and threatening position (Horowitz, cited in Brett & Ostroff, 1985). The person has no guidelines for responding to this event and finds himself or herself in a state of suspended animation; emotionally numbed, unable to attend to stimuli and out of touch with their environment. To defend the self from being overwhelmed she moves into a phase of suppressed association (dissociation or 'stepping out'), in which the connection between the self and the event is broken (van der Kolk, McFarlane & Weisaeth, 1998). In the immediate aftermath of sexual assault, and also after traumatic birth, women have been observed to cope in two distinctly different styles (Karl, 1989) (in approximately equal halves of the population). These styles can best be described as 'expressed' and 'controlled'. The expressed style is that of immediate distress, agitation, anger and disorganised behaviour, which is the **expected and accepted** reaction to trauma.

However terror, helplessness and a sense of loss of control lead **half the population** to respond with a regressive reaction, which results in automaton-like behaviour. This presents as a cool, calm, co-operative, organised and controlled style. In reality, the victim is emotionally numbed, dissociating themselves from their situation and denying

its validity. This is a protective mode in which an oscillating process begins which alternates between the state of numb shock and the emotional arousal which occurs as realisation begins to overpower the self and over-ride the attempts to deny the terror experienced and to make sense of their predicament. This is the unconscious coping mechanism of this group of people and may result in healing so long as symmetry and balance in the oscillations can be maintained. However, it is frequently the case that, after days or weeks, the emotional arousal eventually breaks through the detached state and the distressed and agitated behaviour of the 'expressed' group can be observed some time after the event (Karl, 1989). This may be why birth questionnaires completed in the immediate aftermath of the event may be of little validity, particularly those enquiring about the quality of care or the birth experience itself.

Long Term Effects

If untreated, PTSD is associated with increased physical morbidity, subsequent psychiatric illness, accidental and non-accidental death (DSM IV, American Psychological Association, 1994). It is generally accepted that chronic stress is related to physical problems such as ischaemic heart disease, asthma, arthritis, cancer and susceptibility to infection. Depression is common in sufferers and there is an increased incidence of alcohol and other substance abuse. The impact on social and occupational functioning may be considerable; as may the breakdown of family and marital relationships. Finally, PTSD and depression after traumatic childbirth may have profound implications on a woman's ability to make meaningful relationships. Her impaired ability to make affectional bonds with her baby (Henry, 1993) may cause the long-term effects of PTSD to continue to the next generation.

Conclusion

Far from always being a benign and normal experience, for many women childbirth is a traumatic experience which, untreated, can profoundly and negatively affect her family and her psychological health for the rest of her life. It is important for midwives to understand the events that lead to trauma and how it impacts on the physiology of their clients so that practice can be centred around giving the woman the locus of control, rather than the professional. Finally, it is important for midwives and health professionals to understand and monitor their own responses to traumatic events in the workplace. Elevated stress levels are a common cause of 'burn-out' and high rates of 'sick leave' which may be alleviated by sympathetic debriefing.

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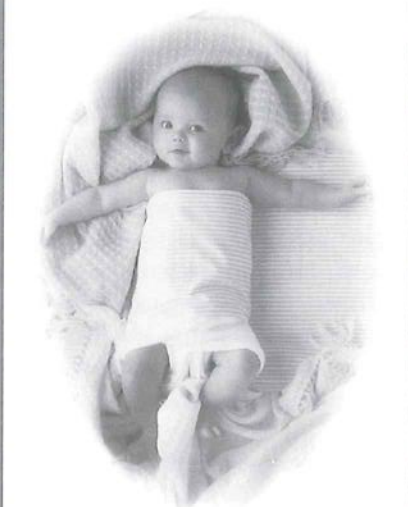


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I am occasionally rung by Lead Maternity Carers (LMC) for advice when confronted with the presence of intra-cardiac echogenic foci on routine 18-week ultrasound scan reports. It is heartening to hear that midwives are recognising that this finding can represent a dilemma and that they want to know how they should respond to this 'soft sign'. This type of reflective practice, and the accompanying desire to think through the issues it raises, is very healthy.

I do not propose to address the wider debate surrounding the prevalence and appropriateness of 'routine' scanning as a diagnostic tool in pregnancy as that debate is best left to consumers and professionals. Instead I will attempt to discuss the issues surrounding the LMC responsibilities to the woman when such findings occur. For ease of consideration I will divide the discussion in to 'pre-scan' and 'post-scan findings'.

