



NEW ZEALAND
COLLEGE OF
MIDWIVES (INC)

JOURNAL

Tips on writing for publication

Sarah Stewart

New Zealand Research

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A student perspective

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Raising issues from
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Practice Issue

Vitamin A - when too much
of a good thing isn't

Sandra Elias



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as a normal life event for the majority
of women, and the midwifery profession's
role in effecting this.

Provoke discussion of midwifery issues.

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Introduction

Midwives can be daunted at the thought of writing an article for publication. This article identifies some of the issues to consider when preparing and submitting an article.

Why a midwife will write for publication

There are various reasons why a midwife might write for publication. These include to:

- disseminate research findings, as part of the research process;
- generate new knowledge;
- encourage debate and discussion;
- achieve promotion or pay rise;
- meet employer/institutional requirements for research outputs (van Teijlingen & Hundley, 2002);
- meet professional portfolio requirements for research/scholarly activity as part of Health Practitioners Competence Assurance Act 2003.

Getting started

As with any skill, writing becomes easier the more one does it.

- It is best to write about something one is familiar with, and excited about.
- Start with a short item, such as a letter to the editor or book review.
- Collaborate with a more experienced writer.
- Read articles that have been published to assess the format and style of articles.
- Decide what form the material should take - research report, literature review, discussion, commentary or letter to the editor.
- Know what has been written on the topic by carrying out a literature search.

Choosing a journal

The choice of journal is determined by what the author wants to achieve.

- The journal requirements can be found in the guidelines for contributors, which helps the

writer match the content of the article to the purpose and focus of the journal (van Teijlingen & Hundley, 2002). An article that is a personal clinical commentary is likely to be published in a clinical-focused journal, but it might not be accepted in a research journal.

- Journals generally publish their guidelines for contributors at least annually. The best place to access guidelines is via the publisher's web site.
- If the aim is to reach an international audience, choose a journal that is indexed in electronic databases such as CINAHL, where citations can be accessed from anywhere in the world.
- Think about whether the journal is professionally or academically credible. Midwives who are required to publish as part of their employment and institutional requirements, will choose to publish in academically credible journals. Journals that have a peer review process for potential articles are considered to be more academically credible than those without a review process.
- Journals that have an impact factor are considered by academic institutions to be more academically credible. The impact factor is a measure of the number of times an average article from a journal has been cited in a year (van Teijlingen & Hundley, 2002). *Midwifery*, *Journal of Advanced Nursing (JAN)* and *Nurse Education Today* have designated impact factors, which can be found on the journal web site. The *NZCOM Journal*, *British Journal of Midwifery*, *The Practising Midwife* and *Midwifery Today* do not have impact factors. This may explain why many midwives submit their articles to the *JAN*, rather than midwifery journals.
- Tailor the style of writing to match the journal. The style of writing in an academic research journal such as *Midwifery* is more formal than a clinical practice journal such as *The Practising Midwife* or *Midwifery Today*.
- Consider - "Who is the readership?" Focus the article so that the content is of interest to the target audience (van Teijlingen & Hundley, 2002).
- If there are questions about article content and submission, then contact the designated

receiving editor for advice. The editor's details are usually found in the contributors' guidelines.

Format of an article

Every journal has its requirements for format of a article submitted.

It is best to write about something one is familiar with, and excited about.

- Check the journal's guidelines for contributors for details about format and presentation of an article. Most journals have specific requirements for abstract, subtitles, headings, word count, referencing style and key words.
- Be aware of the journal's copyright requirements, especially when using diagrams, quotations, pictures and photographs.
- Aligning with an institution may increase the possibility of having work published (van Teijlingen & Hundley, 2002). However, be aware of institutional policies such as requiring an in-house review of the article before submission for publication. This is to prevent inferior work being published and reflecting on the institution.

Developing writing style

There are plenty of resources available that will advise writers about writing style such as *'The art of writing for publication'* (Davidson & Lunt, 2000).

- Pay especial attention to grammar, punctuation and spelling. Editors are much more likely to reject a manuscript if it is poorly written, what ever the content (Newell, 2000).
- Be professional in style and tone. Avoid exaggeration and contrived emphasis with exclamation marks and underlining. If writing a research report, acknowledge limitations of one's own research (Daft, 1995).
- Ensure there is a clear progression and integration of ideas from paragraph to paragraph (Wink, 2002).
- Clarify definitions. Do not assume that the reader has the same interpretation as the author.
- If writing a research report, explain design decisions, ethical approval process and provide theory or explanations for the research findings (Daft, 1995).
- Ensure the conclusion is congruent with the body of the article (Daft, 1995).

- Take care that all ideas and words belonging to another writer are properly referenced according to academic convention and particular journal guidelines (Erlen, 2002). Using material that is not one's own without adequate acknowledgement is plagiarism, and is considered to be theft. Where this is identified by a journal, publication may be precluded.
- If co-writing an article, decide who is responsible for particular sections of the article and the order in which authors' names are presented. This is important for midwives working in academic institutions because first authorship is considered desirable for research outputs.
- Ask a critical friend to read drafts for content, structure and relevance of material.
- Ask a colleague or critical friend to proof read the article before submission.
- Check that all citations are in the reference list and that the reference list uses the style required by the journal. Information about the reference styles is usually given in the contributor's guidelines or can be found on the Internet. Commonly used styles are American Psychological Association (APA) (www.apa.org) or Harvard (<http://lisweb.curtin.edu.au/referecing/harvard.html>).

Writing and publishing is time-consuming and challenging, nevertheless it is extremely rewarding to know that a published article has added to the body of publicly available midwifery knowledge.

Submission process

Once the article is written, submit it to the journal utilising the appropriate submission process. The following points provide background on this process.

- Many journals will only accept electronic submissions, therefore become conversant with the Internet and computer.
- Journals generally require that an article is original work and request that it is not submitted to other journals whilst the review process is undertaken. This is to avoid reviewers completing unnecessary work (Erlen, 2002).
- The time from submission to publication can take up to one year or more, and varies from journal to journal.
- After an article has been reviewed, the author is informed of the outcome which is generally: acceptance without amendment; re-submission with amendments; or declined for publication.

- If the reviewing/managing editor asks for the article to be re-submitted, make the effort to carry out the amendments as directed. Use the feedback so that the amended article fits the style of the journal (Newell, 2000). Learn from the feedback.
- If required to make amendments it can be difficult to regard the work in an objective manner, so pause before revising the article. This can facilitate a clearer perspective of the work.
- When resubmitting an article, write a covering letter to the editor that lists amendments made and clarify why any changes requested by the editor are not appropriate. This increases the probability of the paper being accepted (Newell, 2000).
- Do not be deterred from writing if the article is rejected. Submit the article to another journal, or accept it as a learning experience and move on to the next project. Remember that even the most experienced and eminent writers have had their work rejected at some stage.

When an article is published

Authors feel a great sense of pride and achievement when an article is published.

- Be prepared to feel nervous once the article is published because the work is now public and open to both challenge and congratulations.
- Consider reflecting on the process of writing and publishing work, and include this in a professional portfolio.
- Enter details in your curriculum vitae (CV). Details of articles that have been submitted for review, or have been accepted and waiting for publication may also be included in the CV.

Conclusion

Writing and publishing is time-consuming and challenging, nevertheless it is extremely rewarding to know that a published article has added to the body of publicly available midwifery knowledge.



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Barriers and enablers to successful implementation of the midwifery standards review process for district health board-employed midwives

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Abstract

This paper outlines key findings from a clarificative evaluation study undertaken in 2003. The purpose of the evaluation was to provide information that would be useful during the introduction and implementation of the New Zealand College of Midwives' Midwifery Standards Review process for employed midwives in a large metropolitan District Health Board.

Background

There has been an increased emphasis on improving health quality within the New Zealand Health and Disability Services and legislation such as the Health Practitioners' Competence Assurance Act (HPCAA) (2003) is motivating changes in health care provision and quality assurance (Minister of Health, 2003 a&b).

To support midwifery standards and competence, the New Zealand College of Midwives (NZCOM) Midwifery Standards Review Process¹ (MSR) is currently being introduced in many district health boards (DHBs). Implementing MSR for DHB-employed midwives is a significant systems change aimed at meeting the recently legislated healthcare provider competency requirements for improving health outcomes. The health and wellbeing of the 56,500 New Zealand women who annually give birth, and their infants, is highly dependent on the skills and competence of midwives. MSR focuses on the evaluation of midwifery practice to ensure that practitioners are safe, meet standards for practice, and comply with legislative requirements as health professionals. Since this evaluation in one DHB was undertaken the Midwifery Council of New Zealand has sig-

nalled its intention to include NZCOM's MSR as an essential component of its Recertification Programme (Midwifery Council, 2004). In the future all midwives who wish to hold a practising certificate will be required to undertake MSR at least once every three years (Midwifery Council, 2004).

Kwast (1998) suggests that reviews of practice and professional education and training are important determinants of quality in health care and may influence birth outcomes. Research and professional studies of the Midwifery Standards Review process (Barlow, 2001; Pairman & Guilliland, 2001; Skinner, 1998) have provided evidence of its efficacy for evaluating and improving aspects of self-employed midwives' practice and some of the limitations for evaluating midwifery practice within existing DHB policies. The researchers in this study were interested to ascertain the issues relating to the introduction of MSR for DHB-employed midwives.

Ethics

Ethics approval was obtained from the Regional Ethics Committee and from Auckland University of Technology (AUT) Ethics Committee. The Ethical Issues Review Committee and the Clinical Board Executive of the DHB also approved the study.

Evaluation design and methods

Owen and Rogers (1999) suggest that the purpose of clarificative evaluation is to conceptualise and describe the characteristics of a program, provide validation of its quality and assist management. There is a strong formative aspect to this approach. Scriven in 1980 aptly termed formative evaluation as evaluation that "is done to provide feedback to people who are trying to improve something" (cited in Ovreteit, 1992, p.1). The evaluation carried out in this study recognised that MSR was still in an introductory phase for Lead Maternity Carer (LMC)² case-loading team midwives and planned a short time afterwards for implementation with the remaining community and core hospital midwives within the DHB maternity services.

The study identified and considered some of the major issues for implementing MSR that were highlighted through a series of face-to-face interviews with key stakeholders and midwives at the DHB. Documentation that related to MSR and to the existing quality assurance (QA) and Profes-

sional Development Programmes (PDPs) was also considered. Participants included:

- five DHB-employed LMC team midwives and two core midwives
- four managers including the managers of the current QA programmes (nursing and midwifery)
- two group managers for Maori and Pacific Island cultural support teams
- the New Zealand College of Midwives (NZCOM) Midwifery Advisor
- local Midwifery Standards Review Committee coordinator and committee members.

Interviews were transcribed and qualitative content analysis focused on Kurt Lewin's (1890 - 1946) approaches of identifying barriers and enablers to success and/or potential improvement of the review implementation within the DHB organisation. Participants were given their transcripts and an opportunity to review quotations and consent to report material prior to publication.

The midwifery manager specifically requested identification of areas where management support could assist the successful implementation of MSR, and a 'feedback' session with managers and midwives took place with the researchers early in 2004. At this meeting the key findings were discussed and an action plan was developed with staff.

Findings and discussion

Barriers and enablers

Kurt Lewin first proposed during the 1930s-40s his social psychology theory of 'Force Field Analysis', which suggested that patterns of human behaviour either facilitated or created barriers for organisational change. He said it was important to understand the dynamics of change, to ensure that 'restraining' or resisting forces were overcome and 'driving' or enabling forces were strengthened for positive effects (Coghlan & Brannick, 2003; Skymark, 2003). According to Lewin, important steps for achieving change are enlisting key stakeholder support, ensuring their adequate involvement, dissemination of key strategic objectives and benefits of change, working alongside those affected by the change and providing feedback during the process and at completion.

Study participants identified barriers and enablers to the introduction and implementation of MSR for the DHB midwives in the following key areas.

- Organisational culture
- New Zealand Nurses Organisation (NZNO)

- Existing QA programmes and professional development for midwives
- Knowledge about MSR
- Day-to-day planning and implementation of MSR
- Midwifery Standards Review Panel

Organisational culture

...And you see this is about midwifery professional development, and it is about quality. This is professional stuff, this is not a little tick box thing you sit in your room somewhere in the hospital and do. (NZCOM Midwifery Advisor)

Barriers within the organisation meant that midwives in the DHB found the processes of change slow, and there was a feeling that some midwives went with the flow of the organisation, or waited to see what would happen, rather than play a proactive midwifery role. The politics of the organisation meant that not all people were accepting of the need or value of change. There was also uncertainty about the value of MSR and whether or not it would be a compulsory requirement for employees. An important aspect discussed in interviews was the difference between an employer-driven quality assurance process that was mainly concerned with risk management and a reflective professional review that included consumers and focused on professional development. Midwives identified the different purposes of each and the midwives' and employers' responsibilities in each approach. Midwives, for example, were apprehensive about the confidentiality of an internal process but were also anxious as to whether MSR Reviewers (midwives and consumers) would be sympathetic towards core midwives and their practice.

