



# JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, DECEMBER 1992





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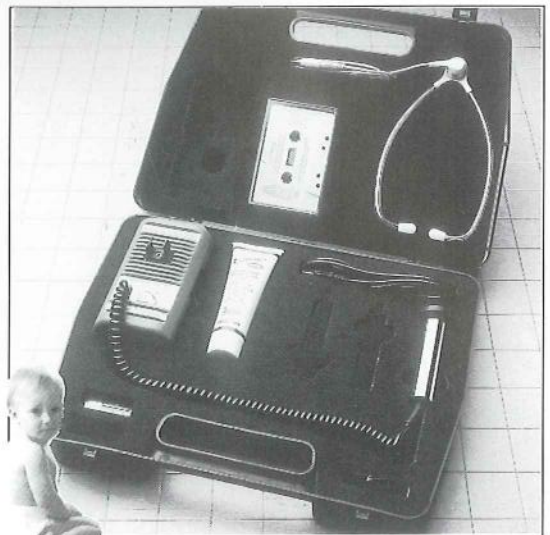
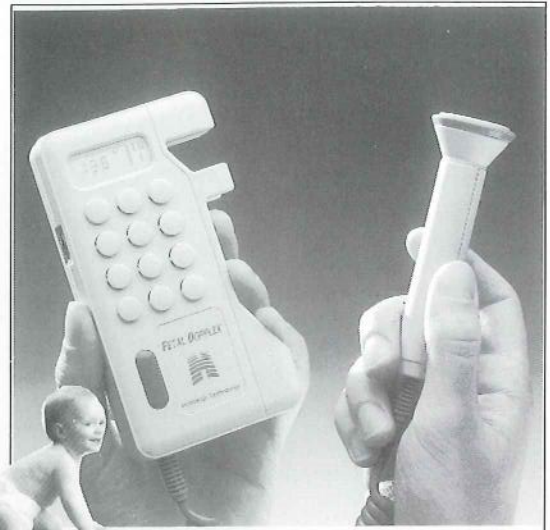
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- \* Promote women's health issues as they relate to childbearing women and their families.
- \* Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- \* Provoke discussion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

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## EDITORIAL

**M**y election as President of the College is a great privilege and a personal challenge. I am committed to the continuance of a strong midwifery profession in New Zealand.

We have achieved much in the last few years, but there are battles still to fight. The recent onslaught of media misinformation has caused a great deal of confusion and distress to women and midwives, as well as damage to the midwifery profession. It is important that as midwives we continue to provide the woman centred care which women seek from us and do not get caught up in working against each other.

It was women and midwives together who opened up the options for birthing in New Zealand. We must continue this partnership to ensure that these choices remain a reality. We must not let our present uncertainty about how and where we deliver our



service, the maternity benefit funding or the health reforms drive wedges between us. These things we will work through in time. We must hold on to our shared purpose of providing flexible and creative choices and care to birthing women.

The next two months are busy ones. Karen Guilliland and the rest of the team have been working very hard, with help from many of you, to prepare the College's case for the Maternity Benefit Tribunal. The hearings are in the week of 23 November and the Tribunal will report to

////////////////////////////////////

I was becoming very disheartened by this recurring blockage when my other nipple became blocked with a white spot too. I couldn't believe it! On further investigation I noticed the blocked duct was at the top of the nipple on both sides.

I was fortunate to have access to La Leche League's publication: 'An Overview of Solutions to Breastfeeding and Sucking Problems.' On looking up the section entitled 'Soreness at the Top of the Nipple,' I discovered that my blockages (white spots) were caused by incorrect positioning. The top of my nipple was rubbing against Amber's mouth. I realised that the comfortable arm chair I had been sitting in while breastfeeding Amber in the evenings was the problem. It was scrunching her up and changing her position. Once I began nursing her on a couch my white spots cleared up, along with the callouses which had been forming on my nipples over the ducts.

I hope this experience will help other women suffering from blocked ducts and white spots.

*Yours faithfully,*  
G.M.Campbell. Waikanae.



the Minister of Health before Christmas. Whatever comes out of this will provide the basis for funding of maternity services until contracts begin with Regional Health Authorities.

For those of you who were not present at the Annual General Meeting at Conference, I would like to pay tribute to Karen. She has been a wonderful President for the past four years and has provided inspiring leadership during this critical time in the development of the College.

Karen is witty, articulate, clear thinking, with a great sense of humour. Her ability to hold her own with all sorts of people and to share her vision of midwifery has done much to enhance the credibility of the College and is an inspiration to us all.

Thankfully, Karen's abilities are not lost to us, as she continues in the role of Coordinator. For my part, I want to work with all of you to continue down the path we have begun.

*Sally Pairman - President*

Photo: Sally and son Oscar (aged 6 months).

## LETTERS TO THE EDITOR

### White Spot

*Dear Editor,*

I recently read two articles from your magazine 'The Mysterious White Spot - Mary Hammond,' and 'Further to The Mysterious White Spot,' - Kath Ryan. I found them most interesting and would like to share my own experience with White Spots.

I have had white spots a couple of times and most recently about two months ago when Amber was about 20 months old. I noticed my breast was hard and sore and becoming painfully engorged at one point. I tried to get Amber to drink from it and clear it. She, however was aware that it was sore and was reluctant to drink from it! Help! So I did what I have done before and that was to soak the nipple in warm water either by standing over a basin or holding a cup half filled with water to my breast. I have found that about 20 minutes of this helps to soften the plug. I then tried expressing but only managed to get a tiny stream of milk to come out. I was able to get Amber to feed in her sleep however, which cleared it, now it was softened. I had to keep working on this spot for a couple of weeks because it kept getting blocked. I also used needles to clear it during this time.

### Midwifery Practice

*Dear Editor,*

In 1993, the Auckland Institute of Technology will have a paper available for Registered Midwives, called 'Midwifery Practice'. It will require attendance on-campus at Akoranga one day a month from March to October.

The paper encourages the student to reflect on her own practice of midwifery. It invites her own values and attitudes, and to consider her ways of 'knowing.' It then seeks to define the practice of midwifery. The student will then choose one aspect of practice to explore in depth. Decision-making is examined and linked to accountability. The final theme explores the complexity of evaluating practice.

There are many readings to promote thinking, and strong encouragement to reflect on and bring examples from practice. There are four assignments with a variety of options for presentation.

This is at present a 'stand alone' paper, but it is hoped that it will be given direct credit within the Auckland Institute of Technology - Health Science (Nursing) Degree and the Massey University Social Science (Nursing) Degree. It will also demonstrate 'prior learning' for entrance to other programmes.

Any inquiries are welcome.

*Yours sincerely,*  
Liz Smythe  
Midwife - Teacher  
A.I.T. Auckland.



### Letters to the Editor (Continued)

#### Thanks

*Dear Editor,*

The teachers of the Auckland School of Midwifery, Auckland Institute of Technology, would like to thank the College of Midwives for their generous gift of books. Publishers, such as Medical Books, from time-to-time donate books to the College for review. Those who facilitate the publishing of the journal ensure that once a book has been received, it is passed on to one of the schools of Midwifery. They are received with delight, and appreciation. It is vital that the new generation of midwives have access to all that is fresh and new in midwifery. They bring the enthusiasm that is part of a new beginning, the

willingness to capture new visions of practice, and the thirst to read about new ways of thinking. New publications are highly prized. We would recommend this process of distribution as a worthy investment in expanding the knowledge of midwifery, and in promoting the books themselves. Thank you for supporting student midwives in this way.

*Yours sincerely,*  
Liz Smythe  
Midwife - Teacher.  
A.I.T. Auckland.

#### Thanks

*Dear Editor,*

Thank you very much for the copy of 'Your Pregnancy' by Sue Pullon which you donated to us. I have sent the book to the library. It will be a valuable resource for the midwife students and is very much appreciated. ■

*Yours sincerely,*  
Sally Pairman  
Course Supervisor Midwifery,  
Nursing & Midwifery Department  
Otago Polytechnic.



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Earlier this year, I was privileged to take part in the midwifery education workshops which took place at Victoria University. Many of you will have heard about the workshops through your regions of the New Zealand College of Midwives and most of you will have seen the results of the work that was done in the "Midwives Handbook for Practice" which incorporates the New Zealand College of Midwives Code of Ethics, Standards for Midwifery Practice, Decision Points for Midwifery Care and Guidelines for Referral.

But hearing about the workshops and seeing the result cannot convey the wonderful sense of unity of purpose and consensus of opinion that pervaded the three days that we were together.

There were thirty-three midwives from all over New Zealand from all spheres of practice. Independent practitioners, some of them newly independent, some of them domiciliary midwives from way back; hospital midwives, some staff midwives, some charge midwives; managers of maternity and obstetric units, managers of services for Area Health Boards; midwifery educators; new graduates.

Joining with us in our endeavours, were two consumers representing La Leche League, Lactation Consultants and the Home Birth Associations of New Zealand; and representatives from the New Zealand Nurses' Association and the Nursing Council.

We worked hard and determinedly to articulate the beliefs that midwives hold about themselves, their profession, the women that they serve and the childbearing process itself.

I want to explore some of those beliefs. I want to look at where those beliefs have come from and the framework from which they operate as well as the framework in which they operate. I will consider whether the set of beliefs that midwives hold form a midwifery "ethic" for the whole profession and the effect that "ethic" has on our relationships with women, with colleagues both midwifery and medical and with the world at large. I am also going to look at the dilemmas which midwives sometimes (often ?) find themselves in when they attempt to maintain the midwifery ethic in their practice.

So, what are "ethics"?