Pre-Scan

The first matters to consider are why the LMC is recommending that the woman should have a scan and what information sharing is appropriate for the woman making the decision whether to agree to this screening. Generally the LMC recommendation will be based on a clinical rationale and although this should be the dominant, some would say the only, reason to justify an ultrasound investigation the occasional woman may expect a scan as a matter of right. The motivation for this expectation is often tied to wanting some type of visual introduction to her baby. However, any woman who approaches a scan tends to do so with a mixture of anticipation and some degree of apprehension. The latter arises from a fear of finding out that there is something wrong with her baby; a fear of perhaps having to make a decision about the continuing pregnancy based on what the scan discloses; or a fear of how she will cope if complications arise. A normal scan result can do much to allay these types of anxiety by reassuring the woman that the baby is viable and normal. It is always ironic to me personally that this same technology can both cause and relieve such fears.

Informed Consent

LMCs will be well aware that an 18-week ultrasound examination is a screening tool, which has the potential of revealing unexpected anomalies,

and the woman must be prepared for this possibility. As with any screening the LMC has legal and ethical responsibilities to comply with the common law doctrine of informed choice; the *Code of Health and Disability Services Consumers Rights* ("the Code"), the *New Zealand Bill of Rights Act 1990* and the professional obligations and standards of their professional body. Access holders and employees may be further constrained by the protocols of the local hospital. There is also a growing body of case law that requires a full disclosure of 'material' information to be given to any patient undergoing treatment or investigation. LMCs need to be aware of their obligations and the duty of care owed to the woman under the various laws.

Let us just consider one section of legislation on this issue as an example. The Code requires the following under Right 6.

Right 6 - Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -

- (a) An explanation of his or her condition; and
- (b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
- (c) Advice of the estimated time within which the services will be provided; and
- (f) The results of tests; and
- (g) The results of procedures.

The section also gives the consumer a right to honest and accurate answers about the qualifications of the provider (eg of the sonographer, radiologist, LMC), their recommendations, and a written summary of information given if this is required. This legal recognition of the right of a consumer to be fully informed recognises that the scan finding is information belonging to the woman and that it is relevant to the ongoing decisions a woman makes about her pregnancy and care.

Pre-Scan Preparation

As stated the first information that the LMC should discuss with the consumer is whether there is a clinical reason for the ultrasound being rec-

ommended. This discussion should include what that reason is and the potential risks and benefits to the woman and her baby of undergoing or foregoing the ultrasound examination. If the woman decides to have the scan then she needs to think

about what she might do if the scan shows that something is wrong with her baby. The LMC should ideally provide general written information on ultrasound and give the woman some time to consider her decision.

LMCs will be well aware that an 18-week ultrasound examination is a screening tool, which has the potential of revealing unexpected anomalies, and the woman must be prepared for this possibility.

Once the decision for an ultrasound is made the LMC has further responsibilities in terms of the information relayed. If this is done carefully and in a structured way any future concerns over a 'soft' finding should be minimised. The LMC first needs to talk about the procedure itself and what this involves. Often women are expecting to go and see a clear picture of a baby and are unprepared for the fuzzy image they will see on screen. The LMC can explain what will happen and that the actual scan is taken over a period of time by an ultrasonographer who will scan the baby, take some measurements and establish certain information. They need to explain that the findings of the ultrasonographer will then be checked by a specialist radiologist (or obstetrician) and this report, including any concerns identified, will be relayed to the LMC. The LMC will then contact the woman to discuss these results.

At this point in the conversation it is useful for the LMC to say that sometimes an abnormality will be picked up on a scan but that these are rare and generally not established by ultrasound alone. The LMC should distinguish between 'major' anomalies and the 'minor' anomalies, which sometimes occur. The LMC could prepare the woman for possible findings such as intra-cardiac echogenic foci by describing them in lay terms saying something like this:

"Sometimes the scan will pick up small changes - like a little area of the heart where it seems lighter than the tissue surrounding it. These type of things are thought to be due to collections of calcium and on their own are not something we tend to worry about or need to follow up."

(I may not be clinically accurate in this description as I am not familiar with the nuances of ultrasonography but the illustration is just to give a

general example.) Once this simple explanation is made then the LMC can stress that the small changes that are sometimes picked up on scans do not influence the ante-natal management and should not adversely affect the pregnancy or well-being of the mother or baby in any way

If this type of preparatory statement is made during 'pre-scan counselling' and the scan does show an echogenic foci, then it is a simple matter to say to the woman "Remember before you had your scan and we talked about little areas which sometimes look different to the surrounding tissue - well this is what the radiologist is describing in this report". Previously relayed information is generally more easily recalled and the woman is likely to be reassured about the finding.