I think it is good to have an outside organisation like the College to do it, it feels less threatening. They have more of a handle on what you actually do, might be able to criticise you a bit more, I don't know, but it is quite nice to have someone from outside doing it, it is less threatening. (Case loading midwife)

Managers could also see some value in external monitoring, in that midwives might be more inclined towards openness if the judgements about practice were not employment related.

Members of the region's Midwifery Standards Review Committee anticipated the impact as the implications of the HPCAA were felt by DHBs across New Zealand.

This step has the potential to cause a revolution in hospitals, especially in the big city and up and down this country. (Committee Consumer)

Overall, participants reported that the establishment of MSR within the organisation's culture required strong midwifery leadership; a clear enunciation of whose or which criteria would be used for making judgements about midwifery practice, and full information about MSR and what it involves.

New Zealand Nursing Organisation (NZNO)

NZNO could be perceived as a barrier to the implementation of MSR if the members' employment contracts do not consider how MSR participation can be supported. An important aspect of the DHB culture was the presence of the NZNO as the main industrial union for nurses and midwives employed in the DHB. NZCOM is the professional organisation for midwives in New Zealand with membership of over 80% of practising midwives. It is not a union but it has been responsible for negotiating the Section 88 payment for LMCs. Some midwives were members only of NZCOM and some were members only of NZNO, with few willing to have the expense of both memberships. There is still confusion for some about the different roles of these organisations. For example, one participant observed that some core midwives had a history of alienation from the College, as, in her view, the midwifery partnership model of practice (Guilliland & Pairman, 1995) appeared to exclude midwives who did not provide continuity of care. It has taken time for the skills and competencies of core midwives to be professionally acknowledged and for core midwives to feel more comfortable about the College. The *Handbook for Practice* (2002) updated the earlier (1993) version partly to address this. Despite NZCOM's greater understanding of and support for the core midwife role as it developed, some midwives in the DHB remained loyal to a seemingly less critical and more industrially active NZNO, and had not affiliated themselves with NZCOM. As one core midwife explained:

... historically because of the fight for midwifery autonomy, the College really had to focus on independent midwives and their role and focus on implementing the model of continuity of care that we have first in Section 51, now Section 88. I think when any organisation focuses on one group, the other group, in this case core midwives, feel second class, feel alienated, feel they don't care about us... And I don't think the problem is so much whether you use (the

existing QA) or Review for many core midwives, it's the involvement of the College in it.

Existing DHB QA programmes and professional development for midwives

Some participants saw NZCOM's association with MSR as a barrier to its introduction. For these participants the midwifery standards had less value as indicators or criteria for practice than the existing QA programme supported by nurses and

NZNO and written into midwives' and nurses' industrial contracts. Some believed that MSR could be added on to the existing programme. For example:

I think it is good to have an outside organisation like the College to do it, it feels less threatening. They have more of a handle on what you actually do, might be able to criticise you a bit more,

I don't know, but it is quite nice to have someone from outside doing it, it is less threatening. (Case loading midwife)

The credentialing programme as we have set it up is educationally sound, our assessment processes are sound, the way we've structured is, quite robust ...My

argument is that the NZCOM standards of practice, and competencies specific to midwives, could be easily incorporated into the programme, thus making the existing programme specific to the needs of midwives. (QA Co-ordinator, Nursing)

The current process in this DHB is based on a nursing model for practice, and appeared to treat nurses and midwives equally but not differently. It also provided financial rewards for 'excellence' and there were comments from midwife participants that changes would be needed to this system.

We've got a model [the existing QA process] that perhaps doesn't really work for us because it is a nursing model. And yes, that we need something that more reflects who we are as midwives My opinion is that it [MSR] fits really nicely, I think the employer needs to get clear that nurses and midwives are not the same breed, that we're a different fruit so to speak. I think the establishment of the Midwifery Council will enable that, just to really help... and more people have recognised that we can't say nurses and also mean midwives as well, that you can't have that conversation. (Core midwife)

At the time this evaluation was being undertaken there were already clear signals for the profession that change was coming. The HPCAA 2003 (still in Bill form at the time) emphasised the importance of evidence of ongoing competence for practice for practitioners and this was identified as an enabler for change. For example:

continued over...

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Midwives will have to demonstrate to the Midwifery Council how they have maintained competency by presenting their portfolio and evidence of Review. The only Review that has been approved to date is New Zealand College of Midwives' Review. (National Midwifery Advisor, NZCOM)

Existing DHB quality assurance processes differ significantly from MSR. For example, most DHB processes do not enable consumer feedback either directly or indirectly. Participants felt generally that meeting specific task competencies was a reasonable employer demand. Some midwives expressed feelings, however, that requirements to participate both in the existing QA programme and MSR would be strongly resisted.

Participants also suggested that the development of the Midwifery Employment Relationship and Advisory Service (MERAS), a recently established midwifery union allied with NZCOM, could draw some midwives away from NZNO. It could facilitate greater interest in MSR; if only for the pragmatic reason that it would help to achieve competence-based practising certificates, necessary for practice following the HPCAA Act. Concern that midwives might join MERAS instead of NZNO might lead to lack of support for MSR by NZNO.

To enable midwives to participate more easily in MSR, midwifery management at the study DHB had agreed to pay MSR fees for the DHB team midwives undertaking their reviews in 2004. Supporters of the existing NZNO-supported QA programme within the organisation might be unhappy with this. Some participants observed that the higher costs for non-NZCOM members could motivate employers to consider alternative review approaches, although it may prove challenging meeting the expected Midwifery Council criteria³.

Knowledge of the review process

I know that it is very complex and convoluted documentation, that's what it looks like to me... I assume it is going to be quite time consuming... I think that we are just continuing to reflect on our practice really, and the fact that they have got consumer people on it as well as professionals I think is going to be really holistic... So whether or not I ever get reviewed I don't know, but I think it will be a positive thing. (Case loading midwife)

So there are quite a lot of midwives in the hospital who are still unaware of the fact that at some point in the future they are going to have to go through the Review Process. Oh yeah, there'd be a lot that would be totally unaware that there is a Review Process go-

ing on now even, let alone that will apply to them in the future. (Core midwife)

The interviews revealed inconsistency in knowledge among the participants. Some midwives articulated MSR clearly and believed that it was a holistic and appropriate model of midwifery practice evaluation that compared favourably with the existing DHB QA programme. They reported that hearing positive comments from others who had been reviewed was encouraging and that they were feeling very positive about being reviewed. Areas that were often unclear included:

- the different nursing and midwifery philosophies that underpinned the existing QA programme and MSR
- the purpose of MSR, how to prepare for a review
- what actually happens at reviews
- the nature of the roles of MSR Panel consumers and midwives
- the requirements of the HPCAA legislation for practice competence certification.

At the time of the interviews (mid 2003) some participants were not aware that the Nursing Council of New Zealand (1999) had already identified MSR as meeting its guidelines for competence-based practising certificates for midwives. It was therefore likely that MSR would receive endorsement from the Midwifery Council of New Zealand⁴ when it released its requirements for competence-based practising certificates under HPCAA.

Clearly, a lack of knowledge hinders the acceptance of any new approach, especially if motivation is needed for participation. A lack of knowledge or misunderstanding about elements of change in an organisation may also bring uncertainty, fear and mistrust, whereas providing knowledge and information about the process can be enabling as it allows for self-control and self-determination (Bolman & Deal, 1997). A number of study participants believed that it could be very helpful to have the national and/or local coordinator of the MSR Panel(s) provide a personal presentation or workshop and answer questions about MSR.

Day-to-day planning and implementation of MSR

Midwives anticipated the impact of implementing MSR within the DHB.

I am really looking forward to it, I think that I'll get a lot out of it, I'm not sure what it will be but that's what reflection is, it is a bit of a journey and I am really looking forward to it. As a matter of fact I have been pleasantly surprised in just collecting the data, I was thinking, oh groan, it's going to be a bit

of a hassle collecting all this data, but now that I've collected a lot of it, I can look at my data sheet and say oh gosh, just by looking I can see trends, ethnicity, gravity, how many births I'm actually there for and how many my backup actually does, those simple sorts of things are obvious at a glance. And so I am really looking forward to deeper reflection of my practice. (Case loading midwife)

I think it is going to be a slow process because it is always hard when you get down to the core midwives of how do they provide the evidence that supports the written stuff around the standards. (Core midwife)

Considerable DHB management restructuring at the beginning of 2003 slowed the process of MSR implementation and the delay in the HPCAA during 2003 removed the immediate urgency for compliance. This was a barrier to the introduction of MSR as it removed a need for immediate action while clouding some staff perceptions of MSR and the future quality assurance programme for the maternity services. Some midwives reported that the working party planning for quality assurance and MSR participation of DHB midwives consisted of NZNO members and this had a potential for hindering the introduction of MSR. The midwifery QA Coordinator had substituted the midwifery standards for practice into the reflections component of the existing QA programme and reported that midwives generally responded well to this move towards using MSR tools.

Enabling approaches for introducing MSR suggested by core midwives were consistent with change theory, namely that it was good to have Charge Midwives well informed about MSR. It was good to start at "grass roots" level in familiar safe ground such as the tearooms and on the wards, so that staff discussed and became familiar with the concepts, finding them less threatening. It was felt that any working party around MSR was more likely to promote MSR for hospital midwives if the members had a strong midwifery commitment and some familiarity with the process and its values.

Within DHB management was a positive commitment to professional development funding. Despite financial support, some midwives experienced general difficulties with the quality assurance aspects of preparing for MSR, including cost, time and energy to complete requirements. Midwives also had concerns about the limitations and relevance of medical databases for midwifery practitioners, the methods for collection of midwifery maternal and infant birth outcome data as well as the issues of individual's accountability using group or team statistics. Midwifery management

was developing an Excel spreadsheet for recording birth outcomes statistics on the DHB intranet and for downloading as hard copy that would be helpful, ease the recording tasks and enable reliable and valid records to be available. Administrative assistance was also provided for mailing out feedback/evaluation forms to women.

An 'expert' Pasifika participant suggested that it was important to recognise the differences amongst Pasifika groups. This person believed that culture and ethnicity could affect midwifery practice and outcomes, how midwives and women perceived choice and informed decision-making, women's satisfaction with care and the nature of responses to maternal satisfaction surveys. Therefore, some approaches for Pacific Island women could be explored with local and national MSR committees to ensure individualised and accurate responses from Pasifika consumers.

Midwifery Standards Review panel

The nature and number of midwifery and consumer representatives on MSR panels was concerning for the region's MSR Coordinator. She reported difficulties identifying and recruiting representatives from Māori and Pacific Island organisations. The Māori Health Group Manager at the DHB viewed as essential the need for all panel members to keep informed about Tikanga Maori. Whilst acknowledging the issue, the priority for the NZCOM and Review coordinators and panels was adaptation of the process for core midwifery practice.

The Regional coordinator noted that few core midwives in the region had been reviewed and anticipated that the introduction of the HPCA Act would see a dramatic rise in the numbers of midwives wishing to be reviewed. She thought the voluntary nature of the panel membership could become a barrier to the process. It was likely that payments for panel members would be introduced and MSR costs re-assessed, which would impact on DHB midwives. To facilitate a smooth transition from MSR focused primarily for self-employed midwives to one that included DHB-employed midwives, the number of midwives applying to be reviewed would need to increase slowly. In addition early planning and co-operation between DHBs and MSR Panels could enable a larger panel pool to be prepared and resourced.

Implications for midwifery practice

Managers specifically asked for information on existing and potential areas of support for MSR within the maternity services, and three main factors were identified when the evaluation report

was discussed with managers and midwives in a group meeting.

Managers agreed to develop their ongoing communications/relationships with Midwifery Council and national and local NZCOM Midwifery Standards Review coordinators. The implementation committee had already made arrangements for the National NZCOM Midwifery Standards Review Coordinator to conduct a workshop for the team LMC midwives. Managers agreed to arrange cover so that all midwives preparing for MSR could attend the workshop. This would enable clarification of MSR including data collection methods. The NZCOM *Handbook for Practice* (2002) would be purchased for the midwives and payments with NZCOM national office (Christchurch) confirmed so that midwives could receive their MSR information packs and begin MSR preparation. Information about MSR would also be available for all new staff (especially midwives from overseas).