According to Webster's Dictionary, ethics are "a particular system of principles and rules concerning duty; rules of practice in respect to a single class of human actions; as, social ethics; newspaper ethics." And we could add "midwifery ethics".

And what is this "Code of Ethics" that the midwifery profession in New Zealand has come up with? And where did we get it from?

The Code of Ethics is a series of statements grouped under headings about the responsibilities of the individual midwife, which fits in very nicely with Webster's definition of ethics.

We developed it from several sources the most important of which was the group of midwives and consumers who met in Wellington. We had some resource material which included the New Zealand College of Midwives "Standards of Practice and Service," the Australian College of Midwives "Standards for the Practice of Midwifery" and the International Confederation of Midwives draft "Code of Ethics for Midwives".

This code provides midwives with something to aspire to; to live up to in our midwifery practice; which can direct our behaviour and the decisions that we make as midwives in any situation. It can act as a guide to the things we *should* do, where our loyalties lie and so on.

I am suggesting that this Code of Ethics gives us a set of beliefs which form the midwifery ethic - that is the composite principles and guidelines which direct the behaviour of midwives in their relationships with individuals, institutions and the world. We spent a whole day articulating this at the Midwifery Workshop. And it was the consensus in the group of midwives present which has stimulated my interest in this subject - that we were able to be so "together" on this matter and that when we sent the draft out to College members for comment, there was little disagreement with the Code of Ethics that had been produced.

So how come all these women, trained and educated to be midwives in different ways for different periods of time, even in different countries are able

# Current Ethical Considerations

Bronwen Pelvin

Independent Midwife

Presented to the  
NZCOM Conference

to articulate or agree with the same set of beliefs? Women with different ages, backgrounds, races, sexual preferences, religious beliefs and so on. Midwives working in all the different areas that midwives can work. Could it be that being a midwife puts you in touch with a particular world view? Gives you a way of seeing things that other professional groups don't have?

I think the answer to that question is "Yes, being a midwife does give you a particular way of looking at the world and what goes on in it."

How do midwives look at the world? What brings them to their particular view? The answer is fourfold.

1. **It's historical.**

Midwifery is an ancient profession, perhaps the oldest one of all, older even than prostitution. Midwifery occurs in most cultures in one form or another. It is only in recent times, since about the 1700s, that midwifery has been connected with hospitals and the practice of medicine. It is even more recent that midwifery has been associated with the nursing profession and in many countries in the world, midwifery has never been associated with nursing or care of the sick and the dying. And even more recently still, is midwifery's association with institutional care of birthing women. It is unthinkable to me, that a woman becoming a midwife in the 1990s does not connect up in some way with the history and tradition of midwifery that has preceded her and that she does not absorb the attitudes and beliefs that form part of what "midwifery" is.

2. **Midwives are women.**

Now, I make no apology for identifying midwives as women. Apart from one or two members of the profession who are male, midwives *are* women. The midwives I know, particularly those practising independently, are women and the midwives I see who are involved with their professional organisations are women. Internationally, midwives are women; there are very few countries where men become midwives and they are all Western countries. I'm sure there is no reason why a man can't become a sensitive, accompanying wise guide to a pregnant or labouring woman but the fact and reality is that few men assume this role and it seems that few women actually want that accompanying presence to be a male one. The fact that midwives are women gives them a particular way of seeing the world and interpreting how the world works. Sociologically, much work has been done in recent times about the view that

women and girls have of the interconnection of people, events and things. It seems to be a concern of women that people get on, that conflict is resolved, things work out and that everyone is happy. Women invest a great deal of energy in their family and working and organisational lives to ensure that amicable relationships are maintained. So midwives come from this social conditioning and this has to affect the way they look at the world.

3. **The nature of the job.**

We all know the derivation of the word "midwife" - from the Anglo-Saxon, meaning "with woman." And the midwife's traditional role is as an accompanying, experienced, knowledgeable and supportive presence to the labouring and birthing woman. Although there are still some cultures in which the role of the midwife is limited solely to labour and birth, in the West and elsewhere, that role has broadened to encompass the care and advice given to women during their pregnancies and the supportive, guiding role taken by midwives the world over as they support and guide mothers and their other caregivers, in the care of themselves and their newborn infants.

It is this accompanying role, the sense of going through an experience *with* another person, while at the same time remaining outside that experience and also maintaining a care and a concern for the person going through the experience, enables midwives to develop their particular view of things.

4. **The physical, biological, emotional, psychological, spiritual, cultural and sociological process of pregnancy and childbirth itself has a profound effect on the way in which midwives see the world and all that happens in it.**

Birth is a fundamental event in human existence and along with death, is something that every single human being has to go through. Being present at a birth can give a sense of infinity, the continuity of life, of families and relationships and a sense of how we are all related, that is, connected to each other. Birth is also a basic biological act; one that we share with other animals so there is a sense of being connected with the other species and life on this planet. Being connected to a life force that drives reproduction and opens up our questioning minds to-

"Where do we come from?"

"Where do we go to?"

"What are we here for - you know, life, the universe and everything!"

While we may have no answers, I can just about guarantee that there isn't a mid-

wife on the planet without an opinion on these matters.

I believe that, it is our connection with women as they go through this fundamental life event, our history and traditions and the fact that we are women ourselves which create the ground from which the midwifery ethic grows.

**More importantly, I believe it is in the relationship between the midwife and the woman that she accompanies through the childbearing experience that the ethic which underpins midwifery is learned and internalised by the midwife as she develops in her profession.**

So I have some strong objections when midwifery is practised in a way which disconnects the midwife from the woman; when there isn't an ongoing relationship with the woman and the family on the receiving end of the care.

I'm going to be emphatic about this. Midwifery *must* be done in relationship with the woman; in fact, I'll go so far to say that midwifery *is* the relationship which exists between the woman having the baby and the woman attending her. For with the relating to another person, comes the knowledge of that person - who they are, what they think, how they feel, what they want, what they need, how they express themselves, what they believe, how they see things, what's important to them in their lives. And if you as a midwife don't have that knowledge of the woman that you are attending at this very special time in her life, you are unable to *be* her midwife. Now, don't misunderstand me; you will be able to care for her, you will be able to give her good care but you are not able to be '*with woman*' in any significant way. You will not be able to fulfil the role of the accompanying presence throughout her labour and birth especially if you are in an employment situation which does not permit you to stay with one woman until her labour and birth are over. And if you are fortunate enough to be able to attend her throughout the labour and birth but without caring for her before or after that event, you are still providing care outside of a relationship with her. So in this situation, there is a profound element missing for both the midwife and the woman. The woman has no idea who this person is who is caring for her - what she thinks, what she believes, how she practises - and more importantly, the woman is very aware that this midwife has no knowledge of her. The midwife has no knowledge of the woman and all that she brings to her childbearing experience and she also knows that the woman and her family don't know her from a bar of soap. So she is at a grave disadvantage in attempting to provide midwifery

care to any woman in this situation at the same time as attempting to develop a relationship with her. It is to midwifery's credit that there are some very fine, capable midwives who can provide excellent care under these circumstances. But let us not mistake providing excellent care with *being* a midwife.

I am aware of the hundreds of midwives in New Zealand who work in this way. I am also aware that a large number of them see no problem with providing midwifery care in this way. And I am aware of a number, I hope not large, of midwives who provide care to women just antenatally or just during labour and birth or just postnatally. Three factors have contributed to this development in the midwifery world.

### Nursing

Nursing is a different discipline to midwifery; it functions from a different ethic. It is related to the care of the sick and the dying and the response to those situations. It has little to do with accompanying a woman through a normal life event and the response to that. Historically, nursing has a completely different development from the road that midwifery has taken. And modern nursing comes from the disciplined environment of army hospitals being run to care for wounded soldiers and for many years, has functioned in a disciplined and hierarchical way with a roster system to ensure that the sick and injured and dying have access to twenty-four hour care.

For about fifty years, in New Zealand and in other countries, nursing education and experience has been seen as a prerequisite for midwifery and the nursing system has gradually eroded the midwifery one. Not only that, nursing has had complete control over midwifery practice and education and it is only recently that midwives have regained control over their own profession and have had the opportunity to develop midwifery's view of what midwifery is.

### Medicalisation

The increasing medicalisation of pregnancy, labour and birth in New Zealand and elsewhere has led to the primary relationship between a woman and the doctor that was providing her with medical care, rather than with the midwife who was going to be there throughout the labour and birth. There was also an undermining of midwifery knowledge and skills especially if it was direct-entry midwifery, that is without nursing education as well.

### Institutions

Once childbearing women were hospitalised, we saw a compartmentalisation of

the process as areas were set aside for the three phases: antenatal, labour and birth, and postnatal care and midwives were compartmentalised too, in order to meet the needs of the institutions which ensured that they had contact with the woman only in one phase of the process. This also included being on a rostered duty system to provide the institutions with 24-hour cover which effectively divorced the midwives from the women that they served.

Hey presto, chango!! Midwifery had lost its focus: the woman.

Once that focus was lost and midwives had been very effectively divorced from the women they attended, the midwifery ethic was weakened to the degree that it became very difficult for midwives to hold up their particular view in the face of opposing or dissenting views, which came from the nursing and medical profession and hospital managements.

But we never lost our view because it is deep seated in our job and the process and in the history and traditions of midwifery. And it remained deep-seated within the individuals who chose a sphere of practice where they could practise according to our view of the world - the midwives who went out and attended homebirths. It also stayed with the hospital practitioners who felt increasingly uncomfortable with the intervention taking place in the normal birth process in hospitals. Most importantly, the midwifery ethic existed in the minds and hearts of the women who demanded better and more personalised care, a homelier environment in which to give birth and refused the interventions of the medical profession. Midwives and women collaborated and conspired all over the country to ensure that women were left alone to give birth normally and without intervention.