Describing the shortcomings of technology in most areas of medicine would be the responsibility of the person using that technology - in this case the ultrasonographer - but for some reason it seems that, in maternity care at least, part of this responsibility has devolved to the LMC. S/he therefore does need to address, with the woman, some of the general problems associated with scanning. The LMC will be aware that the 18-20 week scan has limitations such as the uncertainty of the significance of factors such as the low-lying placenta or unusual placental anomaly *at this gestation*. Another difficulty with 18-week scans is that some abnormalities such as hydrocephalus, hydronephrosis, late obstructive defects and foetal growth disturbances may not yet have manifested. The woman need not be told of every one of these possibilities unless they specifically arise but she should be made aware that sometimes abnormalities cannot be diagnosed by a scan at this stage or they can be missed and although that is rare, it does from time to time happen. The woman should therefore know that there are false positives and negatives with all diagnostic technology and that the findings may not always be correct. A reference to this possibility is probably sufficient and if this is an issue about which the woman wants more information, then it will be appropriate for the LMC to suggest where she can obtain this information to assist her.

The woman should be reassured that if a major abnormality is identified on the scan, then a management plan, further testing and referral will be arranged and that she and her support people will be fully informed and involved in this decision making. All of these conversations and decisions should be documented and the LMC should be

checking that the consumer has understood the information given.

Post-Scan Findings

The radiologist will report to the LMC the interpretation of the scan and any diagnosis made. It is up to the LMC to initially convey those results to the woman. I sympathise with LMCs who are reluctant to worry or increase the anxiety of their client when the only anomaly identified is of uncertain clinical significance. The legal view however, is that the woman should be given the full information. The days of shielding people from unpleasant or unneeded worry, even when this is based on the kindest of motivations, is likely to be viewed as misguided paternalism (or maternalism) and be seen as cutting across personal self determination and autonomy. If the LMC does not give the woman the full information about the ultrasound finding it could leave her and her partner feeling aggrieved. It is very clear in law that apart from a few narrow exceptions, the woman has the absolute right to all the information obtained during a scan and she can require that information to be put in writing. Legally the LMC would be wrong not to discuss the entire result and its implications. This is quite a change from the 'therapeutic discretion' a practitioner once had in deciding what information the patient needed to be told.

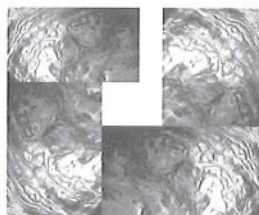
It may be of some comfort for LMCs to know that several studies¹ have shown that disclosing full information reduces anxiety. It also enables

parents to dispel any misconceptions about the nature of the anomaly, as parents often pick up during the scan procedure if there is something that has caught the interest of the ultrasonographer or s/he is giving off messages that something is not quite right or the ultrasonographer appears worried. It may also help parents to instill a sense of realism into what they are being told.

The LMC should go through the scan report with the woman and give a preliminary explanation of the clinical significance of any findings. Where there are significant abnormalities or the LMC feels unable to fully discuss the report s/he should promptly arrange a specialist interpretation. In the case of more benign findings such as intra-cardiac echogenic foci, the discussion could be accompanied by a 'user friendly' pamphlet based on the information sheet approved by the Foetal Abnormality Advice Group. I understand that the Ministry of Health is currently working on a national consumer pamphlet for nuchal translucency and this type of publication could be a useful guide.

Although a single 'soft' sign is not considered particularly worrying, it goes without saying that the LMC must bear in mind any other factors which could compound this finding. These might include such things as a family history of congenital anomaly, the gestational age at scanning and maternal age. The 'soft' sign is also often described as transient and benign but it is important that the woman be told that if she remains concerned af-

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ter considering the information, she is entitled to a second opinion. If the woman becomes extremely concerned or demands further tests or referrals then the LMC may need to give her further information on available services and arrange appropriate follow up. Once again all conversations, decisions, and recommendations should be fully documented.

Institutional Responsibilities.

There would seem to be some other responsibilities in ensuring that the responsibilities to the woman are met and these may be carried out by the institution or the radiology unit.