It was decided that managers and midwives could examine some of the opportunities for new contractual arrangements with MERAS, and consider the streamlining of QA processes to ensure that midwives were not overburdened. Managers observed that NZCOM was exploring a 'Professional Recognition Programme' (PRP) for midwives that would assist to standardise the assessment of midwifery practice across different locations and employment contexts within New Zealand. A staff member undertook to attend national PRP workshops and report back to staff. It was deemed likely NZCOM developments relating to midwifery scope of practice, competencies and standards would support the implementation of MSR within DHBs.

A concern for peer support and mentoring in MSR participation was acknowledged and the QA manager offered to be available for reflective discussion about the midwifery standards of practice. There was a suggestion to include MSR topics in study days, as this would give attention to MSR and value those elements of practice and professional development as much as other clinical content. Staff also wanted time to complete MSR requirements and a suggestion was made to use a day currently allocated for the existing QA programme. Managers agreed to continue to sup-

port the QA/Review working group and to facilitate communication between the group and midwifery staff.

Support for MSR data collection would continue and managers would investigate means of making the statistics recording efficient and effective. Midwives wanted the Excel spreadsheet to be easily accessible and useable in hard copy. It was noted at the meeting that access to client records for MSR

purposes could be difficult at times, and MSR Panels would also need to recognise the differences in obtaining case records within a hospital organisation compared with self-employment where midwives held their own case-notes. It was also suggested that midwifery management liaise with different cultural groups and NZCOM to ensure consumer feedback

was obtained appropriately.

Conclusion

A clarificative evaluation considered the introduction of MSR for a group of midwives in a major city DHB during 2003, in order to provide information that would be useful during the wider implementation of MSR.

Midwives, managers and other key participants highlighted major issues within the areas of organisational culture, NZNO presence, existing quality assurance and professional development programmes, knowledge of MSR, day-to-day planning and implementation, and issues relating to the Regional MSR Panel. Based on Kurt Lewin's theory of change, a number of barriers and enablers were identified in participant interviews, and participants provided a number of suggestions for supporting the process such as dialogue, enlisting key people, beginning at a ground level, providing management support, professional study days, and strategic planning. The full report provides a deeper analysis of the evaluation findings.

Although the study concerns only one DHB, there may be similar issues within other DHB contexts. The small number of participants is a limitation of the study and further studies could engage wider perspectives particularly those of core midwives. The issues of MSR for Māori were not explored or evaluated and warrant attention, particularly by Māori midwifery researchers as approaches to

continued over...

Barriers and enablers to successful implementation of the midwifery standards review process for district health board-employed midwives

quality assurance and professional development could perceive these differently.

Despite many obstacles and barriers, within the DHB organisation there were a number of very enthusiastic supporters of MSR and this group keenly held a midwifery philosophy. It is likely that if these sources are tapped and with management support of the 'enablers' identified in the evaluation there will be the momentum for change.

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Whilst published in the NZCOM journal the content of the article is part of a larger report at the Centre for Midwifery and Women's Health, Auckland University of Technology. For those interested please contact authors or midwifery.research@aut.ac.nz.

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- MSR is a national review process co-ordinated by NZCOM. Currently it is a voluntary process, mostly undertaken by self-employed midwives, but increasingly by employed core midwives. Midwives undergoing review present their annual practice to a trained review panel of two peers and two consumers. During the review the midwife reflects on her outcome statistics, consumer feedback, measurement against the 10 NZCOM Standards for Midwifery Practice and with the reviewers develops a Professional Development Plan for the forthcoming year. MSR is intended to improve midwifery practice.
- Lead Maternity Carer: The general practitioner, midwife or obstetric specialist who has been selected by the woman to co-ordinate and provide comprehensive maternity care, including the management of labour and birth (Report on Maternity 2000 & 2001, MOH, 2003).
- Note that the Midwifery Council Recertification Policy states that the fee for NZCOM's MSR has been set at the same level for both members and non-members of NZCOM and is subsidised by the Midwifery Council. Further subsidies may be made by DHBs or NZCOM but the fee is now significantly lower than that being charged when this study was undertaken.
- The Midwifery Council of New Zealand was established under HPCAA in December 2003. It took over regulatory responsibility for midwives from the Nursing Council in September 2004.

Comment from Sally Pairman, Chair of the Midwifery Council and member of the Editorial Board

Since this study was undertaken the Midwifery Council of New Zealand has released its requirements for midwives to demonstrate ongoing competence to practise through participation in the Midwifery Council's Recertification Programme. One component of this programme is that all midwives (core and case loading) will be reviewed through the New Zealand College of Midwives Midwifery Standards Review Process at least once every three years. Details about the recertification requirements for midwives can be downloaded from the Midwifery Council website www.midwiferycouncil.org.nz. NZCOM and the Midwifery Council have already addressed some of the concerns raised by midwives and panel members in this study in relation to fees and resourcing of MSR.

This article provides timely information for DHBs who will be looking at ways to facilitate access to MSR for their employed midwives. The Midwifery Council is encouraging DHBs to incorporate its recertification requirements into their other quality assurance mechanisms so that midwives can complete a single set of requirements for two purposes. This article provides some useful strategies for DHBs to consider in this process.

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Defining normal birth: A student perspective

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Abstract

This study sought midwifery students' definitions of normal birth and recorded their observations of "how midwives practice" in keeping birth 'normal'. As a component of the wider study, this paper reports only on students' definitions of normal birth. Data was gained from a series of focus group interviews and descriptive content analysis was applied to the transcripts. Students uncovered an understanding of the complexity of the socio political influences that inform the defining process. Their definition of 'normal birth' may be considered 'ideal' against an observed reality, where the definition of 'normal birth' is influenced by who defines 'normal' and what counts as intervention.

Introduction

As a part of the Bachelor in Health Science (Midwifery) students undertake a normal childbirth paper. During the clinical component, students work alongside midwives who, in a climate of growing interventions, are facing the challenge of keeping birth normal. To date, the student perspective of normal birth, their experiences of midwifery practice and observation of how midwives

keep birth normal have not been studied. This study reports the first part of an ongoing longitudinal study which aims to explore issues of keeping birth normal with student midwives and new graduate midwives in order to inform our educational programme which aims to safeguard the midwife's role as the 'guardian of normal childbirth'.

The New Zealand College of Midwives Handbook for Practice (2002) states, "the midwife promotes and supports the normal childbirth process" (p. 4). As the number of normal births decrease and intervention rates increase, keeping birth 'normal' in midwifery practice provides a real challenge, especially in a climate of habitual intervention (Surtees, 2004).

Evidence of the trend away from 'normal birth' is found in recent maternity statistics. The New Zealand trend is not dissimilar to other countries in the western world (NHS, 2004). In New Zealand, the caesarean section rate has increased from 11.7% of all births in 1988 to 22.7% in 2002 (Ministry of Health [MoH], 2004). Forceps and vacuum extraction rates sit at around 10% (MoH, 2004). The remaining 67% of New Zealand mothers had what is described in the MoH (2004), 2002 *Report on Maternity* as a 'normal vaginal birth'. Interventions such as the induction of labour and epidural anaesthesia are also increasingly common, with 20% of women having their labour induced and 25% having an epidural anaesthetic (MoH, 2004).

Students are confronted by a range of midwifery and obstetric research literature and textbooks, which variably define normal birth (Lee, 1999; Gould, 2000; Page, 2000; Stables, 1999; Sweet, 1997). Page (2000) acknowledges that defining normal can be problematic, and highlights two principal considerations to guide the definition of normal birth and practice. These principles are that intervention should only be used if there is clear evidence of clinical indicators, adequate support and informed consent in regards to the intervention. Gould (2000) asserts that midwives' failure to define normality in practice has allowed increasing interventions into the normal physiological process of birth.

Research Design

Two research officers who were not known to the students invited all final year midwifery students to join a focus group. Of thirty six possible par-

ticipants, eleven accepted the invitation to join a focus group, thus forming a self-selected sample of midwifery students consisting of both third year direct entry and registered nurse to midwifery students. Four focus groups were arranged at different locations and times in the Auckland region to try to accommodate as many students as possible. The voices of students were tape-recorded and transcribed, protecting the students' anonymity. Ethical approval for this study was granted by Auckland University of Technology Ethics Committee.

Findings and Discussion

Student definitions of normal birth

One of the key questions asked of students was how they would define normal birth. Most of the students considered the 'ideal' definition of normal as spontaneous vaginal birth with no pharmacological interference, or no intervention at all.

Normal is where labour is left to unfold on its own with no interference, not even the interference of the midwife.

Normal is where labour is left to unfold on its own with no interference, not even the interference of the midwife.

This ideal definition fits with some textbook definitions, for example Lee's (1999) definition of a normal labour and birth, which is taken to mean a physiological labour and a vaginal birth with little or no external intervention. One student recalled her nursing education definition as the ground from which she learnt to define normal.

As a student nurse, they told us it was after 37 completed weeks and a spontaneous onset of labour and delivery within 24 hours of established labour with an intact perineum, and no pain relief. Very few people actually have normal birth I suppose.

This student went on to discuss the influence of midwifery education on her understanding of normal birth and distinguished between her nursing experience and her understanding of what distinguishes a midwifery perspective.

You see when I was a student nurse we did obstetrics, and hardly ever saw a woman having a normal birth. Because of a nursing background you assume a nursing situation where people are acutely ill... and you don't have to assume that in midwifery.

continued over...

Defining normal birth: A student perspective

Students identified several influences on both their understanding and description of normal. These include:

1. what counts as intervention;
2. the role of the midwife and documentation; and
3. the role of women and cultural/social expectations.

Interventions - what counts?

Students' experiences of clinical practice and their observation of how both women and midwives define normal, tended to shift their view from the ideal to the pragmatic. They said that in practice 'normal birth' is used synonymously with 'spontaneous vaginal delivery.'

I mean obviously the ideal is without any pharmacological interference of any sort, but that is not to say that when we have a woman who does have two shots of Pethidine, or whatever, in her labour and still goes on and has a fairly nice normal vaginal delivery, that that is not normal either.

This fits with Murphy-Lawless (1998) who suggests that as long as the actual moment of expulsion of the baby is unaided, from an obstetric perspective, the actual birth of the baby is considered 'normal.' Crabtree (2002) agrees when she states that "in common practice 'normal birth' is also used to describe a vaginal birth, which may have included a wide variety of pharmacological, technological or surgical interventions" (p.11).

Most of the student participants felt it questionable that birth could be defined as normal if the birth involved such interventions as epidural and syntocinon augmentation. They found however, that midwives and women might still define the birth as normal despite various levels of interventions.

I would like to think of normal birth as being something that is far more often seen in places like [birthing units] where the option of having an epidural, that sort of intervention, is not available.

In my observation, epidural and 'synto' is classed as normal, which I don't know, I personally would not class epidural and 'synto' as a normal birth.

I think as long as you deliver vaginally, it does not matter what help you had to get there, it is classed as a normal delivery now.

In one focus group, discussion turned to the use of 'natural' substances which might be used in labour, such as homeopathy or aromatherapy, and whether these could also be seen as interventions in the normal process. Students distinguished between natural intervention and medical intervention.

What I count as normal things, are things that do not dramatically affect the baby, or which may help the mother to cope, they are interventions but not a medical intervention.

Participants from this focus group concluded that if women use complementary therapies in everyday life then it would follow as 'normal' for her to use them in labour.

...you might use homeopathy in everyday life, you might use aromatherapy in everyday life, and you might use water in everyday life as a form of relaxation... but you wouldn't use an epidural, you wouldn't use synto, and you possibly wouldn't use forceps or a ventouse, or an episiotomy!

Exactly, and you wouldn't climb into a bed with a CTG monitor, and say don't you move it. I think that is a good definition actually, what you can use in everyday life.

The role of the midwife and documenting birth

An important consideration in the framing of the students' definitions of normal childbirth was the midwives' influence. What the students saw in practice was often quite different from their previous beliefs.

Since I have done my training I probably think differently about normal childbirth now than how I felt as a consumer and a mother.

You try to hold on to the normal but what one midwife thinks is normal is quite different from the other ones, and so it is quite difficult.

Gould (2000) asserts that defining normal birth is crucial to sustaining quality midwifery care. Page (2000) also agrees that there has never been a "greater need for midwives to protect and support normal processes" (p.105). However, it appears that midwives themselves remain unclear about specific definitions and boundaries of the normal process (Downe, 2001; Gould, 2000; Sandall, 2004). Student participants also identified and commented on this with particular reference to the differences between what happened and what

was recorded in the clinical notes.

Well at a booking when they go over perhaps a previous delivery, it is written down as a normal vaginal delivery even if it has been an augmented induction of labour, that is still put down, normal delivery.