Midwifery is still largely practised in the medical and institutional framework and it really doesn't sit well in it. We are all used to midwives who practice in hospitals telling horror stories that sometimes occur and we sympathise with their powerlessness in that situation. We are used to the stories of women who are cowed by the advice they receive from their medical practitioners or made to feel guilty that they are not doing the best for their unborn babies. Sometimes we have a sinking feeling in our guts when we hear these stories or we just *know* that the care or advice given to the women is wrong. That's the midwifery ethic speaking to us. That's the internalisation of our ethic which changes us from women with a job into women who *are* midwives with every fibre of our being.

Becoming a midwife - there is even an American book of midwifery education entitled just that. Those of us trained and

educated in modern New Zealand have many things to overcome in becoming a midwife. Our nursing background. Our institutional experience. Our fragmented approach to pregnancy birth and postpartum care. Our medicalisation "obstetrification" - I think I've just invented a new word! Our lack of confidence in our own knowledge, skills and abilities. The lack of recognition by our nursing colleagues; our medical colleagues and the management of the areas in which we work.

We can and do overcome these things when we work in partnership with women; when we *allow* women and the process of childbearing to teach us the aspects of being a midwife that we do not know. Communication, sharing, understanding from one woman to another about our experience of life as women; how our knowledge of the process relates to the total experience of being pregnant, giving birth, breastfeeding and relating to a new, dependent life.

And underpinning this is a belief - that being pregnant and giving birth is normal. (Sure, it sometimes goes wrong and requires intervention to ensure a live mother and a live baby at the end of it. And midwives become crucial here in order to normalise the event as quickly as possible so that the woman and her family can get on with their lives.) Women, especially in the West and in these times when we have lost the knowledge of the normalcy of this process, need midwives to articulate this belief in the face of the anxiety that exists in the community and in the other caregivers - doctors, obstetricians, nurses - and women need the support of midwives to see them through the process.

Once started on the road of becoming a midwife, you never stop. You never stop being vitally interested and concerned about women and their passage through pregnancy, birthing and childrearing. You never stop learning - through experience; through discussion and sharing stories with your colleagues; through interaction with your medical colleagues; through interaction with the women you attend and through attendance on the process itself. You become able to "midwife" other situations and events - policy meetings, planning meetings, committees, tendering for contracts and so on.

We still have a long way to go to ensure that the midwifery ethic as embodied in the Code of Ethics developed by the New Zealand College of Midwives pervades all aspects of midwifery practice in this country. We have midwives who have internalised the medical model - that is the interventionist model - and who see no reason to change. We have midwives who do not belong to the College and who have no idea of the changes that have gone



on in midwifery in the last two years. We have midwives who have no contact with a profession which has reclaimed itself and is redefining itself according to a midwifery ethic rather than a medical or nursing one. We have midwives who may be the only one in their ward or hospital who believes in the midwifery model and who is having a very tough time trying to improve the care for the women who are on the receiving end of it. We have midwives in independent practice who do not practise from the midwifery model and independent midwives who are providing fragmented care.

The midwifery view is part of a wider perspective and I had the opportunity to explore that earlier this year when I was in Auckland. I had a very entertaining conversation with the Professor of Philosophy at Auckland University. As you are probably aware, one of the functions of philosophical debate is to come up with evidence that proves or disproves the existence of God. Well, for the purposes of our conversation, we took God as a given and moved on to discuss the nature of this being. The stimulus for this particular conversation was the comments that I had made about the way in which midwives practised when they had internalised the midwifery ethic; the accompanying nature of midwifery, being "with women" as they went through one of life's most profound experiences.

We discussed two models:-

The first being the idea of an interventionist being who had the power to intervene in any situation that arose in a person's life and who could be requested to make changes when the going got tough or wasn't to a person's liking. We came to the conclusion that the idea of a powerful being acting as an agent of change was a male view of how the world worked and had resulted in the concept of God as most Western religions understood. We also concluded that this concept underlay the medical model, which we thought was an extreme example of the male view of the world - the power to intervene in life and death itself.

The second view of God that we examined was the idea of an accompanying presence which guided and supported a person as they went through their life experiences. This presence was probably an internal one which a person could connect with at any time in their lives but which did not have the ability to change someone's life circumstances. We felt that this presence facilitated a person's ability to empower themselves to overcome life's adversities as well as enjoy their achievements; supporting and encouraging them through all the experiences that came their way. In short, a midwife!

These views are opposite views of how life, the universe and everything works. There are times when these two views can be complementary. I acknowledge that there are times and situations where midwives will refer women on to medical care because intervention is what they require in order to ensure a safe birth for themselves or their baby or to alleviate a life-threatening situation. Just as people will seek medical help when they need it in their everyday lives - you don't go to a doctor when you're *not* sick.

For the most part, midwives will espouse and exemplify the midwifery model and their conduct will be guided by the midwifery ethic. The Code of Ethics will assist midwives when they find themselves faced with dilemmas in their practice of midwifery, which they will surely do.

I was faced with a dilemma prior to the 1990 Amendment to the Nurses Act. What to advise women who were fit and healthy, experiencing normal pregnancies and unable to find a general practitioner to support them in their choice of a home birth. If they went to hospital to have these babies, I was unable to be their midwife because of the policies in place at that time; I was relegated to being a support person. This was unsatisfactory to the women and unsatisfactory to me. There were no obstetric reasons for these women to go to hospital; they wanted to give birth to their babies at home and there were no reasons why they shouldn't.

I'd been a domiciliary midwife for about ten years. I was angry at the system which gave doctors the power to dictate to women where they should have their babies; I was also angry that another profession could determine where I could or could not practise my profession.

I reflected on my situation; I investigated the legalities governing childbirth. I said to the women "If you go into labour, and you call me, I will come and be with you when you have your baby." They did and I did and eventually, I spoke out publicly about it. I expected to be prosecuted; I wanted to be prosecuted but the Health Department declined to do anything about it. I felt very strongly that I was fulfilling my obligation as a midwife to attend the women but I was aware that if they hadn't had the reassurance from me, few of them would have stayed at home on their own. It did feel that we were in partnership in making the decision about where the woman would be when she gave birth.

I realise now that the midwifery ethic was guiding me to make the decisions that I made. And that same ethic will guide every midwife as she faces the dilemmas of her own practice.

The woman who is sick of being pregnant and wants to be induced; the woman who continues to smoke or take other drugs in her pregnancy; the obstetrician wanting to do a caesarian section that you are unsure is necessary late at night so he doesn't have to do it in the early hours of the morning; the multigravid woman who is going to have her breech baby at home; a woman who has had a previous lower segment caesarian section who wants to give birth at home; the woman who lives miles away from anywhere in very primitive facilities who wants to have her baby at her home; the woman in labour at thirty-six weeks gestation who doesn't want to go to hospital; the woman who wants an epidural at 8 cm dilatation; the list is endless!

The Code of Ethics can be used in any of these situations to assist us to our solutions. And we will make our decisions in relationship with and in partnership *with* the woman. We will communicate our point of view honestly; we will listen; we will not coerce or subtly pressure. And *together* we will come to a solution about what will be done. And the woman will feel at ease, respected and cared for because we do it together.

I believe that the Code of Ethics developed for the midwifery profession in New Zealand is a timely, workable document. I believe that it documents fairly the beliefs that midwives hold about their profession and their practice. I believe it is a timely reminder of where our responsibilities and obligations lie and to whom. Use it to reflect on your practice; use it when you confront that dilemma; use it to influence the way in which midwifery care is delivered, especially in our institutions.

You will benefit by its implementation, your practice will benefit and the women you care for will benefit.

And if every midwife in New Zealand does this, the profession will benefit and so will the country.

This 'Code of Ethics,' is not a dry, dusty piece of paper; it is a living, breathing embodiment of the spirit of midwifery and we are the ones that make it not only live, but sing and dance with the joy of life itself. ■

#### Resources:

- NZCOM Midwives Handbook for Practice. Draft 1992
- ICM Code of Ethics
- Donnison J. Midwives and Medical Men Heinemann. London. 1988.
- Flint, C. Sensitive Midwifery. Heinemann Nursing. U.K. 1986



# Protocols?

Joan Donley O.B.E.

At the recent Second International Homebirth Conference (Sydney), Professor Marsden Wagner, that gadfly of the obstetricians, spoke about the battle raging throughout the western world between the medical and midwifery model of childbirth.

The issue, he said, is fundamental: freedom of choice versus totalitarian repression. To maintain their power, doctors raise the issue of 'safety' to generate fear and uncertainty. They also use the old tactic of divide and conquer - separating the woman from her fetus and fostering antagonism between different groups of midwives, between nurses and midwives, doctors and midwives and women providers against women consumers.

So, what's new? Ever since the Nurses Amendment Act, 1990, we have experienced the whole gamut of the above tactics. In fact, even during the Bill's gestation period, the NZMA told the Select Committee that they saw no reason to change the role of the midwife from that complementing doctors, both within and outside the hospital environment. "We do not believe that there is any advantage to the patient if this role is compromised, i.e. the midwife is seen to be working in competition to the doctor" (1).

The latest forays are two Department of Health (DoH) documents, both of which promote the medical model of childbirth:

- \* Pregnancy and Childbirth Standards, Protocols, and Access Agreements, (Draft - June; Project Report - August.)
- \* Future Regulation of Pregnancy and Childbirth Services, (July).

The first was in response to 'two birth incidents.... identified in 1991 and investigated by the Department of Health on behalf of the Minister... These issues potentially contribute to poor outcomes for mother and baby.