- The skill, qualifications, experience, review, ongoing education and supervision of the ultrasonographers or of any other practitioners performing scans are critical. (This could also be said of the LMC and radiologist.)²
- The radiologist needs to think carefully about the information that is conveyed when s/he is writing the scan report. An example is the current debate which radiologists are having over whether they should be reporting on nuchal fold thickness when this information has not been requested. The radiologists need to consider whether what they are reporting is information accurate and clinically significant.³
- It is also important that the LMC be able to access the radiologist and vice versa, particularly if the matter is urgent, to discuss any findings of concern or of uncertain significance. Such open communication should be encouraged by hospital/unit management for the ultimate benefit of the woman and her baby.
- Scanning equipment needs to be well maintained and fit for its purpose.
- Statistics need to be kept and records maintained so that the department is aware of its own screening characteristics and is able to compare these with departments with similar demographics.
- Such data collection needs to include the frequency of diagnosis of minor anomalies such as choroid plexus cysts, echogenic bowel and intra cardiac foci. Inclusion of these 'soft' findings would help 'demonstrate the specificity of routine ultrasound in detecting major abnormalities'.

This type of information will also assist in auditing the utilisation of services, helping identify regional trends, enable users and providers to have

current and accurate information on ultrasound screening and help determine whether accurate detection of anomalies is occurring. Such regional data would be particularly useful if prenatal findings, even of minor sonographic markers, are considered in conjunction with long term paediatric outcome. This would provide some understanding of whether 'soft' signs are just a developmental variation or if they have a long-term clinical significance.

Conclusion

It might be helpful for regions and educators to schedule a short education session with LMCs, radiographers and radiologists to discuss this in more detail. This would help protect and support individual practitioners to think about what they would do in various circumstances, provide them with some tools and ensure an informed and uniform response when such findings occur. A small working party could be established to develop an information pamphlet for LMCs to give to women.

As stated the Ultrasound Utilisation Committee of the Health Funding Authority is looking at Ministry of Health sponsored pamphlet on nuchal translucency and this committee may also be interested in assisting with this issue.

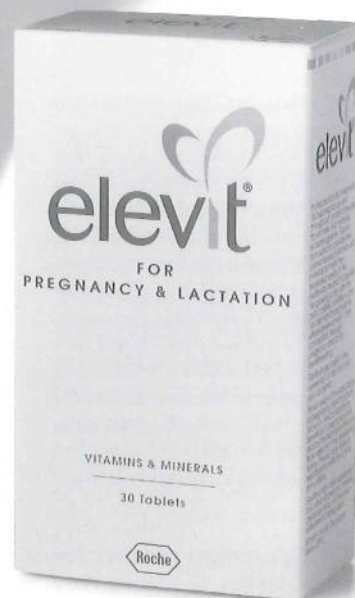
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- Thornton, J., Hewison, J., Lilford, R. & Vail, A. (1995). A randomised trial of three methods of giving information about prenatal testing. *British Medical Journal*, 311 (7013), 1127-30 which showed that the offer of extra information on ultrasonography had no overall adverse effects on anxiety.
- My thinking on this subject has been assisted by an article written by the medical ethicists Frank Chervenak and Laurence McCullough (1989) entitled *Ethics and Ultrasound in the Journal of Ultrasound Medicine*, 8 (9), 493-7.
- Furness, M. (1987). Reporting obstetric ultrasound. *The Lancet*, 1(8534), 675-6 writes that increasingly 'patients' read the scan reports and so report writers should ask themselves 'What am I saying in my report? Why am I saying it? Could the wording be improved? If I suggest another scan - what will it achieve? The article while useful in part, needs to be considered with some caution as some of the premises would not be acceptable within the current NZ medico-legal climate.

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Over 15 years of history in Europe, and has been used in over 1 million pregnancies worldwide.⁽³⁾

ELEVIT is well tolerated. In rare cases gastrointestinal disturbances (eg: constipation) may occur, however these generally do not necessitate withdrawal of therapy.⁽²⁾

For more information please refer to Prescribing Information elsewhere in this publication.

References 1. Czeizel A.E. Prevention of congenital abnormalities by periconceptional multivitamin supplementation. BMJ 1993; 306: 1645-1648.
2. Elevit Data Sheet prepared October 12, 2001. 3. Elevit Data on file. Roche New Zealand.

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*Sarah Stewart RM, DPSM, Bsc(Hons)
Midwifery Lecturer, Otago Polytechnic*

If a woman asked you about induction of labour, or you were invited to present a session to colleagues about fetal heart monitoring, where would you go for up-to-date evidence/research on which to base your information-sharing? The Internet is becoming an increasingly useful tool that supports searching for evidence for practice. Here are some web sites that a midwife can explore with regard to evidence-based practice.

www.nzgg.org.nz

The **New Zealand Guidelines Group** aims to train health professionals and consumers in the development and implementation of evidence-based best practice guidelines, with the long term intention of improving quality of health service provision in New Zealand. The web site has information about the process of developing guidelines and various links to resources that help you critique evidence. The library has completed guidelines such as smoking cessation, management of genital herpes and prescribing HRT. You can also sign up for the NZ Evidence-Based Healthcare Bulletin that summarises news about EBP in NZ and over seas. The web site is self-explanatory and easy to navigate. I look forward to the time when there are more guidelines relevant to midwifery practice.