But it doesn't say that there was an epidural, or pethidine or synto or whatever. It says NVD, normal vaginal delivery, often and they might put those extra things as an added, but they will still put NVD. It definitely depends on the midwife like as you say about the woman's definition of it too.

These observations, made by the students, highlight for midwives how they can conspire to alter the definition of 'normality' in birth. Weston (2001) in her article on the midwife practitioner's view on normal childbirth agrees that students or others reading the clinical notes often do not get the full story. We have a tendency to reduce the wonder of birth to a purely clinical version. She suggests that women should be encouraged to write their own versions or recollections of their birth experience and for these to be included in the clinical records.

Gould (2000) suggests that it is the pervading medical culture that has created the paradox "where midwives may believe natural childbirth to be normal but do not really believe that normal childbirth has to be natural" (p.420). Downe (2001) agrees by suggesting that midwives are often the brokers of the common medical interventions and goes on to ask the question "are midwives still the guardians of the normal?" (p.11).

The role of women and cultural/social expectations

Some students felt strongly that it is the woman who defines what normal birth is in relation to her experience.

One student stated:

For the woman normal birth is what she deems to be normal.

Another student stated:

In my first year I naively commented that normal birth was where a woman stayed at home and does all the things she wanted to do. Half the class and the lecturers disagreed and claimed that normal birth is what the woman says is normal.

The students illustrated this defining of normal birth by women by presenting two stories in which the women talk about their births.

Just last week a woman I was caring for was having to be induced for IUGR and decreased movements, and she wanted a normal delivery. She was induced and had an epidural, and delivered about three hours later and she thought she had had this wonderful normal delivery, and that it all went really well.

This woman planned a home birth and then had cholestasis in pregnancy and had to be induced early. She had a normal vaginal delivery and did not have an epidural or anything like that. It was just she had been induced and she had planned a home birth. She saw what happened as a terrible event and it was nothing like she had planned. For her it was not normal at all and of course it wasn't.

In these stories, students capture the complexity of the notion of "normal birth" from the women's perspectives. On one hand an induction and epidural is claimed as a "wonderful normal delivery" and on the other hand an induction is claimed to be a "terrible event". These stories make it clear that the notion of 'normal birth' may indeed be that which individual women deem it to be. The question such a claim raises is where does the "notion of normal birth" come from for each of these women? Beech (1999) claims that 'normal' has been interpreted to mean that which is the most common experience of women at any given time.

Surtees (2004) supports this in her exploration of the notion of 'normal' in relation to women choosing epidurals and she suggests that for many women 'normality' is about choosing an epidural because it is so available and commonplace.

Who defines 'normality' in childbirth?

Davies (1996) suggests that "until we address the question of what constitutes 'normality' we will only be paying lip service to the ideal of being 'women centred'" (p.286). If, as the students suggest individual women should define normality, then a single definition of 'normal birth' seems unlikely. Rather it would appear that if normal birth were what a woman deems to be normal then this notion would have multiple meanings. Beech (1999) claims that such meanings cannot be seen as a fixed concept but rather have to be viewed and acknowledged as historically, socially and culturally defined. In this instance the notion of 'normal birth'

would be defined by the historical, social and cultural influences of women's choice and women centred care.

Students in one of the focus groups concluded that women and midwives have been so influenced by society, obstetrics and culture that the definition of what was normal in childbirth had become ambiguous. This group suggested that normal birth ought to be redefined and renamed as 'physiological birth'.

Normal birth is a culturally defined thing ...whereas physiological is just what birth is.

Birth left to unfold on its own, that is what we really call physiological birth as opposed to normal birth.

As Walsh (2002) points out, "[Normal vaginal delivery] is an intensely political phrase [it is a] long way from a beautiful life-affirming birth experience that leaves you in awe of a woman's courage and strength" (p.12). The question raised by this study is why we are even striving to define 'normality'. As one student put it;

Normal in some ways trivialises the whole experience for the woman, it is astronomically abnormal for her... giving birth is a major, don't call her normal.

Conclusions

This study illustrated that although students held that the ideal definition of normal was labour and birth as a completely physiological process with no interference whatsoever, what they see in practice is that definitions of normal birth can include a wide range of interventions. Students identified that midwives, women and culture influenced the definition of normal birth. The question has also been raised, of not only what constitutes normal, but also who defines it, and for what purpose?

What is normal birth, who defines it and why define it? This study has uncovered more questions than answers, but it is clear that students are very aware of the issues around the concept of 'normality' in childbirth. As educators we need to discuss and debate these issues with students. This will ensure that as new midwives they constantly review and challenge the assumptions and beliefs around what constitutes "normality" in childbirth.

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Evidence based health care: Raising issues from a midwifery perspective

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Abstract

This paper explores the evidence based health care movement and its implications for midwifery practice. While it is acknowledged that understanding and utilising research evidence is an important skill for midwives, this is not without its difficulties or issues. Further, the woman midwife relationship and the role of evidence in informing decision-making is explored. It is suggested that both partners have important responsibilities in the relationship and that evidence is one of many factors that influences decision-making. This paper also explores the availability of useful research evidence for midwifery practice, suggesting that available research evidence does not always answer the sort of questions midwives or women have about care. It is therefore important that midwives become active in contributing to the body of knowledge and evidence in our discipline and that we do this in collaboration with the consumers of our service.

Introduction

Throughout history, health care practices have been based on many factors including; custom, habit, observation, trial and error, ritual and expert authority, to name just a few. It is only in more recent times that the concept of evidence based health care has emerged (Chalmers, 1991).

Not only has the evidence based health care movement (beginning with evidence based medicine), gained momentum in the western world but increasingly, midwives and other health care practitioners are required to demonstrate accountability for their practice. Along with this, consumers are approaching health care in new ways; as consumers rather than patients. The term "patient" implies a passive role in health care whereas "consumer" indicates that health care is perceived as a

service, similar to other services we consume. As consumers, individuals become active participants in decision-making processes and with this comes the demand for knowledge on which to base their decisions for health care.

As the cost of health care technology spirals (Slocum, 2004), those funding and managing health care are also demanding clear evidence as to the value of interventions and technologies. Using evidence to inform decision-making has therefore become important for consumers, those involved in management and policy decisions, and for all health care practitioners.

In New Zealand, the midwife's role in maternity services has changed dramatically since 1990 and this has had a major impact on the ways midwives work with women to make decisions concerning their care in childbirth. Prior to 1990 midwives had predominantly been employees of hospitals, working within a fragmented system of care where they were involved in a woman's experience during a rostered shift, often in only one area of practice (Donley, 1998). Many hospitals also dictated strict routines and as employees of the hospital, midwives were expected to follow these rather than work with women to make individualised care decisions. The responsibility for the woman's care rested with a medical practitioner as midwives were prevented by law, from taking this responsibility. So, the midwife's role in decision-making was limited in many respects. Midwives were constrained by their fragmented contact with women in childbirth, their status as employees and their inability to take full responsibility for a woman's care.

The 1990 amendment to the Nurses Act (1977) opened the way for midwives in New Zealand to work with women in new ways. Midwives no longer had to be employed by hospitals and were not necessarily bound by practices or routines that were part of the hospital system. However, with autonomy came responsibility and accountability. In this new climate, accountability for maternity services rests with the individual midwife who assumes responsibility for the care of women in childbirth. Many provide continuity of care so that they have an opportunity to get to know and work with the women in their care over a period of time. Since 1990, New Zealand has experienced a growing understanding of the role and responsibility of the independent midwife, whether employed or self employed. The profession has set about recreating itself and working with women to de-

velop relationships and ways of working together that are based on respect and equality rather than the power of authority (Guilliland & Pairman, 1995).

This effort to develop new ways of working with consumers of health care is not unique to midwifery as the paternalistic approach to health care has been challenged on many fronts (Charles, Whelan, & Gafni, 1999). Yet, midwives and women are blazing a new trail in many respects and this journey has not been an easy one; nor is it finished by any means. Part of this journey has been exploring what evidence-based health care means in practice and how evidence can inform decision making in maternity care. This article explores some of the critical issues as I see them, from a midwifery perspective.

The ethics of evidence based health care

Over the last eighty years childbirth has become highly medicalised in most western countries and during this medicalisation process women have a history of being "done to". In the name of medical science women have been; exposed, shaved, swabbed, draped, examined, strapped down, silenced, cut and drugged. Many of these interventions have amounted to no more than medical experimentation and some practices have been demonstrated subsequently, to be unnecessary or harmful to women or their babies (Donley, 1998).

As Bunkle (1998, p. 240) states,

Scientific medicine was promoted as a source of unquestionable authority and used to justify sexist put-downs of women who sought information about themselves or control of their own choices.

The inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital (Cartwright, 1988), highlighted issues arising from the authority of the medical profession, relating to issues such as informed choice and consent in health care treatment, or participation in medical experiments. The ensuing inquiry into the treatment of women by Dr Green at Auckland Women's Hospital, the Cartwright Inquiry (1988), resulted in a number of recommendations aimed at addressing some of these issues and included; the establishment of a Health and Disability Commissioner and the introduction of the Code of Health and Disability Consumer's Rights. In 1996 the Code of Health and Disability Consumer's Rights became law in New Zealand providing consumers of health care with rights to; respect and privacy, fair treatment, dignity and independence,

proper standards of care, effective communication, information on which to base choices, the ability to make their own decisions, the right to support, to decide whether to participate in teaching or research, plus the right to complain (Health & Disability Commissioner, n.d.). Not only do we now have a legislative framework for the protection of consumer rights in health care but also for many, health care has come to be seen as a service or product like any other. This is something they will make choices about and have control over rather than something to which they should gratefully submit.

We are working in an environment where law protects consumer rights and many are choosing to become actively involved in decision-making concerning their care. As practitioners, accountability for practice is foremost in our minds. To address these issues it is important that we become skilled in locating and appraising evidence and use this knowledge to inform decision making in practice. This is not without difficulty and the following paragraphs explore some of the issues which can arise when we set out to use an evidence based approach in practice.

The politics of practice and evidence

In the area of maternity care it was Archie Cochrane who asserted that the field of obstetrics should be awarded the "wooden spoon" for failing to take the opportunity to evaluate one of the most significant of maternity interventions in the history of maternity care, this being the movement of women from home to hospital for the event of childbirth (Cochrane, 1979 cited in Enkin, 1996). Like many interventions since, this practice gained momentum without ever demonstrating that it was an effective, safe, useful or importantly, harmless thing to do. Sadly, there are too many interventions in maternity care that have been enthusiastically supported only to discover later that they have been devastatingly harmful to women or their babies.

In 1991 Smith estimated that as little as twelve percent of medical interventions were based on evidence of their effectiveness. It is interesting to ponder the powerful forces, both social and political, that have allowed those practices (whose effectiveness or safety has never been established), to become commonplace in maternity care. So commonplace in fact, that some seem to have become a firmly established cornerstone of maternity care; routine ultrasound for normal pregnancy being a case in point. The routine use of continuous electronic fetal monitoring in labour is another example of a technology that has gained widespread support in practice without ever es-

tablishing its effectiveness. In fact, research points to negative consequences as it has been associated with increased rates of caesarean section without any increase in improved outcome for the baby (Kaczorowski, Levitt, Hanvey, Avar, & Chance, 1998). In an article drawing out the lessons to be learned from the example of the increasingly widespread use of electronic fetal monitoring in labour, Thacker (1997, p. 58) comments, *"Adequate assessments with randomised controlled clinical trials rarely precede the widespread diffusion of a technology."*

Clearly, the availability of evidence is not the only factor influencing practice. So what are these other forces that help shape practice in any discipline? In describing some of the factors that influence a practitioner's decision to intervene in a pregnancy or childbirth for example, Chalmers (1991) includes such things as tradition, fashion, the need to use equipment, fear of litigation and commercial interests. Very often, availability of clear evidence for the effectiveness of an intervention is lacking.

These same factors along with other social and political forces allow certain practices and interventions to continue long after research has clearly demonstrated them to be ineffective. Researchers in Canada for example (Kaczorowski et al., 1998) surveyed all hospitals providing maternity services in that country with the aim of describing the routine use of procedures and technologies in maternity care and determining whether this was consistent with existing evidence. They found a prevalence for practices not supported by evidence and that a hospital's size, geographical location and affiliation with a university led to greater routine use of procedures and technologies that were not supported by current evidence. They concluded that the use of some of these procedures and technologies (including perineal shaving, administration of enemas, episiotomy and use of cardiotocographic [CTG] machines) were based on habit rather than existing evidence which clearly demonstrates them to be ineffective at best and even harmful at times. For example routine use of CTG leading to an increased rate of caesarean section (Kaczorowski et al., 1998). The authors commented that they felt discouraged by their findings because evidence against the routine use of some of the procedures studied had been around for considerable time. For example, evidence against the routine use of perineal shaving had been in existence for at least 75 years (Kaczorowski et al., 1998).