They are:

- \* failure to apply existing protocols
  - \* lack of confidence in methods of ensuring practitioners' competency and peer review processes
  - \* inadequate information for women making choices regarding services for pregnancy and birth
  - \* lack of cooperation and communication between practitioners
  - \* inadequate monitoring systems.'
- Pretty woolly!

We all know about these 'two incidents'-

\* The first homebirth was in Auckland in the days before 'independence'. A homebirth was transferred to National Women's Hospital at the first sign of fetal distress. A caesarian section was not performed until three hours later. Auckland Area Health Board has acknowledged its part in the delay. The baby has cerebral palsy (CP).

\* Shortly after independence, a homebirth in Nelson resulted in a neonatal death. NZ's foremost neonatal pathologist, Dr. D. Becroft testified that 'such unexplained deaths do regrettably occur in hospitals and in circumstances where the latest technology is available.' (2)

The coroner called upon the Minister of Health to review the law allowing midwives to deliver babies without a doctor's supervision. (The coroner has since been challenged in the High Court.)



Photo: Jane Scotts

Joan Donley, O.B.E.

Both these midwives have been before the Nursing Council and both had their charges dismissed at the Preliminary Hearing.

Is the DoH inferring that the Nursing Council's disciplinary procedures are inadequate? That it ignores 'unsatisfactory practice and lack of accountability?' Or is the DoH responding to medical and managerial pressure and using these two incidents to curb midwives?

Since the DoH investigated 'two birth incidents', without recourse to the midwives involved, i.e. in secret, and came to unsubstantiated conclusions, the Auckland midwife wrote to the DoH inquiring if she was one of the midwives, and if so, she would like a copy of the proceedings.

The Auckland Women's Health Council also requested a copy of the deliberations.

Both received similar replies from Kay Saville-Smith, Manager, Health of Women & Younger People Policy, saying that while the first document alludes to issues arising out of birth incidents, the DoH did not investigate the professional conduct of the particular practitioners, nor their specific activities. Therefore, it would be quite inappropriate to identify any of the incidents which contribute to the decisions to undertake that work' - whatever that may mean!

Since then, the GP involved in the first birth incident has been before the MPDC. The MPDC found medical misadventure but preferred the evidence of the GP to that of the midwife, (although the midwife was the only one to present documentation). It was 'dismayed at the lack of national protocols which define the respective responsibilities of medical practitioners and midwives ...' The circumstances of this case are to be drawn to the attention of the Minister of Health, RNZCGP, RNZCO & G and NZCOM.

Rigid, medically oriented 'protocols' are a convenient way to place independent midwives under 'control'. This is an old tactic. 'Not of Woman Born,' tells of the independent and competent midwives of the earlier Middle Ages who were replaced in the later Middle Ages by women caught up in a web of medical regulations and municipal ordinances aimed at either prohibiting their practice altogether or, at least, placing them under total control (3).

Auckland Area Health Board (AAHB) is leading the way to do just that. It has already adopted these protocols and is using them to justify its discriminatory agreement edicts. Now, when a woman is transferred from a homebirth she has either to be assessed by the registrar within 15 minutes of admission, or by a private consultant within one-half hour, who will

decide if the GP or midwife (who have access agreements) can continue care. According to the conventional wisdom, if a woman is transferred, she is no longer 'normal'.

These 'protocols' conflict with the philosophy of AAHB Maternity Services, deprive a woman of the right to select the practitioner of her choice and discriminates against those GPs and midwives doing homebirths. The matter has therefore been brought to the attention of both the Board's Review and Ethics Committees as being of Section 27 of the Commerce Act, 1986, (restricting competition in the market).

The Frontline programme 11 October used was to undermine the midwifery model of childbirth and create public demand for safety 'protocols' to protect women from midwives who don't do routine episiotomies, - resulting in babies with cerebral palsy. (Would such protocols protect the public from the obstetrician whose glasses fell off into the woman's abdomen when he was doing a caesarian section? I also wonder if DoH appreciates that rigid protocols will give obstetricians and managers the ability to define the majority of women as 'high risk' to keep them out of the hands of midwives - and will astronomically increase the cost of maternity care?).

As a result of the strong protest, the second Frontline, (8 November) dealt with hospital 'disasters'. It was interesting to hear Professor Colin Mantell say that "The actual process of delivery is not always the cause. Everyone has this expectation, this vision that childbirth is going to be normal. The fact remains that the cause of the problem babies is exactly the same as they were earlier. People have to be realistic. There are times when we just cannot predict and are surprised at how bad the outcome is. I believe this will continue to happen as long as there is obstetrics."

Thanks, Colin. Does that also apply to midwifery? Or can we expect continuation of the witch hunt against midwives - one of the "greatest threats to modern obstetrics?"

Everyone concerned about the continuation of independent midwifery should obtain a copy of "Pregnancy and Childbirth Standards, Protocols, and Access Agreements", (P.O. Box 5013, Wellington.) Speak to your MP - she or he will be coming up for re-election next year.

#### References:

1. New Zealand Doctor 17.4.90
2. Nelson Evening Mail. 20.6.1991
3. Renate Blumenfeld-Kosinski. p.91. Cornell University Press. 1990.



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# Midwifery Issues

Bronwen Pelvin

Independent Midwife

Highlighted by the recent  
'Frontline' Programme.

There are a number of issues for midwives to consider when looking at the events surrounding the case involving Sian Burgess which was highlighted on the 'Frontline' programme - 11 October 1992.

These are:

- the decision to have a homebirth under the care of a midwife and who made it;
- the issue of induction;
- artificial rupture of membranes;
- meconium-stained liquor;
- monitoring of the fetal heart;
- mechanism of transfer to hospital; and
- midwifery accountability.

I would like to consider these aspects individually and then sum up the situation as a whole. My opinions about the case have been formed from discussions with Sian Burgess and after viewing the 'Frontline' programme.

At some point during her pregnancy, the woman involved in this case decided to have her baby at home. She engaged Sian Burgess, midwife, and her G.P. to attend her. The G.P. must have been agreeable to the birth taking place at home, as these events occurred before the Nurses Amendment Act was passed. We have to assume that the woman, having had babies in hospital before, investigated what having a home birth would mean before she made her decision.

We also must assume, the midwife she engaged explained the way in which she practised and that the woman made a clear decision to opt for midwifery care, rather than the medicalised care she would have received in hospital. One of the basic issues about choosing homebirth is the woman and her family accept responsibility for the choice that they make.

The management of prolonged pregnancy is an area of obstetrical debate. In 'Effective Care for Pregnancy and Childbirth,' by Enkin et al, the point is made, that no research, to date, has shown any advantage of induction over observation, in managing prolonged pregnancy. The majority of experienced homebirth midwives are likely to advocate observation, rather than support a call for induction. There has been a recent tendency amongst some obstetricians to not even consider pregnancy to be prolonged until 42 weeks have passed. In this situation, the woman was caught between the approach taken by her midwife and that of her G.P. The woman seems to have felt the doctor called the shots, and the induction spoken about was a foregone conclusion, unless she went into labour. It appears that this woman had insufficient information to make a balanced informed choice about her care.

This woman did make a choice. She asked her midwife to help her get into labour so she would avoid two things :

- continuation of her pregnancy and
- induction in a hospital setting.

Responding to her client's expressed need and her level of distress, her midwife agreed to try some acupuncture to get labour started. She assessed her vaginally prior to giving her acupuncture and again after contractions had been established, and in her professional judgment, determined that the woman was in labour. With the woman's insistence and her informed consent, the midwife ruptured her membranes.

Admittedly, this is an intervention not often used by midwives especially in a homebirth setting. Membranes are ruptured at times, and that decision *must* be made by the attending midwife, who will consider all the factors involved.

Artificial rupture of the membranes during labour is often used in the hospital setting, mostly for the spurious reason of seeing the colour of the liquor - that is, as a test of fetal well-being. Rupture of the membranes is a serious business and one which no midwife should undertake lightly. Firstly, it removes the protective membranes and amniotic fluid from around the baby's head, and secondly, it is a commitment to the birth of the baby. However, there will always be situations which, in the midwife's judgment, the membranes should be artificially ruptured. This is the one case in which the midwife made that decision.



When the woman's membranes were ruptured, the liquor which drained was stained with meconium. Meconium-stained liquor is an extremely contentious issue and every experienced midwife will have attended many cases where meconium stained liquor has been no indicator of the baby's well-being. Given the above, and the lack of agreement on whether fetal cardiotocography is an effective indicator of fetal distress, each midwife will make a decision and give information based on her own experience and her assessment of what is safe practice. There is no doubt, that meconium in the liquor is an indication for closer monitoring of the baby's condition and this was done in this case.

The decision to transfer this woman to hospital was made at the appropriate time - that is, when there was a clear indication of fetal distress and the birth was not imminent. The transfer was effected in the quickest possible manner. The woman's G.P. was notified.

On arrival at the hospital, a discussion took place as to which consultant would

be engaged, not an uncommon discussion in base hospitals where there is a choice. There was a delay until the obstetrician arrived, and a further delay until the anaesthetist arrived to insert an epidural anaesthetic. The fact that this wait took place suggests there was no sense of urgency about delivering the baby or an anaesthetist would have been summoned urgently and a Caesarian section would have taken place under a general anaesthetic. For midwives working in hospital and those involved in transferring women from home to hospital, delays until treatment is effected are not uncommon.

Sian Burgess, the midwife involved in this case, has accounted for her actions at an Auckland Area Health Board Perinatal Mortality Review, the Domiciliary Midwives Standards Review Committee hearing and twice before the Preliminary Proceedings Committee of the Nursing Council which included an obstetrician. She also appeared as a witness in the Medical Council's hearing about the actions of the G.P. involved.