www.moh.govt.nz

The **Ministry of Health** has several guidelines that may be of interest to midwives, particularly along infant nutrition and breast feeding. Also, don't forget the NZCOM consensus statements that are available on **NZCOM web site**, which include vaginal birth after caesarean section, vitamin K, ultrasound scan and third stage of labour. These consensus state-

ments are regularly reviewed and based on evidence for best practice. www.midwife.org.nz

www.nice.org.uk

The **National Institute for Clinical Excellence** based in the UK has developed several guidelines that are relevant to midwifery. The news on the site is probably of minimal interest to people outside the UK, however the guidelines produced are very pertinent especially caesarean section, induction of labour and fetal heart monitoring. It took me a while to find my way around the site because a lot of the internal links did not work, and I also found it took some time to work out which guidelines were completed and which were in the process of being developed. Currently guidelines around routine antenatal care and routine anti-D prophylaxis for rhesus negative women are being developed.

www.tripdatabase.com

The **TRIP database** is a UK database that provides links to providers of evidence-based information such as Cochrane database, British Medical Journal, Journal of American Medical Association, Royal College of Nursing and NHS Centre for Reviews and Dissemination. The search facility gives you results that fall into several categories: evidence-based, query-answering service, peer-reviewed journal, guidelines and e-textbook. This is a very useful web site to become familiar with and is free of charge.

http://cebmr.jr2.ox.ac.uk

The **NHS Research and Development Centre** provides numerous online tools and references to evidence-based practice including critical appraisal tools, as well as how to practice and teach evidence-based practice. Whilst the site deals generally with evi-

dence-based medicine, it is a site that is worth exploring until you find what you can specifically relate to your own situation.

www.rcog.org.uk/guidelines/nscs_audit.pdf

The **Royal College of Obstetricians** has published the 2001 National Sentinel Caesarean Section Report. I have to confess to not having read it in great detail, the report is worth looking at if you are interested in issues relating to caesarean section.

www.attract.wales.nhs.uk/about/one.htm

ATTRACT is a service for Welsh general practitioners, whereby they can ask clinical questions online, and be sent an answer that has been researched and summarized by the ATTRACT team based on literature available to them. This service is not a full systematic review and there has been criticism of it. However, midwives can look up the answers to questions such as 'should pregnant women who have haemolytic strep B be treated? Should they be 'allowed' to have a waterbirth?

www.nmap.ac.uk

NMAP (Nursing, Midwifery and Allied Health Professionals) is an excellent UK web site that provides access to online resources that have been evaluated according to specific guidelines. This means that the online resource should conform to a certain standard of quality. Midwives can find a range of links to resources such as a discussion list for people involved in providing antenatal education classes, to the clinical audit of the One-to-One Midwifery Practice at the Hammersmith Hospitals Trust in the UK. This web site is well worth bookmarking.

If you have any web sites you would like to recommend, please contact me at: mazz@paradise.net.nz

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 are proving very successful. Current students are enjoying the papers, with positive feedback received about topics of discussion, networking with other midwives, supportive environment and lecturers and the fun they are having 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 numbers are sufficient.

Applications for second semester papers in 2002 are open now and close on 1st June 2002. Consider our midwifery practice papers for core and continuity midwives, our new research methods paper or our new knowledge sharing paper may suit those of you involved in working with students or providing information sessions for women.

Unsure if you are ready for postgraduate study? Why not ask about our 'preparation for postgraduate study' short course. We can offer this to suit you.

For further inquiries please contact:

Sally Pairman or Deborah Davis at the School of Midwifery, Otago Polytechnic, Private Bag 1910, Dunedin. Phone 03 479 6149 or 03 4796151 or email ddavis@tekotago.ac.nz

or contact our Christchurch-based lecturer, Chris Hendry on 021 655 355



Abstract of masters thesis

Abstract of masters thesis titled "Towards a sustainable model of midwifery practice in a continuity of carer setting – The experience of New Zealand midwives" undertaken at Victoria University, Wellington during 1998/2000

Christina Engel *RGON, RM, B.A. (Educ), MA in Midwifery*

Currently I am working as a midwifery lecturer at University College Hospital, Galway, Ireland in an undergraduate midwifery programme that has a joint partnership with the National University of Ireland. I also have a small homebirth caseload. I worked in New Zealand until May, 2000 as a midwifery lecturer at Massey University Wellington and prior to that as a self employed midwife in the Wellington area.
Contact: Christina.engel@whb.ie

New Zealand midwives may have gained autonomy in the 1990 Amendment to the Nurses Act but that alone did not enable midwives to offer full professional midwifery services in an equitable way to women around the country. Being able to access the government funded Maternity Benefits Schedule on an independent basis was the single most significant factor for the midwife in becoming an independent practitioner within the publicly funded health service.