Clearly evidence is not the only factor shaping midwifery and obstetric practice and this raises important issues for understanding how change can be brought about in maternity care.

In search of the question

I was recently working with a group of midwives in a postgraduate programme. The class was attempting to assist a fellow student to develop a

searchable question arising from a clinical situation she had experienced using the evidence based practice framework developed by Sackett, Straus, Richardson, Rosenberg & Haynes (2000). In this situation a woman was having her first baby and

had been in labour for some time. Both mother and baby were well but the woman's cervix had not dilated beyond six centimetres for quite a few hours. Her progress had been charted on a partogram - a tool used in obstetrics to provide a visual representation of progress in labour which includes cervical dilation and fetal descent along a graph of hourly intervals. The partogram was developed by Phillpott and Castle (1972, cited in Walsh, 2000) using the earlier work of Friedman (1954, cited in Walsh, 2000), who determined that a normal rate of progress for someone having their first baby was cervical dilation at the rate of one centimetre per hour (Buchmann, Gulmezoglu & Nikodem, 1999).

Clearly the woman in the above scenario was not progressing normally according to this definition. A definition of normal that has become a firmly established convention in the medical fraternity (Beischer & Mackay, 1986; Llewellyn-Jones, 1990). A common obstetric practice in this sort of situation would be to augment this labour, with an intravenous infusion of Syntocinon. The introduction of this intervention carries certain risks and potential sequelae. These include the potential for fetal distress and uterine hyper-stimulation (Arulkumaran, 1994) requiring continuous monitoring with a CTG monitor. Augmented or induced labours may be more painful than natural labours (Thorpe & Breedlove, 1996) and this increases the likelihood of epidural anaesthesia (introducing another host of risks and potential complications). These interventions may require transfer to a different hospital if this was a rural or primary birthing unit (perhaps disrupting the support network of the woman), and the introduction of new health care providers as obstetricians become involved in the "case". Inevitably, this in-

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intervention radically changes the quality of the experience for the woman as well as her own perceptions of the efficiency and adequacy of her body in birthing this baby. From both quantitative and qualitative perspectives, it is obvious that this clinical situation is multifaceted. We make it complex because we apprehend the situation in its entirety; with all its shades of grey, its potential consequences, its twists and turns, its layers and possibilities and "what ifs".

We make it complex because we apprehend the situation in its entirety; with all its shades of grey, its potential consequences, its twists and turns, its layers and possibilities and "what ifs".

Midwives approach the woman and childbirth in a holistic way. We attempt to get to know the woman not just as a vessel in which a fetus grows or a vehicle through which it will pass in childbirth, but as a human being with unique needs and desires. A woman in childbirth may also be a daughter, a partner, or a mother. She is someone who is embedded in a cultural and social context with values, beliefs and needs relating to childbirth that extend beyond the outcome of a "live birth".

So where do we start in gathering evidence that informs our decision making for situations like this? Do we focus on the value of partograms, the assumption that progress at one centimetre cervical dilatation per hour is normal, the effects of augmentation of labour, the experience of augmentation of labour, the experience of transfer from primary to secondary setting in labour, or the likelihood of further interventions becoming necessary once labour is interfered with? Clearly all these factors will contribute to decision making to some degree. And this is of course the art of what we do. Yet we can usually only set about finding the evidence for one facet of the scenario at a time and to do this we do need to narrow our focus, (hone in on just one aspect) and this can feel very unsatisfactory.

We need to focus our attention on one aspect of the scenario and develop a focused, searchable question. From there, we set about finding the available research evidence on that clinical issue. In narrowing our focus we lose some of the richness and complexity of the real life situation (that gave rise to the question in the first place) but in finding a focus we create an opportunity for locating evidence and informing our practice. As I discuss later in this paper, the evidence informed practice process (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996) does not end with the identification of the evidence on any particular issue. We do return to a real woman with a real, complex and unique clinical situation and

use that evidence to inform (not dictate) joint decision making.

This is not to imply that we must gather evidence on every aspect of our discipline one by one. It would be impossible as a practitioner to remain up to date with every published research report on every topic relating to maternity care. The re-

sponsibility to ascertain and appraise the evidence on maternity care cannot fall to each individual in practice alone but must be a collective effort. This raises issues with reliance on the interpretation and appraisal of evidence by others, even when protocols for this are clearly articulated as in the Cochrane Collaboration (The Cochrane Collaboration, 2004). Nevertheless, with a critical eye open we must take every opportunity to network and share knowledge and information through such media as journals, discussion groups, and collaborations such as the Cochrane Collaboration and the New Zealand Guidelines Group. Both the Cochrane Collaboration and the New Zealand Guidelines Group encourage collaboration between consumers and various health and research professionals. The latter aiming to educate consumers and health professionals in the development of evidence based, best practice guidelines (The New Zealand Guidelines Group, 2004).

In search of the evidence

So, having narrowed our focus to just a fragment of the whole in order to develop a searchable question using the evidence based practice framework, we set out to find the evidence. However what I commonly find as a midwife is that the research that has been conducted is not answering the type of questions that I am asking. The following scenario will illustrate my point.

At a seminar I attended on the clinical use of epidural anaesthesia in obstetrics, an anaesthetist conducting the presentation described the procedure, its uses and some of the associated problems. These included the fact that the drugs injected into the epidural space affected not only pain but also motor impulses. For women in labour this meant that not only was the reception of pain interfered with but also the ability to use muscles was lost from the waist down. This meant of course, that women couldn't mobilise during labour and had to lie on a bed. The upright position and mobility that aided progress in labour was absent and the muscles that help facilitate the physiological processes of birth were rendered in-

ert. If having an epidural meant exposing women to certain risks and potential problems with the processes of birth then the sort of questions I was formulating as I sat in the audience, were along the lines of; "in what ways can we support women in childbirth so that they don't choose to have an epidural in the first place and expose themselves to the risks and problems associated with them?" This wasn't the sort of question that the anaesthetist was asking. He went on to describe a research proposal for a new type of drug that could be used in epidurals that would minimise the effect of the motor blockade. This is not to say that this wouldn't have been a useful piece of research but illustrates that certain disciplines may approach a subject from quite different perspectives.

This example raises issues concerning the politics and practice of research. Where researchers from within a particular discipline (medicine for example) are conducting the majority of the research in a field, we find that the topics being researched and the kind of questions being answered, are not those that we are necessarily asking. The Term Breech Trial (Hannah, Hannah, Hewson, Hodnett, Saigal, & Willan, 2000) is a prime example. My reading of this research suggests that it was a trial comparing a medically managed vaginal breech birth with caesarean section. As large multi centre trials go, this was a robust piece of research and certainly something that cannot be ignored. As a midwife however, I am still left with the nagging question. If the women in the vaginal birth arm of the research experienced care that facilitated and supported the physiology of birth (in the myriad of ways that midwives believe childbirth can be supported and facilitated), would that have made a difference? Thus the question of the best method of birth for a breech presentation has not been answered entirely to my satisfaction.

This can be a problem when we set out to find information and evidence on a particular topic. We find that our questions have yet to be answered, have not been asked or are not answered to our satisfaction. The same applies to the questions of consumers. Just as midwives may have a different perspective to our medical colleagues on a practice issue, consumers may have another perspective again. It is important that these perspectives get on the research agenda. To achieve this we need to become more active in research and also foster greater collaboration (partnership and collaboration between midwives, other professions and consumers). This raises important issues, which include the development of midwives' skills in conducting research and the ways in which such research is funded.

The meta analysis and randomised controlled trials (RCT) are regarded as the pinnacle of the evidence hierarchy for questions of treatment (Hamer & Collinson, 1999). This research method was originally designed to measure the effectiveness of certain medicines and has since been applied to measure the effects of many and varied treatments and interventions in childbirth. However, not all clinical practices lend themselves to this type of research. Say for example that I wanted to conduct a randomised controlled trial on the safety of water birth. I would have to randomly allocate women to either the experimental group (water birth) or the control group (birth out of water). Where would I find women willing to participate? Often women have strong opinions on water birth and either do want a water birth or don't. There aren't many women who are so ambivalent that they would be happy to be randomly allocated to one group or another. If this research could be conducted would this ambivalence itself have an effect on the outcome? And how does the desire for something (a strong belief in water birth, the conscious decision to have a water birth), affect the outcome in these situations?

This research could be done¹, it is not impossible, but it does not lend itself readily to a randomised controlled trial. Many of the sorts of questions midwives have about practice do lend themselves to this type of research but equally, many do not. We can of course do other types of research on these clinical issues, which fall below the standard of the randomised controlled trial in terms of levels of evidence, but the findings from these types of research will always be considered a poor cousin of the RCT. Not quite the gold standard, not quite measuring up, not quite convincing enough.

Where does this leave those clinical questions that do not easily fit experimental research designs, or those perspectives that aren't being addressed in current research? Importantly, what clinical questions do consumers have? The current approach to research renders them invisible, it is as if they do not exist. This has serious implications for the development of practice in any area of health care. Practice has the potential to become skewed in the direction to where there are answers, and where there is evidence, leaving other areas (those harder to research, those researched with methods other than the RCT or even qualitative designs) to wallow in the realms of questionable, unproven practices.

It is important that we ensure that our questions and the questions of consumers are on the research agenda; being asked, being answered and being valued. As a profession certainly, we need to make sure that we contribute to developing a body of

evidence that is relevant to the way we practice, at the same time ensuring that the way we practice meets the needs of consumers of maternity services.

Evidence informed decision making

As paternalistic approaches to decision making in health care diminishes (Charles, Whelan & Gafni, 1999), practitioners and consumers need to develop new ways of working together and making decisions. Within this both practitioners and consumers must consider how they work with evidence and use it to inform their decision-making.

Historically the concept of professionalism implied a paternalistic relationship. One where the practitioner held authority, was aloof, objective and in control of their own profession and professional decision-making. The midwifery profession in New Zealand has attempted to redefine professionalism, making consumers central and integral at every level of midwifery; from the professional structure of the New Zealand College of Midwives Organisation, through to the day-to-day practice of midwifery. The partnership model of midwifery (Guilliland & Pairman, 1995); describes the relationship between the woman and midwife as one of partnership, and underpins the midwifery profession in New Zealand. In many ways this move was heretic, challenging the historical notions of professionalism and the paternalistic models of decision making that had been fundamental to the professional/consumer relationship (Tully, Daellenbach & Guilliland, 1998).

But what is it to be a partner in providing or receiving health care? This new way of working with consumers as partners demands that there is equality within the relationship, with each partner respected for what they bring to the partnership. The health care provider is respected for their professional knowledge and practice skills, and the woman receiving care is respected and valued for her knowledge of herself; and of her individual and unique needs and desires (Guilliland & Pairman, 1995).

Richards (1997) reminds us that no health issue is purely a chemical or physiological one. It is always part of the complexity that is the human condition. Health is physical, social, psychological, environmental, spiritual, cultural and political. This complex mix of factors will contribute to a client's decision making; a decision in which evidence will play just one part. For some it may be a major part for others a small part. When we commit to a partnership relationship then we must approach care in a holistic way, value autonomy and respect a client's right to make decisions that are right for them.

We do not necessarily have a blueprint for working in this way because it is new for many; both consumers and health providers. The last fourteen years have seen midwives and women grappling with issues arising out of their commitment to work in partnership. These include such questions as; where are the boundaries between personal and professional? What are the rights of each partner within the relationship? What are the responsibilities of each?

In health care we have been at one extreme of the spectrum; where the health professional made the decisions. Inherent in this was a paternalistic approach to decision making. The practitioner made the decisions for the patient and the patient "...*passively acquiesces to professional authority ...*" (Charles, Whelan & Gafni 1999, p. 781). For me, equally untenable is the other extreme of the spectrum, where the demands of the client are met without regard for the professional role and responsibilities of the practitioner. These two models described above represent two ends of a spectrum and in reality most relationships and decision making probably fall somewhere in between.

Within the partnership model of care (Guilliland & Pairman, 1995) decision-making involves negotiation. This model acknowledges that both partners have rights and responsibilities within the relationship, with the ability to negotiate facilitated by the development of a relationship over time. Continuity of care provides the opportunity for the trust and knowledge of the other partner to develop. For midwives this enhances our holistic understanding of each woman's childbirth experience and the factors contributing to her decision-making. The midwife's responsibility within this relationship is to share knowledge of, and have access to, available evidence. It does not mean that women will make choices dictated by evidence or that midwives must act on all women's choices. Both have rights and responsibilities within the partnership and evidence will join the myriad of factors that contribute to that woman's decision making. The evidence based approach to care must be kept in perspective and never be allowed to become a 'recipe based' approach. Page (1996, p.192) summarises this point nicely when she says, "*Like any good health care practice, evidence-based maternity care requires thoughtful attention to the individual woman and her family, keeping their individual concerns, values and clinical needs uppermost.*"

The art of what we do as practitioners is to work with individuals. When we ensure that the individual and their unique needs and desires are fore-

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most, then evidence has an important and rightful place in informing decision-making.