Cerebral palsy remains a mystery. Is it a result of birth asphyxia or is it an antenatal event? Do labours 'go wrong' because the baby is already brain damaged or is it the baby brain damaged because the labour 'goes wrong'? Who knows? The birth experience of the woman concerned in this case gives no insights into this matter and the media coverage in the 'Frontline' programme has only served to damage the midwifery profession without enlighten-

ing us with a balanced investigation of the issues. Whatever the answers about cerebral palsy, the woman and her family must take the responsibility for the decisions she/they made in relation to their baby's birth, as Sian Burgess is taking the responsibility for the decisions she made when she acted as their midwife.

I believe this case highlights the need for a different model to deal with the complaints that clients have about their midwife's actions - one which can bring the two parties together to resolve the situation in the presence of an able facilitator. Tragedies *do* occur at birth, and less than perfect babies *are* born. The complaints procedure should be one which seeks to increase our understanding of these events, not one which seeks to apportion blame. ■



### Nursing Council of New Zealand's Complaints Procedures

**W**hen a complaint about a midwife is received it is acknowledged by the Registrar and referred to the Convenor of the Preliminary Proceedings Committee (PPC).

The PPC consists of three Council Members appointed by Council. The present members are Isobel Sherrard (Head of Health Studies, Carrington Polytechnic) Eileen Johns (Manager, Health Development Unit, Wellington Area Health Board) and Gordon Cumming (Retired Obstetrician, Palmerston North).

Although the Convenor of the PPC may decide the matter need not proceed any further this in fact happens rarely but may occur where the complaint is about midwives in general, rather than a specific complaint is clearly vexatious or trivial. In almost all cases the Convenor proceeds the complaint to enable the PPC to investigate and decide whether

any further action should be taken. This was the process in the complaints against Sian Burgess.

The following is quoted from the Nursing Council document "In the Public Interest Disability and Disciplinary Provision of the Nurses Act 1977".

#### Investigation

p3: *"An investigation by the committee involves the collection of further information to substantiate the matter of the complaint. This may take the form of correspondence, interviews with witnesses and complaints, written statements, visits to the work place, examination of records, drug registers and other documentation. This work is undertaken at the direction of the Committee by legal advisors, Council Staff or other appropriate persons nominated and on occasions by the Committee*

*itself. Before the Committee makes any decision on whether or not any further action should be taken, a notice is sent to the midwife concerned. The notice specifies the substance of the complaint with sufficient particularity to enable the midwife to answer it".*

The midwife is then given the opportunity to be heard by the Committee. If the Committee is satisfied by their investigation and the explanation provided by the midwife, the matter will proceed no further. This was the outcome of the complaints against Sian Burgess.

When the Committee believes there is a case to answer there would be further inquiry, then charges of professional misconduct would be laid and a date set for the hearing of the charges to the full Nursing Council. ■

## CONFERENCE OPENING SPEECH

Hon. Simon Upton, Minister of Health.

The Health and Disability Services Bill which was introduced to the House last week will pave the way for a system that puts the user first. Not the purchaser, not the provider – but the user..... People are living longer, and requiring more services. Currently an estimated 44 percent of the health budget is spent on those 60 and older.

Almost three quarters of the health budget is spent on secondary services. And of the quarter left for primary services, just over a half goes on medicines. Now, you are a professional group providing a community-based service to younger women. A service which has been able to bridge the traditional barriers between primary and secondary care. I'm sure I don't need to explain to you why this balance in the way we spend health money must change. And why, particularly, we must change the popular belief that health equals hospitals.....

It is the Government's view that there is little room for more public expenditure on health. We're already planning to spend \$3.3 billion more this year than we receive in taxes. What we can and must do is change the way we fund and provide health services. This is the only way we will achieve a better level and quality of health care for the same money.....

From July 1 next year, the four RHAs will be responsible for buying the health services their communities need, from a fixed sum of money given to them by the Government. They will strive to buy integrated, managed care for every member of their population. Progressively we will see fewer patients bounced like ping-pong balls across traditional professional boundaries. Neither will it pay RHAs – either financially or in terms of improving the health status of their communities – to continue to pour resources into secondary care at the expense of primary care. RHAs will be looking to contract with a variety of public, private and voluntary providers for the services their communities need.....

It will, of course, be entirely up to RHAs to plan their own purchasing. But I can outline for you some of the options they might be looking at.....

Under the new system, the Government will remain the chief funder, but will pass responsibility for purchasing to RHAs. They will be looking to sign up providers to contracts which are far more

precise than ever before. Contracts which will specify not only price, but quality, and often quantity of services.

RHAs will be keen to ensure that the purchasing option they choose for maternity services actively encourages women to get the care that's most appropriate to their needs. They will want maternity services to be accessible, efficient, and safe for women and babies. They will have to give women scope to choose their own provider.

RHAs will consider other factors too, such as the extent to which a service integrates primary and secondary components, and how successfully it enables them to control their expenditure. So let's have a look at some of the purchasing options RHAs might consider.

The most obvious is simply to continue the present Maternity Benefit arrangements. Contracted practitioners would then claim a fee for service, just as they do now. This form of contract has a number of problems. The current arrangements for funding maternity services have led to rivalry and poor communication. They have hampered integrated service between the main primary providers - GPs, obstetricians and independent midwives. And they have led to cost-shifting from the secondary sector to the benefit.

RHAs will receive fixed budgets from the government and have to operate within them. Continuation of open-ended, demand-driven payments for some services would perpetuate the problems of the current system, and shift budget pressure on to other services.

As well as giving the funder little financial control, fee-for-service arrangements encourage over-servicing. And have provided for little formal, performance-related accountability between the Government and providers.

Without change to the current contract, RHAs would be unable to anticipate their exact expenditure on maternity services. Considerable concern has been expressed about the cost of midwifery services under the new legislation.....

A second contracting option for RHAs, would be to pay providers a block fee for the provision of a specified set of maternity services to a particular population – one or more of antenatal, birth and post-natal services. In this case, the provider might become the budget-holder, managing the budget for all parts of the service. And their remuneration would be based on how many enrolled patients they had, as well as on the actual services for which they are responsible.

Such a scheme is not new. A global fee for complete maternity care was paid from 1941 to 1966, when it was replaced by a fee-for-service contract because the New Zealand Medical Association found it too restrictive.

Service components would be explicit. And providers would be encouraged to provide all aspects of care, so that patients received the benefit of continuity of care. A further advantage of this scheme is that it would enable RHAs to forecast expenditure quite accurately on the basis of predicted patient numbers.

Users would be free to choose one primary provider of maternity services as their agent. That provider would then act as a gatekeeper to other services, and exercise considerable influence. This arrangement would facilitate a managed care approach to maternity service.

RHAs might prefer to sign such contracts with groups of providers willing and able to provide between them a comprehensive pregnancy and childbirth service for a specific number of patients.

This sort of service could cover both primary and secondary care, bringing in midwives, GPs, obstetricians, and others. Patients would be able to choose from within the group of providers. RHAs would be able to control expenditure. And primary and secondary care would be integrated.....

There are other options.

Maternity services could be purchased as part of the full range of bulk-funded primary care. Bulk-funded primary care providers could then sub-contract with others for maternity services.

Finally, hospitals could employ salaried practitioners to deliver maternity services, and endeavour to secure contracts with the RHA. Such an integrated arrangement would certainly allow RHAs to predict expenditure accurately, and might be particularly useful in rural or remote areas. But providers faced with losing their independence might not be so enthusiastic about it.....

Midwives feature in three of the ten pilot projects currently trialling new ways to deliver primary care. These will run over the next year.

In Wellington, a group of midwives is trialling comprehensive service provision based on bulk-funding. They aim to make it cost-effective and accessible, and are looking for a high level of user satisfaction.

Another Wellington group is involved in a Union Health Service trial of a capitation contract covering a range of services, including maternity care.

And in Papakura, a midwife is involved in a marae-based project to provide a culturally appropriate maternity service for Maori women.

All these projects will provide you as midwives with useful models when you come to consider how to develop your services in the reformed system.

I have no doubts that you will find a niche in the new world. ■

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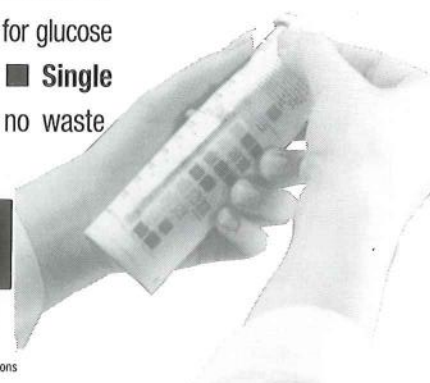
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1. Brigden, M.I., Edgell, D., McPherson, M., Leadbeater, A., and Hoag, G. 'High Incidence of Significant Urinary Ascorbic Acid Concentrations in a West Coast Population - Implications for Routine Urinalysis'. Clin Chem 1992;38/3:426-431

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185515	Combur-7-Test	100				x	x	x	x	x	x	x
784656	Combur-6-Test + Leuco	50		x		x	x	x	x	x		x
398454	Nepthur-Test + Leuco	50		x	x	x	x	x				x
1008552	Nepthur-7-Test	100		x	x	x	x	x	x			x
784672	Combur-5-Test + Leuco	50		x	x		x	x		x		x
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# Vitamin K in Relation to Haemorrhagic Disease of the Newborn

Joan Donley

Independent Midwife

**H**aemorrhagic disease of the newborn was described almost 100 years ago in 1894, by Townsend, as a bleeding syndrome in newborn babies, not due to trauma or an inherited bleeding disorder eg haemophilia.