This was both enabling and potentially disabling since it is apparent that funding of maternity care directs the way midwives practice and influences the size of their personal caseloads. Caseloads can have a direct bearing on the financial viability of the midwives practice and a large personal caseload may result in burnout or conversely has the potential to lead to less than satisfactory continuity of care for clients.

This study used a feminist narrative methodology to explore midwives' experience of working in a continuity of carer model of midwifery practice. Midwives from five different midwifery group practices participated in the research. The midwives had all worked for more than three years in a continuity of carer model and there was a variation in the funding model within each midwifery practice.

The findings show that as well as personal and professional issues requiring a constant balancing act the funding model within each midwifery practice influenced the size of individual caseloads and the way in which midwives organised their practice. This thesis concludes with recommendations to the Health Funding Authority to consider more flexible funding models such as direct capitation that would enable self employed midwives to have more financial stability in managing their midwifery practices.

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Dear Editors

It is disappointing that the Minister of Health, the Honourable Annette King, relegates the midwife into third place as a primary health care provider in the Guest Editorial (NZCOM Journal, No 25, October 2001, p. 5). Extraordinary really when it was written specifically for a midwifery publication!

The midwife is the backbone of the maternity service in Aotearoa/New Zealand providing the majority of Lead Maternity Carer services, let alone the bulk of the primary maternity care in the hospital service.

Let it be a warning that we need to maintain our vigilance in informing the New Zealand public of the rightful place of the midwife. The alternative (and historically set precedent) of a doctor-led maternity service with the midwife relegated to the appendix of 'other' health professionals, may be just around the corner in governmental policy and public education.

Yours faithfully

Maggie Banks, Home Birth Midwife

Email: banks@ibug.co.nz, 14 November 2001

Dear Editorial Team

I submit this letter and poem, to illustrate a personal view of unprofessional, market place antics being displayed in a growing number of community and hospital based midwifery services, which I consider impacts on women's choice, collegial loyalty and professional ethics.

Initially Section 51 of the Health and Disability Act, endeavoured to provide pay and recognition equity between all primary Lead Maternity Carers (LMCs). A situation which was not approved of by many GP groups around the country. They worked diligently to secure non Section 51 contracts to gain more "incentive" (as it were) to remain in maternity care. An offshoot of this was to woo midwives into their scheme(s) in order to achieve the requirement to ensure the woman had midwifery care and they (the GPs) had the type of cheaply purchased, and also compliant, midwifery service they could work with.

Enter a new player in the field. The midwife who sees the numbers in her practice being enhanced by wooing medical providers, in or out, of Independent Practitioner Associations (IPAs). Both types of midwifery player seem to "glibly" dance over professional ethics and collegial loyalty, which are standards the medical profession has learned to cultivate to their advantage collectively.

Now, hospital team midwifery schemes have set medical dominance, on a significant section of maternity care. Yes, the midwives are "allowed" to offer total midwife care, but usually after the women have been "laundered" through obstetric

clinics for extensive risk assessment. All in the name of safety. The numbers of women each midwife is providing care for are high and when she is required to cover another midwife's caseload for days off, study leave and sickness, they can be unmanageable. A prescription for consumer dissatisfaction with this perfunctory care and likely burn out for the midwife.

Under all medically dominated maternity care arrangements postnatal care remains the poor relation; either because of funding constraints or because the midwife just doesn't have the time. This should raise questions and concerns about outcomes such as postnatal depression, parental competence, breast-feeding statistics and general inappropriate and unacceptably reduced provision of midwifery care.

I shudder at the thought of what is being sacrificed for the kudos of keeping the doctors happy and the ongoing financial rewards. Yes, women get midwifery care in these arrangements. Yes, a midwife is a midwife etc, etc, etc. But, what about the solidarity of midwifery sisterhood? What about the woman focused provision of midwifery care? What about developing the normal childbirth culture and promoting its safety? What about being part of a midwifery collective offering women centred maternity care, and accessing and taking a caseload, using methods more considerate of midwifery colleagues and consistent with informed choice for women?