Conclusion

Evidence based health care has gained momentum in many western societies and has the potential to significantly improve the basis for decision-making in health care. As practitioners, it is important that we develop skills in locating and appraising evidence and it is equally important that we understand the limitations of an evidence based approach to care.

In clinical situations we tend toward apprehending complex wholes rather than incomplete fragments and maintain concern for the uniqueness of the individual. This can make it difficult for us to narrow our focus on an aspect of the clinical situation and develop a "searchable question" within the evidence based practice framework. The art of what we do lies in our appreciation of the individual and this is the key to providing holistic care. It is the nature of the relationship with that individual and effective communication that will facilitate decision-making that meets the person's needs. In a partnership relationship decision-making is negotiated as both partners are acknowledged as having rights and responsibilities. It is important that practitioners are able to access and appraise evidence but they must also acknowledge that evidence is only one of many factors that will influence an individual's decision-making. As Sackett, Rosenberg, Muir Gray, Haynes, and Richardson (1996, p. 71) comment, "Evidence based medicine is not 'cookbook' medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care."

Not all of our clinical questions can be answered by current evidence. We do need to develop skills in locating and appraising evidence and must also acknowledge those areas where uncertainty remains. It is also important that we become active in contributing to the body of evidence in our discipline. Collaboration with consumers of our service is important to ensure that our discipline remains focused on meeting the needs of our consumers. If we don't ensure that our perspective and our concerns and clinical questions are on the research agenda then it is as if they don't exist.

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- 1 A number of studies have been conducted evaluating immersion in water for first stage of labour. A small study by Nikodem (1999, cited by Cluett, Nikodem, McCandlish & Burns, 2004) is the only one I could locate evaluating birth in water. Women were randomised at full dilatation.

Vitamin A - when too much of a good thing isn't

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Abstract

Vitamin A, a fat-soluble vitamin, is an important nutrient during pregnancy. Vitamin A is present in both animal and plant sources. However, only high intakes of retinol from animal products and/or supplements have been reported to have teratogenic effects. High intakes of retinol have been associated with a variety of birth defects including craniofacial malformations. Although high intakes of retinol have been reported in pregnant women, data from the New Zealand National Nutrition Survey indicate that New Zealand women on average do not consume excessive amounts of vitamin A. It is important, nevertheless, for pregnant women to be aware of the adverse effects of vitamin A during early pregnancy while ensuring they meet the recommended intake of vitamin A.

Introduction

The following article provides an overview of the general functions and major food sources of vitamin A followed by the effects of excess vitamin A in pregnancy. The focus of this article is the evidence for why vitamin A should not be consumed in excessive amounts during pregnancy.

What is vitamin A?

Vitamin A is a term used to describe a variety of fat-soluble compounds essential for cell proliferation and differentiation, growth, reproduction, vision and immune function. There are two classes of vitamin A, preformed vitamin A known as retinoids and a precursor form called provitamin A. The retinoids include retinal, retinol and retinoic acid and are present in animal products such as eggs, liver and cod liver oil (Figure 1). Provitamin A is present in plant foods capable of producing yellow-orange pigments called carotenoids, for example, carrots, apricots and pumpkin. Dark green vegetables such as spinach and silver beet also contain these carotenoids but due to the presence of chlorophyll the yellow pigment is masked. Retinol is the most biologically active form of the retinoids. Retinal can be converted to retinol in the liver. Similarly, many carotenoids can also be

converted to retinol, thereby contributing to retinol activity.

Vitamin A requirements for pregnancy

The recommended daily intake of vitamin A in pregnancy is 770 RE (retinol equivalents) for females ≥ 19 years and 750 RE for females 14-18 years (Institute of Medicine Standing Committee on the Scientific Evaluation of Dietary Reference Intakes, 2001). This level can easily be achieved by consuming one cup of pumpkin or two apricots.

Vitamin A during pregnancy - the right balance

One of the important roles of vitamin A is cell differentiation. This is the process by which immature cells become specialised. Cell differentiation is necessary throughout life but is very important during embryonic development. Inadequate intakes of vitamin A during pregnancy can result in poor fetal growth and development. However, vitamin A deficiencies in developed countries such as New Zealand are not common. According to the most recent National Nutrition Survey the majority of non-pregnant women between 19-44 years meet their vitamin A requirements (Figure 2) (Russell, Parnell & Wilson, 1999). The vitamin A intake of pregnant New Zealand women is not known.

While consuming adequate vitamin A intakes during pregnancy is important, high doses of retinoids have been associated with adverse pregnancy outcomes. High intakes of plant-based vitamin A (carotenoids) are not teratogenic because their conversion to retinol is regulated by the liver (Gropper, Smith & Groff, 2005). Several epidemiological studies have investigated the relationship between vitamin A intake and teratogenicity, however only one established an association between high vitamin A intakes in pregnancy with increased risk of birth defects (Azais-Braesco & Pascal, 2000).

Few prospective studies have examined vitamin A intake during pregnancy and incidence of birth defects. Rothman, et al (1995) reported in a large study ($n=22,748$) that women who consumed $>15,000$ IU (4500 RE) of vitamin A from food and supplements per day were 3.5 times more likely to have infants born with cranial neural crest birth defects than women consuming ≤ 5000 IU (1500 RE) of vitamin A (95% CI, 1.7-7.3). Women consuming $>10,000$ IU (3000 RE) of vitamin A from supplements were 4.8 times more likely to have infants born with birth defects compared to women who consumed ≤ 5000 IU (1500

RE) of vitamin A. The number of infants with birth defects appeared in women who consumed these high levels of vitamin A prior to week seven of gestation. This study, however, has been criticised for inappropriate classification of birth defects.

It is ethically impossible to conduct randomised-controlled trials to further establish the teratogenic effect of dietary vitamin A in humans. However, animal studies have clearly demonstrated that even one bolus of vitamin A taken early in gestation can have detrimental effects on embryonic development (Collins & Mao, 1999). Likewise, women who consume large intakes of supplemental vitamin A or women taking isotretinoin (Roaccutane), a retinoic acid derivative used to treat acne, have been reported to have infants with malformations involving the craniofacial, cardiac, thymic and central nervous systems (Collins & Mao, 1999).

In the Netherlands, liver paste, a staple food, has been reported to elevate postprandial plasma levels of vitamin A metabolites associated with teratogenicity in women to levels higher than levels seen with vitamin A supplements (van Vliet, Boelsma, de Vries, & van den Berg, 2001). The authors of this study conclude that consumption of liver and liver products such as liver paste should be limited during pregnancy.

Do pregnant women consume excessive intakes of vitamin A?

If large intakes of vitamin A consumed during pregnancy have the potential for adverse consequences it is important to know whether women consume these levels. Voyles, Turner, Lukowski & Langkamp-Henken (2002) reported only 16% ($n=10$) of pregnant American women seeking antenatal care consumed excess retinol (≥ 1600 RE), with the majority ($n=9$) from supplements. The mean vitamin A intake in a group of pregnant Dutch women ($n=58$) was 990 RE. Women who consumed liver or liver products however had large intakes of vitamin A with mean intakes of 2870 RE and 3100 RE, respectively (van den Berg, Hulshof & Deslypere, 1996). Data from the 1997 National Nutrition Survey indicate that women in New Zealand, on average do not consume excessive retinol intakes (Figure 2).

Ensuring safe intake levels of vitamin A during pregnancy

Because of the teratogenic potential of vitamin A it is important to set a safe intake level during pregnancy. A safe upper intake of 3000 RE, referred to as a Tolerable-Upper Limit (TUL) has

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Vitamin A - when too much of a good thing isn't

been set by the United States Institute of Medicine (Institute of Medicine Standing Committee on the Scientific Evaluation of Dietary Reference Intakes, 2001), the World Health Organisation (Food and Agriculture Organization of the United Nations, 2002) and the European Commission Scientific Committee on Food (2002). Chronic intakes above this level are associated with adverse outcomes including birth defects. The American Academy of Pediatrics and the American College of Obstetricians, however, suggest that the safe upper limit during pregnancy be lowered to 1600 RE (American Academy of Pediatrics & American College of Obstetricians and Gynecologists, 1997).

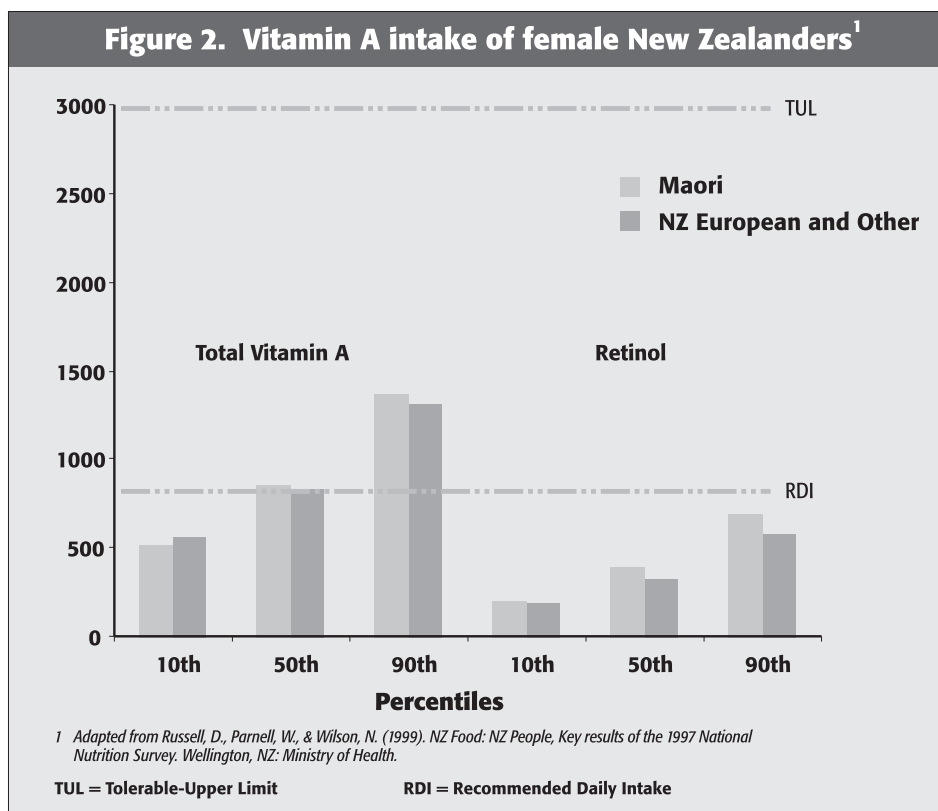
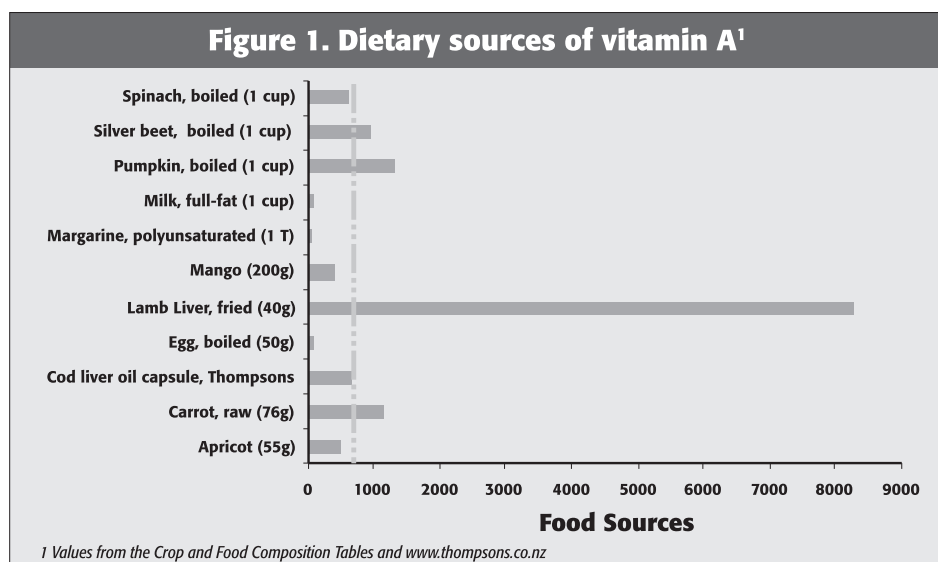
The number of birth defects is relatively low in New Zealand and it is difficult to ascertain whether these birth defects are due to vitamin A (International Clearinghouse of Birth Defects, 2002). **However, prevention of possible vitamin A affected birth defects is simple - avoid high doses of vitamin A in food and supplement form especially in the first trimester of pregnancy.**

Strategies to ensure adequate vitamin A intake during pregnancy:

- Consume vitamin A foods on a regular basis, in particular dark green and yellow-orange fruits and vegetables.
- Limit the intake of liver in the first trimester and when consuming later in pregnancy eat only in small quantities.
- Check all supplements for vitamin A and avoid those with retinol.