A 1955 textbook (1) says, 'spontaneous haemorrhage from the mucous membrane of the alimentary canal is a rare disease', usually occurring within the first three days of life. 'In the vast majority of cases the haemorrhage is associated with a very low prothrombin level in the infant's blood.' It also notes, the normal infant has a lower prothrombin level than the average adult.

At that time, the classical treatment of giving the infant intramuscular injections of whole blood had been replaced by administration of daily 5 mgm injections of synthetic vitamin K until the bleeding stopped. Prophylaxis consisted of giving the mother vitamin K (either by mouth or intramuscularly) at the onset of labour, which resulted in 'a high prothrombin level in the blood of the infant at birth'.

Occurrence of the disease between 2-5 days is referred to as the 'classic' form. Today, very early onset (within 24 hours) and late onset (after one month) are also recognised.

Early onset is seen in babies whose mothers, during pregnancy, have taken

- antibiotics (which decrease vitamin K absorption);
- anticonvulsants (phenobarbitone, phenytoin which increase vitamin K utilisation) or
- anticoagulants (warfarin, coumarin which require vitamin K deficiency to be effective).

Classical haemorrhagic disease of the newborn is manifest by oozing of blood from the gut (melaena), the nose, the cord, broken skin sites. Late onset, manifest mainly by intracranial haemorrhage, and sometimes from the gut, is relatively common today. Lane, (1985) maintains that during the past ten years vitamin K deficiency haemorrhage is an important cause of morbidity and mortality in infants older than one month (3). The disease is more frequent in male infants.

A two year prospective study of 1,671,000 live births in UK (Dec. 1987 to March 1990) places the incidence at 1.62/

100,000 live births (4), (0.00162%). Out of one and a half million live births there were 27 cases of haemorrhagic disease of the newborn. Of these, 25 cases were confirmed on the basis of history, laboratory tests and no evidence of infection (although two had hepatitis!) Two cases lacking laboratory confirmation were classified as 'probable'.

Of the ten classic cases:

- 1 had hepatitis
- 2 had poor liver function
- 1 was on cow's milk formula
- 1 was on cow's milk supplement.

Of the 17 late onset cases:

- 1 had jaundice
- 1 had hepatitis
- 4 had an alpha 1 antitrypsin deficiency
- 3 had poor liver function
- 1 was on soy milk.

Six, (plus one probable) late onset babies had oral vitamin K at birth. Three were receiving formula which is seen to be a source of vitamin K. Twelve of the 27 had conditions which would indicate that vitamin K deficiency was not the primary factor involved.

Previous studies have questioned the efficacy of vitamin K in preventing late haemorrhagic disease of the newborn. Kries (5) states that the concept of pure dietary deficiency as the cause of late onset of the disease appears to be rather unlikely. More likely, are factors which reduce a baby's ability to absorb or utilise vitamin K. These are hepatitis, cystic fibrosis, antibiotics, chronic diarrhoea, bile duct atresia, alpha-1-antitrypsin deficiency, coeliac disease or insufficient plasma transport capacity as in abetalipoproteinaemia. It was also suggested that subclinical cytomegalovirus could be a cause, and that environmental factors could be involved.

Hall (6) is of the opinion that the use of vitamin K in preventing the late onset of the disease requires further study, as there are other coagulation abnormalities associated with liver disease.

## Vitamin K

### What is it? What does it do?

Vitamin K was named after the Danish word 'Koagulation' by Henrik Dam, a student at the University of Copenhagen.

Vitamin K occurs naturally in the body as:-

- K1 - phytonadione or phylloquinone
- K2 - menaquinone produced by bacteria in the large intestine.

As a fat soluble vitamin, it requires bile salts to emulsify the fats so these can be acted upon by the water soluble digestive enzymes.

Vitamin K, stored in the liver, plays a role in the very complicated process of blood clotting, which involves the liver and gall bladder, the blood and gut. Vitamin K is involved in the formation of prothrombin and conversion of coagulation protein factors 11, V11, 1X, & X which are synthesised in the liver. These bind calcium (factor 1V in blood plasma) by promoting the carboxylation of a glutamic residue on the precursor proteins (6).

These proteins are referred to as PIVKA (Protein Induced by Vitamin K Absence or Antagonist) or PIVKA-11 (Protein Induced by Vitamin K Absence like 11). These can be detected in the cord blood when vitamin K is deficient (6).

The blood factors are

- platelets or erythrocytes manufactured in the bone marrow;
- thromboplastinogen which are a number of inactive precursors of thromboplastin;
- and calcium ions.

A blood clot consists mainly of formed elements of blood entangled in a network of protein fibre called fibrin which begins with the breakdown of the fragile platelets when exposed to air (as in a wound) or internal injury (8).

## Natural Sources of Vitamin K

**ALFALFA** or Lucerne (*Medicago sativa*) contains large amounts of vitamin K and vitamin E, and eight important digestive enzymes.

**KELP** and other seaweeds contain iodine necessary for the thyroid gland to produce thyroxin, which plays a role in blood coagulation. Lack of vitamin E inhibits absorption.

**FOODS** which contain vitamin K are egg yolk, spinach, kale, cabbage, cauliflower, tomatoes, carrots, potatoes, turnip greens, all green leafy vegetables (chlorophyll), soy bean sprouts, blackstrap molasses, yoghurt, whole grain cereals, rice bran, pollen, cow's milk, liver.

Absorption inhibiting factors are - mineral oil, antibiotics, phenobarbital, anticoagulants, phenytoin, large doses of vitamin A (oral contraceptives cause increased vitamin A levels, 2) aspirin, antacids, (aluminium hydroxide).

Infection lowers platelet count causing a deficiency of thrombokinasase.

## Synthetic Preparations of Vitamin K

- K3 - Synkavit - water soluble, can cause haemolysis. Has been known to cause haemolytic anaemia in babies who have a glucose-6-phosphate dehydrogenase (G-6-PD) deficiency. Pregnant women should be warned of the dangers of using K3 as it can cause liver damage which has been associated with hyperbilirubinemia in the newborn and kernicterus in premature infants (2).
- K1 - Konakion (Phytomenadione) - fat soluble, not thought to be associated with haemolysis, although New Ethicals warn of jaundice or kernicterus. It may cause anaphylactoid reactions, due to the polyethoxylated castor oil present (6). Roche, which supplies Konakion ampules does not mention any side effects in its accompanying insert.

Recently a 10 year study of 16,193 British babies born during one week in April 1970 found that babies who had received injections of vitamin K had a three times greater risk of developing cancer by the age of ten years (11).

A later study of 111 children with cancer born between 1965 - 1987 in Avon were compared with 558 healthy children. This found a twofold risk of leukemia in children who had received intramuscular vitamin K. The British Dept. of Health has now set up a working party to investigate this finding. It is funded by Roche, which manufactures vitamin K (12).

A NZ 'Decision Analysis' (16) dismissed assays measuring vitamin K and proteins which suggested that newborn infants were not vitamin K deficient of that a heparin like inhibitor caused prolonged coagulation times (18). Instead, it reaffirmed the need for continued vitamin K prophylaxis due to the resurgence of breast feeding, and (believe it or not) to the trend to reduce unnatural interference in the birth process, as well as consumer resistance to intramuscular injections.

Prophylaxis was seen to be cost effective by estimating the cost of an IM injection of Konakion @ \$2.01 compared to 10 days in Dunedin's neonatal unit @ \$640 per day (\$6400) for a baby with haemorrhagic disease of the newborn.

It also claimed that there was an even cheaper oral product available from Sigma US. However, an enquiry from the agent elicited the reply that Sigma does not make chemicals for human consumption - only for research and laboratory use (19).

How come the conventional wisdom has arrived at these conclusions?

Low prothrombin levels are a normal occurrence in the term healthy newborn. Professor Birkbeck, director of the Society's Nutrition Committee says that the levels

fall to day three, then gradually rise to day six (14). Obviously this condition was recognised in ancient times as the Hebrew religion had a taboo against circumcision before the end of the first week (20).

Birkbeck notes that haemorrhagic disease of the newborn seems to be almost unknown in central Africa today, suggesting an environmental mechanism (14).

## Vitamin K in Breast Milk

Not only is vitamin K present in human milk (21), but colostrum contains more vitamin K than mature milk. This content was found to be much greater in the presence of vitamin E (22). Further, the concentration of vitamin K is greater in hind milk, suggesting that the lipid content influences the vitamin K levels (23). Eating good natural sources of vitamin K can produce substantial rises in a mother's levels within 24 hours.

The healthy newborn has fetal hepatic stores of vitamin K which can be drawn upon until the baby's intestinal flora establishes synthesis (21).

Palmer points out that in the days before the use of enemas during labour a woman generally emptied her bowels as she pushed the baby out. This allowed ingestion of a few bacteria to initiate vitamin K production in the gut (24). Finally, breast milk contains thromboplastin (25). Therefore, in these early days, the volume of colostrum and milk intake is important. A baby who has had a normal unmedicated birth suckles much more vigorously than one who has been subjected to interventions.

In 1977, a study concluded that "healthy babies, contrary to current beliefs, are not likely to have vitamin K deficiency ... the administration of vitamin K to the newborn is not supported by our findings." (18).

## Why are these Findings Considered Inadequate Today?

A discussion paper from the University of Amsterdam (26) believes that 'polychlorinated biphenyls (PCBs), polychlorinated dibenzo-p-dioxines (PCDDs) and polychlorinated dibenzofurans (PCDFs) present in breastmilk in industrial countries cause the late haemorrhagic disease of the newborn'.