During a recent conversation with a midwife colleague on the Section 88 issues, she reminded me that 70% of women choose a midwife as LMC nationally. So why are all intervention rates increasing? I believe in part, its because more and more midwives are aligning with the medical pathway. (I wonder how many of the 70% midwife LMC cases include obstetric specialist supervision of care?) Also more and more women are believing the misinformation circulating in their communities that birth without a doctor is risky, women aren't martyrs and epidurals are the way to go, and that women should give birth in a base hospital where "they have everything". Women are supporting the intervention pathway as never before.

We can quote and theorise all we like about the midwife/ woman partnership, but this is just not the reality which is developing. Compliant medically motivated midwives have failed to see the bigger picture. They have failed to recognise the part they plan in the erosion of the midwife/ woman wise way and in the development of another mound in the uneven playing field of how women come to "choose" (more accurately – are directed to choose) their midwifery care.

Yours sincerely

Denise Black, Independent Midwife

October 2001

NATURAL CHILDBIRTH !!!

NATURAL CHILDBIRTH !!!
What does she mean?
Times have changed
Since her Grandma was seen
Writhing in agony
All round the floor
'Til baby was born
Barely there – at all!

NATURAL CHILDBIRTH !!!

Doesn't she know
That's labelled- "Dangerous"
By medics who know
Their way is better.
To manage the care
Is the "In Way" now.
Good girl. There there !

NATURAL CHILDBIRTH ???

Does seem a shame.
Women can't trust
What was normal back then.
When woman and midwife,
Side by side in travail,
Brought forth to birth,
Child, in effort and gain.

NATURAL CHILDBIRTH.

Does it matter a toss.
Live mother. Live baby.
That's what should cause
Us all to comply, and
Be maidens to hand,
In helping the medics.
Together we band.

NATURAL CHILDBIRTH.

Let's ignore woman's way(s),
And com-ply like crazy.
You know it pays.
Reece-ferrals follow
When this is our mode.
Onward and upward.
STILL midwives you know. (???)

NATURAL CHILDBIRTH.

No real support left.
Midwives afraid of
The liii-tigious net.
No – "Being with women".
No- "Can do" – promo'.
Interventions increasing.
Morale very low.

NATURAL CHILDBIRTH

Time to get out.
No body listens.
No woman or "spouse".
Others decide
What her body can do.
The fight is fragmented.
UNITY ??? BALLYHOO !!!

natural childbirth.
When the "blue print" is lost.
And women get used to
Booking Caesars. With cost
No longer measured.
Interventions rates soaring.
And no-body left
Who remembers labouring.