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Family Violence Prevention Education Programme for Midwives: An Auckland Evaluation

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Abstract

The New Zealand College of Midwives instituted family violence workshop training in 2002 to prepare midwives to integrate screening and referral for family violence into their care. In this paper the findings are presented of a qualitative descriptive study in which a small sample of Auckland midwives participated in focus groups to explore their learning experience and the degree to which the workshop objectives were met. Participant midwives affirmed a commitment to incorporate family violence screening into their practice. They also made recommendations for additional and on-going teaching and learning activities to facilitate positive and sustainable change in responding effectively towards preventing family violence during pregnancy.

Introduction

This article reports the findings of an evaluation study of a family violence prevention education programme for midwives in Auckland, Aotearoa New Zealand. The terms domestic, family and intimate partner violence are all used to describe threatening, intimidating and harmful behaviour, expressed in many forms of abuse, such as physical abuse, sexual abuse, verbal threats, isolation and economic abuse (Cohn, Salmon, & Stobo, 2002; Hunt & Martin, 2001). Intimate partner violence occurs inside and outside the home, between intimates, including same sex partners, and ex-partners, and affects the health and wellbeing of a substantial number of women in Aotearoa New Zealand. The New Zealand Survey of Crime

Victims 2001 (Morris & Reilly, 2003) estimated that one in five females have experienced violent behaviours by a partner. It also showed that women were significantly more affected than men by violence from people well known to them. More recently, a population-based study identified rates of physical and/or sexual abuse by an intimate partner of 33% among women living in Auckland and of 39% among women in north Waikato (Fanslow & Robinson, 2004). Prevalence rates are typically higher in women seeking healthcare and among younger women. Forty-four percent of women seeking care in an Auckland emergency care department reported a lifetime history of intimate partner violence (Koziol-McLain, Gardiner, Batty, Rameka, Fyfe, & Giddings, 2004).

Partner violence has been identified as a significant national and international public health problem (Cohn, Salmon & Stobo, 2002; Fanslow & Glasgow, 2001; Fanslow, 2002; Hunt & Martin, 2001). In Aotearoa New Zealand, *The Family Violence Intervention Guidelines* (Fanslow, 2002) aimed to provide health professionals with a resource for effecting safe interventions to assist victims of violence and abuse. This resource was designed to run in conjunction with workshop training for health professionals.

The Ministry of Health contracted the New Zealand College of Midwives (NZCOM) to provide family violence prevention education to member and non-member registered midwives. Maternity care is free for all Aotearoa New Zealand residents and since the Nurses Amendment Act in 1990, midwives have increasingly made up the majority of those taking lead responsibility for care. Midwives make up approximately 75% of Lead Maternity Carers (Ministry of Health, 2004). Repeat visits during the pregnancy and childbirth period, often in the woman's home, mean midwives are well placed to screen pregnant women for partner violence and create opportunities for meaningful interventions. The literature examining family violence during pregnancy, routine screening in midwifery practice and evaluation of health professional family violence training follows. This literature informed the current research, to evaluate family violence prevention education for midwives in Aotearoa New Zealand.

Literature Review

Rates of partner violence during pregnancy as high as 17% have been reported (McFarlane, Parker, Soeken & Bullock, 1992), but are likely to differ across cultures perhaps relating to the respect and sacredness bestowed on women during pregnancy (Counts, Brown, & Campbell, 1999). The rate of partner violence among pregnant women, however, is likely to rival or surpass rates of commonly screened for pregnancy-related complications such as pre-eclampsia and gestational diabetes

(Johnstone, 2003; Wright, 2003). Partner abuse of pregnant women leading to death is just beginning to be acknowledged as a serious cause of maternal and fetal mortality (Horon & Chang, 2001; Krulewicz, Pierre-Louis, de Leon-Gomez, Guy & Green, 2001). A growing body of literature documents the health effects of partner violence on women as well as on their children (Campbell, 2002; Edleson, 1999).

Partner violence screening has been found to be a useful marker for identifying women at risk for future violence (Houry et al., 2004; Koziol-McLain, Coates, & Lowenstein, 2001) and is an activity that serves to counteract the societal norm that keeps partner violence hidden. There is a paucity, however, of studies which report effectiveness of partner violence screening interventions (Nelson, Nygren, McInerney & Klein, 2004; Ramsay, Richardson, Carter, Davidson & Feder, 2002; Wathen & MacMillan, 2003). Although outcome evaluation is rare, one recently published study reported significantly increased 'safety promoting behaviours' among abused women as a result of serial brief interventions from a health professional (McFarlane et al., 2004). Brief screening and referral provide women with the choice whether to disclose violence in their lives and empowers them to continue to seek protection from further harm.

Addressing domestic violence is a relatively new area for midwifery intervention (Bewley & Gibbs, 2002; Cohn, Salmon & Stobo, 2002; Hunt & Martin, 2001). McFarlane, Soeken and Wiist (2000) identify routine screening during prenatal visits as "a public health primary prevention measure for all women and as a secondary preventative measure for abused women" (p. 449).

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Family Violence Prevention Education Programme for Midwives: An Auckland Evaluation

Evidence suggests that most women perceive personal questions asked by their midwife about exposure to violence to be acceptable (Bacchus, Mezey & Bewley, 2002; Stenson et al., 2001; Taket et al., 2003). A lack of education regarding their role in asking women about family violence, however, has been given as a reason why midwives have felt disengaged and unprepared to screen for family violence (Wright, 2003). A study of 145 midwives in two London hospitals reported that training and education were key to midwives' comfort in screening, identifying a potential for emotional problems to surface when interventions were not underpinned by comprehensive training and support programmes (Mezey, Bacchus, Haworth & Bewley, 2003). Taket et al. (2003) suggest the complexities of this topic could make it unsafe for women if midwives screened without adequate training and skills.

The evaluation of health professional training programmes is an important phase in advancing scholarship and practice in responding appropriately to partner violence. Cohn, Salmon and Stobo (2002) illustrate that health professional organisations are well placed to advise members on partner violence competence areas, effective prevention strategies, approaches for overcoming training barriers, and approaches for promoting and sustaining health professionals' behaviour change. The Royal College of Midwives (United Kingdom [UK]), American College of Nurse-Midwives, and NZCOM are amongst numerous internationally recognised professional health groups and organisations that have acknowledged a relationship between partner violence and the health status of women and families and the need to ensure practice competence (American College of Nurse-Midwives, 1997; Campbell, 2002; Cohn, Salmon, & Stobo 2003; Johnstone, 2003; NZCOM, 2002a; Royal College of Midwives, 1999).

Despite agreement on a need for professional education, there is considerable variance in formal health professional training and in professional development about partner violence (Cohn, Salmon, & Stobo 2002). A number of nursing and midwifery competencies for partner violence have been linked with other skills such as interpersonal relationships, ethical and cultural competency. The American College of Nurse-Midwives (2002) partner violence knowledge, skills and behaviour competencies are complemented by "hallmarks of midwifery" such as skilful communication, guidance and counselling. NZCOM scope of practice in this area is clearly defined as

A lack of education regarding their role in asking women about family violence, however, has been given as a reason why midwives have felt disengaged and unprepared to screen for family violence.

providing assessment, identification, information, and support for at risk women and families. Midwives are expected to have the knowledge and skills to assess, intervene and refer appropriately (Campbell, 2002; NZCOM, 2002a).

Research design and methods

This qualitative descriptive study was positioned within a process evaluation framework (Patton, 2002) with the practical aim to inform effective family violence prevention education. Participants who attended the NZCOM one-day workshop were asked about their learning experience and the degree to which the workshop objectives were met. The NZCOM one-day workshop curriculum was delivered by a national training facilitator and co-

ordinated by midwives at a regional level. All participants were provided with resource materials that included general information about family violence as well as copies of key articles addressing partner violence during pregnancy. The purposes of the

workshops included to increase midwives' understanding of family violence and their confidence in screening clients (NZCOM, 2002b; see Table 1). In this study the researchers evaluated the midwife participant experience of workshop training in the Auckland region with particular reference to the stated workshop objectives. Data were collected during focus groups with workshop participants approximately one month following their training. Focus groups provide a comfortable format for persons to share ideas and perceptions with one another, creating rich qualitative data (Krueger, 2000). Groups were facilitated by a convenor and a note taker was present. An interview schedule was followed that included six open ended questions such as "What was the most useful aspect of the family violence workshop?" and "Has your ability to discuss family violence with women changed since attending the workshop?" Ethical approval was obtained from the Auckland University of Technology (AUT) Ethics Committee. Audiotapes of the focus groups were transcribed and data analysed using descriptive content analysis with a focus, as indicated above, on the workshop objective framework.

The study was limited to the Auckland region. Workshop facilitators assisted by recruiting regional workshop participants who had attended one of two training days. Of 40 workshop attendees, 25 agreed to be contacted by the researchers and 15 confirmed their availability to participate in one of three scheduled focus groups. Due to last minute call outs and deliveries on the

scheduled days of focus groups, a total of eight midwives (six were lead maternity carers) were able to attend one of the three focus groups (representing 20% of the attendees across the two workshops).

Findings

Along with addressing workshop objectives, participants commented about their motivation to attend the workshop, the workshop teaching strategies and their learning. Findings are described below with supporting participant quotes included in Table 2.

Motivation to attend

The eight midwives went to the family violence workshops with varying levels of understanding, experience and motivation to attend. For some who attended it was their first exploration into the way in which family violence related to their midwifery practice. Most understood family violence as very 'topical' and that from a practice perspective, it was timely to be exploring the issue and upskilling. Two midwives articulated a more urgent motivation to attend, naming current issues of violence in their caseload and feeling insufficiently trained to manage this well. One of these commented, for example:

I decided to do it because I had two women I was looking after at the time who were in violent relationships and I felt it was really hard getting information on how to deal with it and where to go for help.

Other motivating factors included that the workshops were local and free.

Workshop objectives

1: Understanding Family Violence

Some participants acknowledged that prior to the workshop they were naive about what constituted violence, thinking, for example, that partner abuse involved only physical violence. From the workshop participants learnt to understand family violence in a broader way, making reference to the often 'subtle layers of control' that women might experience. Several participants alluded to possible constraints placed on women in leaving abusive relationships and noted the impact of family violence on children, for example:

They spent some time talking about the effects on children of family violence. I thought that was really valuable because you can't separate women and the impact on their lives from the impact on their children.

One participant noted that while partner violence was primarily a male on female problem, the possibility of violence among the growing number of same sex couples choosing to have children should be acknowledged in the workshop.

2: Understanding Health Implications.

There was agreement across all focus groups that details linking domestic violence to health problems were “not the main focus”. This was attributed to the time constraint of a one day workshop. In general, participants were able to link partner violence with health problems such as stress, the use of unsafe practices in pregnancy (particularly concerning alcohol and drug use) and unsafe sexual practices. Some attributed their awareness of the general health impact of violence to learning activities and experiences prior to the workshop.

3: Confidence to Routinely Screen.

Learning about prevalence and the often hidden nature of family violence was acknowledged as helpful to understanding the need for routine screening. One participant commented: “*It puts it into perspective, that it is not isolated, it is not a random event.*” A better understanding of emotional, economic and physical abuse gained in the workshop was stated to have increased participants’ confidence in family violence screening. They all, however, felt more information about sexual abuse was needed.

Some, but not all, focus group participants reported incorporating screening into their practice since the workshop. They gave examples of the kind of statement they might use to screen, such as referring to their attendance at the workshop to open a conversation with women about abuse. Midwives also reported offering support to women, which included ensuring referral information was available to clients and handing out family violence information cards. Learning how to respond appropriately to a disclosure and having a clear sense of boundaries for supporting women added to participants’ confidence in routinely screening. Confidence that local services were available to refer women to was also important. One midwife said that not knowing the referral resources was her biggest apprehension prior to the workshop. Finally, screening across all midwifery service providers, in each trimester and post-natally, was seen as helping to normalise the screening process. Participants agreed: “*the more we ask women, the more it is out there*”.

4: Safety and Support in Practice.