It says, 'PCDDs and PCDFs are the inevitable by-products of industrial chemical products such as the herbicide, 2,4,5T, wood preservatives (pentachlorophenol) and bactericides (hexachlorophene)... PCBs, PCDDs and PCDFs are a mixture of isomers. They can induce enzymes in the liver such as phenobarbital or 3-methyl-chloranthrene' which can cause liver damage and prolong prothrombin time. Biochemically it is not known how the enzyme-inducer phenobarbital interferes with vitamin K metabolism in the perinatal period 'but it is a clinical fact.' (27).

Birkbeck says the food antioxidant butylated hydroxytoluene (BHT) results in a greater fall in prothrombin levels (14).

Contamination of breastmilk by these pollutants has been confirmed in a number of studies (28). An analysis of 38 samples from NZ women in four regions (a small sample) showed lower levels than in more highly industrialised countries (29). The effects can be viable dependent on nutritional and/or genetic factors.

Not all babies are healthy at term. A 1978 Lancet editorial (30) suggested a selective approach to prophylactic vitamin K. This included babies who were:

- pre-term or low birth weight,
- subject to trauma at delivery,
- bruised or bleeding in the first few days,
- requiring surgery,
- being treated with antibiotics,
- taking inadequate amounts of feeds for early discharge and
- those wholly breast fed, which was first on the list!

Babies who have suffered perinatal asphyxia, or whose mothers had albuminuria or took barbiturates or phenytoin have greater falls in prothrombin levels. Hepatic immaturity also predisposes to haemorrhagic disease of the newborn. (14). Pre-term (premature) babies are particularly at risk of cerebral haemorrhage.

The Fetus and Newborn committee of the Paediatric Society of New Zealand recommends (1992):-

1. All infants should have vitamin K prophylaxis.
2. For healthy term infants the preferred route of administration is oral: 2 mg given at birth with the first feed. For breastfed infants repeat doses (2 mg) should be given at five days and at six weeks. These repeat doses may conveniently be given at the time of the Guthrie test and with the first immunisation but should not be delayed if either of these do not take place on time.
3. For high risk infants (maternal anticonvulsant of coumarin therapy, prematurity, birth asphyxia and traumatic deliveries, known hepatic disease, or any illness in the infant which will delay feeding) the preferred route of administration is intramuscular, 0.5 to 1mg. Ordinarily only a single dose at birth is required, although repeat doses may be necessary in malabsorption states or in infants requiring parenteral nutrition (13).

Currently there is no oral preparation available in NZ, though homeopathic alternatives could be used.

## References

These are available on request from the author.





# Six Years of Independent Midwifery in London

Alice Coyle

Independent Midwife  
London, U.K.

Presented for the  
NZCOM Conference

I feel very, very honoured to be invited to speak in New Zealand where you have in place the system of domiciliary midwifery which, I would love to see in Great Britain. I assure you that we are way behind you in this department. A few weeks ago I had a phone call from a New Zealand midwife who was visiting London. She wanted to meet me to find out how the system worked there. When I learnt that she was a domiciliary midwife with 300 home births to her credit, I didn't get around to telling her much. I was too busy picking her brains!

As an introduction about practising as an Independent midwife in London, I feel it is important to give a few background notes and definitions.

Firstly - What do we understand by the word 'Midwife'? The WHO - clearly defines midwifery education and practice, a definition with which you will be familiar.

The Tao Te Ching says:

*You are a midwife: you are assisting at someone else's birth. Do so without show or fuss. Facilitate what is happening rather than what you think ought to be happening. If you must take the lead, lead so that the mother is helped, yet still free and in charge. When the baby is born, the mother will rightly say: 'We did it ourselves'.*

And my son Jack when aged seven described a midwife as:

*A woman who catches babies so that they don't fall on the floor and hurt their heads.*

Although the first is an accurate job description, personally I prefer the second two.

In England a midwife can be trained by taking an 18 month postgraduate course, or she can do a three-year direct-entry course. She can qualify at diploma or degree level. It is illegal to practice as a lay midwife. In the NHS midwives practise in various ways. Midwives can work in hospital doing ante-intra or postnatal care or in the community mainly doing home visits when women are discharged from hospital.

Midwives can attend any homebirths and domino scheme births. There are not many homebirths, 1% being the national average. They may also teach classes and share care with GPs. Some areas are setting up teams of between 4 to 10 midwives who take on case loads of women and attend them for births at home or hospital. There are midwives who are employed in the private sector and work in private hospitals, clinics and some are employed by GP practices. I am an independent midwife which means that I am self-employed in private practice, mainly taking bookings for homebirths. I am paid directly by my clients. There is no system working like your domiciliary system. There are around 70 independent midwives in the UK, most of whom work part-time. They tend to work in solo practices or in pairs.

## A Woman's Entitlement to Care

By law a woman is entitled to give birth wherever she pleases. She is entitled to give birth completely unattended or aided by a midwife or doctor. The only time she may be attended by anyone else is in an emergency. This covers ambulance drivers and hospital car park attendants who assist! The NHS has a responsibility to provide a midwife to attend the woman for childbirth, in the place that she chooses. A woman cannot be refused admission to a hospital when in labour, and cannot legally be refused care, although she can refuse treatment. She can reject a particular practitioner and is entitled to a replacement. She can refuse to be attended by students.

## Laws For Doctors

GPs can refuse to book a woman for her care but cannot refuse to attend if summoned in an emergency. An obstetrician cannot refuse to treat a woman admitted for care.

## Laws For Midwives

The midwife is trained to be responsible for the woman's care up until 28 days postnatally. However, she usually discharges her prior to that time to the care of the Health Visitor who is responsible for the baby up to the time she or he starts school where the school nurse takes over. The midwife must be registered and notify her 'Intention to Practise' annually, in each area she takes cases or practises. She cannot refuse to attend a woman in labour when called and although she must call for medical aid if there is a deviation from the normal, if the woman refuses to accept medical or midwifery advice or treatment, the midwife must still attend her.

There is a booklet put out by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKC) in which the Midwives' Rules are laid out. These are fairly brief and give a wide scope for exercise of clinical judgment. It is the interpretation of these rules where problems can arise as I will explain later.

## Why Independent Midwifery?

Why, when a woman is protected by law to choose where to give birth, and is entitled to be provided with the carers to deliver it, does she choose to pay for an independent midwife? She has already paid via her national health contributions for maternity care, so she is paying twice? Well, these women may have been advised not to have a

homebirth and found the doctors and midwives were so against her continuing with the idea, she then found their attitudes were unsupportive and inspired no confidence.

For many women it is important to know who will attend their birth, and to make time to build a relationship beforehand. Others look at the statistics and figure that if there are 30-40 home births, in a district out of a total number of 3-4000, these being divided between 18-20 midwives, then this does not add up to much experience with homebirth. There is one district in London where out of the total number of women booked for homebirth, 4 out of 5 are transferred to hospital. I would not be happy to take 'pot luck' at getting an experienced midwife in that area. In some areas where teams are set up, it could still mean a choice of 4-8 midwives to attend the birth.

Why do midwives go into independent practice?

I trained as a midwife to give me the 'rounded off' training required to get a job as a ship's nurse. I had no knowledge of midwifery, and I believe this was, in some ways, a great advantage! Because I had no knowledge, I also had no preconceived ideas.

In 1979 when I trained, there were a lot of practices that were very illogical, cruel and dangerous and not based on research findings. I was constantly in trouble for questioning accepted norms and eventually felt so worn down that, after passing the final examination, did not practise for 6 months. I returned to midwifery for 5 years in-between having my two children. I soon realised the NHS not only wasn't designed for women with children to work in, but that also it wasn't designed with the consumer in mind either. I had altered my practice in various ways, such as - no longer doing shaves or enemas or routine episiotomies, not giving pethidine and encouraging women to be more active in their first stage. The trouble was, when I went for my tea break, more often than not, I would find that 'my' woman had been enema'd or given pethidine in the interim. I was considered a weirdo. I'm sure a lot of you can relate to that! It was a frustrating time.

I saw that the only way for me to cope working as a midwife and spend time with my kids was to leave the system and go independent. Some considered this an unwise step - what about the pension? What about the drop in salary? To me, that was no consideration as I was so unhappy working in the system I soon would have left anyway. At least with independent practice I was working with likeminded people and providing continuity of care for women. I had a very good friend working with me who was equally dissatisfied with the system. She felt strongly the best place to push for change was from within the system. I felt I didn't have the strength to keep fighting day after day and then cope with a family at home. At that time she had no children. I left

and she stayed in. I have the greatest respect for her and the others who stay there fighting. She eventually got the sack from the health service over a difference in clinical judgment, took them to court and was reinstated after they were accused of unfair dismissal. She got so fed up she left and is now independent as well.

I contacted Caroline Flint after reading 'Sensitive Midwifery'. She suggested having a chat to another independent, Melody Weig, an American, British direct-entry midwife who'd been in practice for 5 years. I spent an afternoon with her and was totally converted. She invited me to be her apprentice - an offer I accepted at once. I attended consultations and births with her and then began to take my first cases with Melody providing back-up. One of the first homebirths I observed was a breech.

I was terribly excited about being there but I ended up not seeing a thing as Belinda's partner found the whole situation so traumatic that I was required to take over from him as her supported squat partner! However, the real learning experience for me was the decision process which occurred in the antenatal period resulting in Belinda opting for a home breech birth. I saw truly informed and supported choice in operation. The registrars had no experience of natural breech births and were very sceptical of the whole idea. On that basis Belinda decided the best choice for her to labour effectively and remain relaxed, thus giving her baby a good chance to be born undistressed, was at home. As she had refused medical advice to transfer to hospital, we agreed to continue her care at home.