Denise Black, 2001

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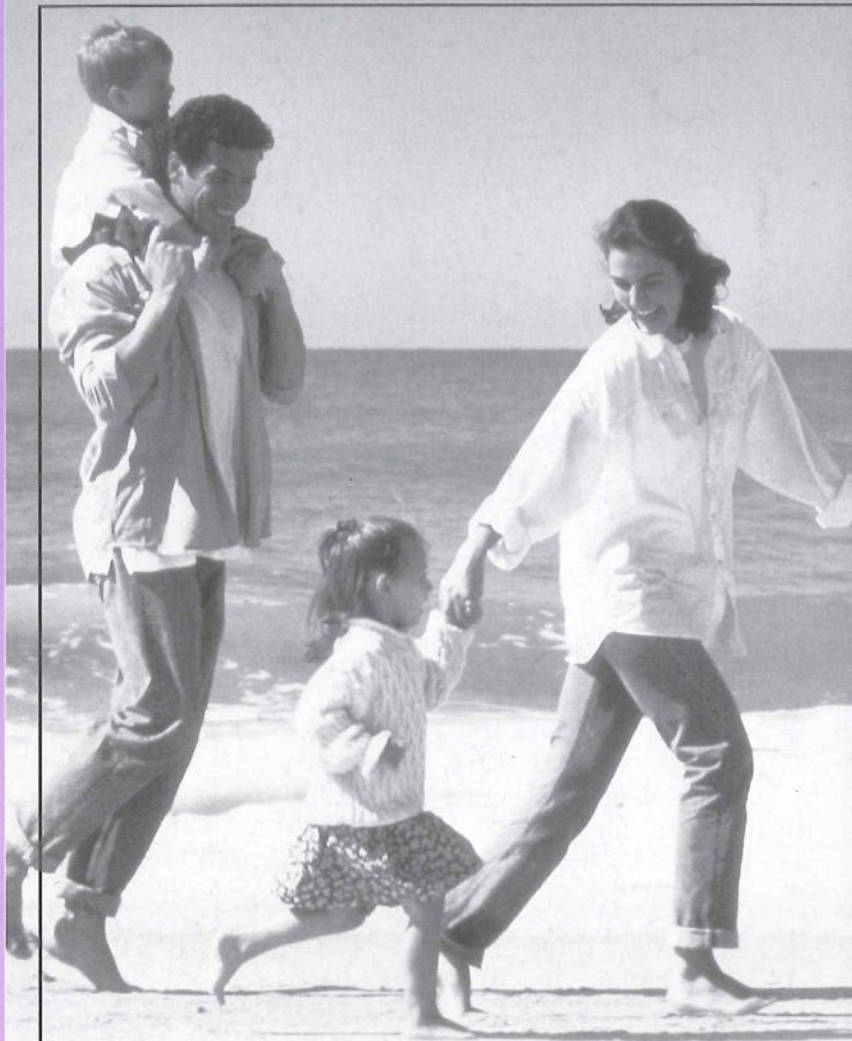
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Presentation: Intrauterine system containing 52mg levonorgestrel with a mean release rate of 20µg/24 hours over 5 years. **Uses:** Contraception and treatment for menorrhagia provided there is no underlying pathology. **Dosage and Administration:** Mirena is effective for 5 years and in women of child-bearing age, is inserted into the uterine cavity within seven days of the onset of menstruation. Mirena can be replaced by a new system at any time in the cycle. Mirena can also be inserted immediately after first trimester abortion. Postpartum insertions should be postponed until six weeks after delivery. Mirena is supplied in a sterile pack and should only be inserted if atropine and oxygen are available. It must always be inserted under aseptic conditions. Before insertion, the patient must be informed of the efficacy, risks and side effects of Mirena. In particular, the expected differences in bleeding pattern, amenorrhoea and hormonal effects should be explained, as good counselling is likely to reduce unnecessary removals of Mirena. Because the insertion technique is different from other intrauterine devices, special emphasis should be given to training in the correct insertion technique. In addition, the practitioner should maintain this skill by inserting IUDs or doing similar procedures regularly. Mirena is removed by gently pulling on the threads with forceps. **Contraindications:** Known or suspected pregnancy; current or recurrent pelvic inflammatory disease, lower genital tract infection; postpartum endometritis; infected abortion during the past three months; cervicitis; cervical dysplasia; uterine or cervical malignancy; undiagnosed abnormal uterine bleeding; congenital or acquired uterine anomaly including fibroids if they distort the uterine cavity; conditions associated with increased susceptibility to infections; severe liver disease or tumour, hypersensitivity to the constituents of the preparation. **Warnings and Precautions:** Mirena may be used with caution or removal of the system should be considered, if any of the following conditions exist or arise for the first time: migraine, focal migraine, severe headache, jaundice, increased blood pressure, hormone dependent cancer including breast cancer, malignancies of the blood, severe arterial disease such as stroke or myocardial infarction. Mirena may be used with caution in women who have congenital heart disease or valvular heart disease (antibiotic prophylaxis required). Low-dose levonorgestrel may affect glucose tolerance and diabetic Mirena users should be carefully monitored. Mirena should not be used as a post-coital contraceptive and it is not the method of first choice for young nulligravid women. Mirena should be removed if the woman experiences recurrent endometritis or pelvic infection or if an acute infection does not respond to treatment within a few days. Mirena must be removed if perforation is suspected and removal is recommended if the woman becomes pregnant because of the possible consequences to the infant. **Side effects:** Side effects are more common during the first months and subside with prolonged use. Changes to menstrual bleeding patterns are the most frequently reported adverse effect. Headache, lower abdominal pain, back pain, skin disorders, vaginal discharge, mastalgia and other benign breast conditions, vaginitis, depression, other mood changes, nausea and edema have been reported. Pregnancy in the case of failure may be ectopic, pelvic inflammatory disease may occur and the system may perforate the uterine wall. Functional ovarian cysts may develop and individual cases of weight gain, hair loss or greasy hair and hirsutism have been reported. **Medicine Classification:** PRESCRIPTION MEDICINE. **References:** 1. Mirena Data Sheet. Available from Schering (NZ) Limited 0800 80 45 45 or www.medsafe.govt.nz. 2. Coleman M, McCowen L, Fairuhar C. The levonorgestrel-releasing intrauterine device: a wider role than contraception. Aust NZ J Obstet Gynaecol 1997; 37(2): 195-201. Mirena is a registered trademark. Mirena is monitored in the NZ Intensive Medicines Monitoring Programme. Full prescribing information is available from Schering (NZ) Limited, P.O. Box 101 691, NSMC, Auckland, Ull 3223.