Participants appreciated learning about safe screening strategies in the workshop, such as taking women to the bathroom to screen when relatives were present. There was also concern about cultural safety after one midwife disclosed not feeling confident to screen clients for whom English was their second language. Others confirmed a desire to have had screening in a cross cultural context addressed in the workshop.

Table 1: NZCOM Family Violence Education Workshop Objectives

- 1. Midwives will understand that:**
 - Family violence is a power and control issue
 - Family violence is mainly a male on female problem
 - Partner abuse and child abuse cannot be separated
 - There are many and varied reasons why women do not leave a violent relationship
- 2. Midwives will be able to link domestic violence to health problems:**
 - Family violence affects the health of women and children
 - It affects health in various ways, such as trauma, stress and somatic problems
 - Women in violence may often develop unsafe practices, such as alcohol and drug abuse and unsafe sexual practices
 - Violence can have an adverse effect in pregnancy
 - Violence in the home affects the health and development of children present
- 3. Midwives will feel confident to routinely screen women for family violence:**
 - Routine screening will occur in each trimester of pregnancy, and once before referring on to the well child provider
 - The woman will be asked about present physical abuse, sexual abuse and emotional abuse
 - Screening will be done in a non judgmental manner, ensuring safety for the woman as well as the midwife
 - Whether there is disclosure or not, supportive statements will be made, ensuring that the woman knows that family violence does not need to be tolerated, and that there is help available
- 4. Midwives will explore the principles of safety and support, both for themselves and the woman, and practice these situations through role-play:**
 - Safety for the woman - ensuring she is on her own before screening, explaining that if violence is present it can worsen during pregnancy, giving the woman ideas for keeping safe if violence occurs, maintaining confidentiality, documentation
 - Safety for the midwife- professional safety, personal safety
 - Support for the woman- available services in the community, understanding power and control issues
 - Support for colleagues so that they are able to debrief from stressful situations
- 5. Midwives will have the opportunity to discuss possible solutions to issues they may face.**
- 6. Midwives will have the opportunity to explore how developing a confidence and expertise in screening for family violence will affect their practice and relationship with women.**

Family Violence Education for Midwives Information Sheet (NZCOM, 2002b)

While some participants reflected that the workshop offered valuable referral resources, others felt that only limited regional referral information was provided. It is possible that different workshop training sessions offered different referral information, or that different levels of services are available.

Participants reflected on concerns for their own emotional and physical safety in practice. Sharing concerns, doubts and questions with colleagues was a commonly named strategy for managing work related stress. The role and value of documentation was recollected by one participant when she shared a story about writing the details of abuse separately from a woman’s notes which could be accessed by her partner, thus promoting the client’s, as well as her own, safety. Others talked of the need and value of having clear workplace policy guidelines for screening. Such workplace support was deemed important to both core and Lead Maternity Carer midwives.

5 & 6: Exploring Issues.

Many participants made comment on the intensity of the workshop and that there was not enough time to go into details of potential issues. Furthermore, they found that they did not have the time to properly process new information and to reflect on issues which they might face in practice. As one midwife said:

I think we just needed time for people to share some of the experiences they had themselves and how they dealt with those experiences because we didn’t really have a finishing off of the day.

It was suggested that a follow up workshop session, a ‘second stage’ be offered.

The final workshop objective required midwives to explore how confidence and expertise in screening for family violence could affect their practice

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and relationships with clients. Participants believed that screening women for family violence had the potential to increase the relationship of trust and care of women, with one suggesting that the midwifery partnership would be enhanced because screening involved creating safe environments that were non-judgemental.

Despite confidence in the workshop, some participants expressed concerns about women feeling a sense of intrusion or of being judged when asked about family violence. Participants were also concerned about not being able to meet the expectations of women after disclosure. Several participants suggested that screening all clients had acted to reduce their sense of concern about women feeling judged, and was critical in achieving the goal of normalising family violence screening.

Teaching strategies

A variety of educational tools was used to teach the content of the workshop. Of note, participants made reference to the effectiveness of using video clips as a means for understanding power and control dynamics. Participants found the presentation of research findings had a significant impact on their understanding of the prevalence of family violence. Overall participants felt attendance at the workshop added value to their practice, and appreciated the strategies and suggestions shared by both the facilitator and their midwife colleagues. This is despite the criticism that the workshop organisers were “*cramming a lot into one day*”. One midwife suggested:

If you could do the day... and then maybe a week later come back and do a couple hours feedback or something like that.

Role-plays allowed participants to practice screening and respond to disclosure in a safe learning environment. Some found the ‘acting’ aspect exposing and difficult, but on reflection could see its value: “*I hated it... I do think that they are a good learning tool*”. Another commented that the role-playing enhanced her empathy towards abused women:

To actually get into the role of a woman who was possibly in that situation, having never experienced it myself; to actually see what it must be like, to see how unnerving and jumpy and vulnerable they must feel.

Participants had been invited by the workshop facilitator to write up a post workshop case study. At the time of the focus group interviews, none of the focus group participants had taken the opportunity to do so.

Discussion

In this study we explored the effectiveness of the NZCOM *Family Violence Education for Midwives* one day workshop in adequately educating and preparing midwives to become actively involved in screening for family violence. In focus groups with a small sample of workshop participants, midwives affirmed the training to be of value to their midwifery practice. They described an increasing sense of confidence in routinely screening their clients and revealed strategies for doing this safely. Despite this, they noted additional education and practice needs that extend beyond what was possible in a one day workshop.

Midwives felt that the time constraints of the workshop limited the content of what could be provided. Significant issues that midwives wanted additional information about were addressing sexual abuse, links to health, and cultural differences. Also, the information for referral agencies was found to vary across the workshops, suggesting that a list of referral agencies and resources be standardised. Further information specifically related to sexual abuse would contribute to greater confidence and more effective screening. Sexual abuse is an often neglected area of family violence education (McMahon, Goodwin & Stringer, 2000; McPhillips, Berman, Olo-Whaanga & McCully, 2002). Some midwives noted that that cross-cultural dynamics and cultural safety were not directly addressed in the workshop, although midwives were encouraged to reflect on their own culture and social attitudes through video and role-play interactions. *Family Violence Intervention Guidelines* (Fanslow, 2002) provide a number of actions and behaviours for health professionals caring for Maori and Pacific Island families at risk that may be a useful beginning.

Midwives also felt that the intensity of new learning over the one day limited their ability to process, reflect, and explore issues likely to arise in their practice. While the workshop was consistent with several key family violence adult learning principles such as including non-didactic teaching methods, providing written resources, collaborating with local service providers, and making provisions for submission of a post-workshop case study (Cohn, Salmon & Stobo, 2002), no formal pre- or post-workshop sessions were instituted. The focus group facilitator noted that participants who had prior family violence education (pre-session) were eager to revisit the issue of family violence and gain additional screening and referral skills. We discovered that our study focus groups served as post-workshop ‘booster’ learning sessions. Hamberger et. al., (2004) suggested that post-workshop family violence training may “*take the form of shorter, ongoing in-services that focus on ad-*

vanced topics that address questions raised from clinical experiences and provide boosters to existing skill and self-efficacy judgements” (p. 9). Participants expressed an appreciation of the focus group opportunity to reflect on their workshop experience and subsequent clinical practice, and were eager to have further learning opportunities made available.

Protheroe, Green and Spiby (2004) examined a midwifery education programme in Leeds (UK) where a one day workshop was preceded by a three hour pre-session 2 to 3 months prior to the workshop. Despite the pre-session, their participants still identified a need for “*a refresher or update on information covered*” following the workshop. Given the sensitive and complex nature of the topic of family violence, it is likely that both pre- and post-workshop sessions are necessary to create positive, sustainable change.

This study has some important limitations. Most notably, the study was limited to a small self-selected group of midwives from the Auckland region. This means that we cannot project our findings onto the population of New Zealand midwives as a whole. As the workshops were coordinated by regional trainer midwives, despite a prescribed curriculum, there are likely to be variations across geographic regions. Additionally, we did not formally test the effectiveness of the workshop, which would require a comparison group of midwives who had not attended a training workshop. And finally, what is needed in education evaluation is outcome data - data evaluating whether midwives’ screening and referring women for partner violence results in increased safety for women and children.

Conclusion

Despite the limitations noted above, important information was gained to inform midwife family violence education. Recommendations for midwifery family violence education and preparation are:

- Expand workshop content to include:
 - sexual abuse
 - health effects of abuse
 - caring for women for whom English is an other language
- Expand learning opportunities to include:
 - pre-workshop activities to promote awareness of family violence
 - post-workshop content to promote integration of learning with practice experience.

A small sample of NZCOM *Family Violence Education for Midwives* one day workshop participants affirmed a commitment to incorporate family violence screening and referral into their practice of partnership with women. The workshop provides a good beginning from which to develop further educational and training opportunities. It is a re-

Table 2. Family Violence Workshop Participant Interview Extracts

Topic	Participant Quotes
Motivation to Attend Workshops	<ul style="list-style-type: none">● I just thought this is something I really need for my practice, because it's just an on-going problem that I have been so confronted with through the years. I felt I've never really had the tools to deal with it.● A really big draw-card for me was it was free, local, and I knew the venue very well.
Understanding Family Violence (Objective 1)	<ul style="list-style-type: none">● Regardless of what area of Auckland you work in, there are always going to be women that are victim to family violence.● The story that stuck out for me, about the middle/upper class women with a lovely home and all the bells and whistles, and how she was desperate to be asked if she was in a violent relationship - because she was. And that taught me a lot about not judging. Just to realise that it can be anybody.● They spent some time talking about the effects on children of family violence. I thought that was really valuable because you can't separate women and the impact on their lives from the impact on their children.● For me the key point was - you just don't know. You absolutely don't know. And that is probably what's inspired me to ask the questions more, because I realised how naive I am. That if it's happening as often as that, there is a lot, you know, that I'm judging. I was really quite blown away by the fact that it can be so hidden. So that's the one thing that's inspired me a lot more to ask, is that I haven't a clue.
Understanding Health Implications (Objective 2)	<ul style="list-style-type: none">● They did touch briefly on like health outcomes for women in violent relationships and the impact on pregnancies... like low birth weights and stuff like that. [The training] didn't spend a lot of time, but they did touch on it.
Confidence to Routinely Screen (Objective 3)	<ul style="list-style-type: none">● I think going to the workshop made it easier [for me to screen] and I often now phrase it as, "We've just done this workshop and found out that [many] women are affected by family violence. And so we've made a commitment to talk to all women about it". And that sort of opens the door. A couple of [women] have even disclosed.● You get better at asking, and once you continue to ask people it becomes easier I suppose. And that's a good thing; the more we ask women then the more it is out there.● Sexual abuse doesn't really get asked. That's like a whole other thing... that wasn't part of the family violence workshop. And yet, you know, I think we need tools for how to ask that, because it's opening up so much.● You talk to [women] about HIV risk and tuberculosis risk and things like that. So I think by the time you get to the family violence question [women] are realising we are going to ask everything - because we want to know the whole picture.● Because even though you can't sort of fix it, you can actually say well "there are these agencies here that can help you. You don't have to put up with this; it's not your fault".● There's something about feeling safer about asking and having done the course.
Safety and Support in Practice (Objective 4)	<ul style="list-style-type: none">● If somebody's not speaking English that well, they might be thinking, "Well, what does she mean?"● If we're approaching people in a public area like the hospital ward, we have to be very professional about what we do. Because, number one, you can't approach the women when her partner is around.● And the biggest thing that I came away with from the workshop was I had a strategy in my own mind of how to actually help someone on the spot. I've actually got that domestic violence number programmed into my phone.● I usually do share [concerns] with a colleague; it would be confidential, but I would talk to somebody else, usually [seeking] advice about what next.
Exploring Issues (Objectives 5/6)	<ul style="list-style-type: none">● Because issues do come up. If you could perhaps do the day, and then maybe a week later came back and do maybe a couple of hours feedback or something like that.● I'd like to think that [women] would realise that there was nothing that was taboo in terms of what we could talk about. And that she had the opportunity to raise any concerns she had about anything, and that I would be able to, if nothing else, to listen. And possibly help in some way.
Teaching Strategies	<ul style="list-style-type: none">● For me the role playing was good to actually get into the role of a women who was possibly in that situation, having never experienced it myself, to actually see what it must be like; to see how unnerving and jumpy and vulnerable they must feel. That was good for me to do.● It was extremely balanced with the video, and then sitting down in groups and there was the role-play, and then there were some speakers. You know it was just filled with everything that makes a good Study Day. [They had] lots of variety and different ways of presenting domestic violence, which I thought was really good.

continued...

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sponsibility of professional bodies, along with educational institutions and employers, to develop policy and mechanisms to develop and support education and practice towards preventing family violence during pregnancy.

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