Six months later I was practising as an equal partner with Melody in the Independent Midwifery Service. That was six years ago.

### Practicalities of Working in London

London has a population of 9 million in the inner area but within the M25, a motorway that circles it, the figure is around 20 million people. This makes for smaller living spaces and very slow moving traffic. It can take 2 hours to cross London by car, and that's not in the rush hour! Imagine what it's like when the Wimbledon tennis or the Chelsea Flower Show is on! I work frequently in both of those areas. Parking is horrendous and the spot fine offence is \$90. Maybe you can understand why I started using a motorbike. My travelling times are much more predictable now and my stress levels lower.

Besides that - it's a lot of fun!

The first two cases I took on, lived about one and a half hours travelling time from my house which didn't seem too bad until you consider one was north-east, the other southwest! Melody later informed me in order to assess whether I was really serious about practising, she had given me the cases she didn't want because of the travelling time involved!

Well, Gillian went into labour in the middle of a very snowy January - she was the north-east one. My sister was over from Australia and spent most of her time trying to keep herself warm in my non-centrally heated flat. She was grounded because no public transport was running and I rushed off excitedly, leaving her to cope with my two children, until my girlfriend could walk over the hill to relieve her. I slithered my way to Gillian's taking 2 hours in the snow where Melody joined me a while later. After a few hours of not doing a lot, Gillian announced that she really felt like a walk in the snow. She was gone for an hour and a half and during that time Melody suggested to me that she probably wasn't really in labour!

We went home. Later that night I was called again when Gillian was cracking on. Five minutes later Melody phoned to say she was just on her way to another woman in strong labour. This one was 25 minutes to the south-east. I went back to Gillian and Melody joined me in time for the second stage. Then her bleep went again to say Judy was in labour about 45 minutes away. Melody rushed off, and I joined her after I had finished helping Gillian. Judy lived in a squat with inadequate heating, so as soon as I arrived, I was dispatched, in the snow still, to find another heater. Luckily my sister-in-law lived around the corner so I was able to borrow hers. That night we'd had 3 births in 15 hours, with thick snow everywhere and a beautiful full moon. That was a dramatic initiation into independent practice and homebirth!

Teresa, my second case - the one in the south-east, was a midwife having her second baby. She had a very irritable uterus and I took her to hospital in suspected premature labour at 26 weeks. She eventually got to term and had a lovely straightforward birth. During her labour I rang Melody who asked me if I wanted her to come. When I thought about it, I realised, I really was happy to carry on on my own, I think this was the point at which I began to really trust in the natural process, and my ability as a midwife.

### How I Practise

I usually book women for home births but make sure that they understand I cannot guarantee they will stay at home. I will stay with them through the labour wherever it takes place. We have honorary contracts to enable us to transfer a woman into two London hospitals where we can continue her midwifery care. We can transfer her to other hospitals as her right, but we cannot practise in them. Instead, we have the status of labour support partner with hospital staff managing her care. We have little control over the situation.

A client's booking visit, in her house, takes around 2-3 hours. Then she visits me for the 45-60 minute antenatals up to 36

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weeks. I do the last weekly visits at her place. I find it is very beneficial having some of the antenatals at my place because I have all my equipment around and it is good for her and her children (if she has them) to get a sense of who I am. My motorbike and our pet New Zealand rabbits are VERY popular with toddlers!

If a visit is required to an obstetrician, I arrange this with an NHS obstetrician, who understands our philosophies and will respect the woman. I attend the consultation with the woman. Any blood tests are arranged through her GP or the supervisor in the women's area. This is a very clumsy system as we have no direct referral rights to NHS laboratory facilities. We can use a private laboratory directly but I resent a woman having to pay for private labs when she has already paid NHS and is paying for us. I am not happy to take on women wanting hospital births, although I have done so, the vast majority have opted to stay at home.

Postnatally, I visit women daily for the first few days and then space out the visits over a 2-4 week period depending on the individual needs. I often get asked who I would refuse to book and I think the answer would be the women self-selects. They tell me what they want, I tell them what I am prepared to offer and at what price, then they decide whether they want it or not. I do not call a woman back to find out what decision she has reached. I have found that she knows what she wants and if she is serious, she'll call me back. We have booked women with twins, breeches, for vaginal birth after a caesarian section, very poor previous histories, and I am about to book our second surrogate couple.

### My Philosophy

I work from the perspective of natural birth with a strong belief in the empowerment of women and the importance of continuity of care. I find that the more experience I gain as a midwife, the less I physically do. This can be confused with the idea the essence of natural birth is to do nothing, and I believe this is a grave mistake. The time antenatally is spent sorting out a woman's own support network; trying to ensure she will have around her, help and support from within her own circle of family and friends she will need for the birth and the postnatal period. I then become a facilitator, providing the help and guidance where necessary, and monitoring as required. When my care is completed, because this network is in place, there is not a gap.

This is my ideal but it doesn't always work. This philosophy of not physically doing a lot during labour, is dependent on a relationship of trust and understanding has been established antenatally. I do not believe that labour is the time to socialise and get to know someone. Rather, by this time we should be able to communicate in

a sort of shorthand.

I use herbs and homeopathy in my practice and liaise with or refer to other alternative practitioners as appropriate - eg acupuncturists, homeopaths, or cranial osteopaths.

When I transfer a woman into hospital I act as her advocate, making sure she is given full information regarding her options, and the consequences of those options. I'm also looking out for her partner, making sure he or she is part of the team, rather than merely being tolerated.

### Challenges of Independent Practice Relationships - Professional

When I became independent, I had to learn to relate to other professionals in different ways. Instead of being an employee, I had to establish my own parameters of practice within the guidelines of midwives' rules. The difficulty comes from dealing with supervisors who are also managers. As managers they are responsible for ensuring the midwives in their establishment work to the policies laid down by the authority. These have been formulated by obstetricians and senior midwives. We and the women are not bound by these policies. My practice is a combination of research-based clinical judgment and support of my clients' choices.

Supervisors are there to ensure a midwife is practising safely. If they are not careful, they can confuse their two roles. There are many supervisors with no experience of homebirth and who have not practised in clinical areas for many years. I can find myself in the situation of explaining to a supervisor the difference between supervision and management. This can become time consuming and unpleasant. Another ludicrous situation is the district supervisor can refer to her regional supervisor who has the power to suspend a midwife from practice.

You may be as stunned as I was to discover the regional supervisor is sometimes a nurse and not necessarily a midwife. In practice because she is not a midwife, and the district supervisor refers a situation to her for consideration of suspension, she refers back to get the midwifery advice to work out what to do. So much for promoting the midwives!

I had to learn to trust explicitly my partner, Melody, and to work in a true team spirit. The burn-out rate for independent midwives in this county is around 2 years. I think one reason for this is the difficulties of working in a partnership. There is a certain point at which the novelty of setting up and establishing a partnership wears off. It's a bit like when the honeymoon part of a marriage is over. If a stable working and supportive relationship is not in place, you cannot deal honestly with the problems as they arise, the partnership will collapse. This is common at around a two-year period. As

student midwives we had no training to prepare us in this area. GPs have sessions on setting up and maintaining a practice. We had crises but managed to get through them - not without traumas along the way! I believe in resolving these, we grew in ourselves and the partnership became stronger.

The other thing I found important was not to be drawn into the issue of being the preferred person to attend the birth. Many women do have a preference for one midwife, but we found that it worked best making no promises so the one who was on call went. We have always found that the woman was pleased with her care whether her preferred midwife was there or not. If she wasn't it wasn't because of who attended the birth, but a far deeper issue within herself. I found the key to dealing with this situation was to thoroughly support and edify each other to the clients, although taking on board and dealing with any concerns expressed by the woman about the other midwife.

If a woman really took a strong dislike to one of us we would suggest she went to another practice. Occasionally one of us would have difficulty with a particular client and if we couldn't clear it up we would arrange for the other to attend the birth. We wouldn't tell the woman this, and at the time she went into labour the appropriate one would attend instead, making some excuse to explain why she was there rather than the one on call.

Sometimes one of us would stay on call for a woman for a special reason. Recently Sue had her third baby. I had been there for her other two and I really wanted to there for her third. I managed to, but I hadn't promised to be there, in case something had happened to prevent it.

Generally, working with doctors is difficult. I don't believe GPs have a place in midwifery. This is not a popular view, however, especially amongst the GPs who earn well from maternity care. In my experience the first person a woman goes to when she suspects she is pregnant is her GP. He rarely tells her of all her options for care, instead asking her which hospital she would like to book into. For a woman with little or no knowledge of the subject, a very strong message is given that birth is an illness rather than a normal, natural process which very occasionally doesn't quite go to plan.

One of the arguments put forward to support GP involvement in maternity care is the old 'birth to grave' theory. I would argue just as a GP will refer a patient to a specialist for other things and have no involvement in that treatment until it is completed, so he should refer a pregnant woman to the specialists in childbirth - midwives. If the woman needs obstetric care the midwife could refer her. Many doctors are unaware of a midwife's full role and have difficulty grasping how we work.

Sometimes when I transfer a woman to hospital I get very tired of, not only trying to cope with the woman's view of her situation, but trying to educate the doctors as well. If I am not careful, they will take any negative feelings they have for me, out on the woman.

### Support Network

Building up a solid support network was and is crucial for me. I joined the Independent Midwives Association and found the support offered by its members second to none. I could discuss cases, ask for help with clinical issues and arrange back-up cover for when Melody was away. The list of independent midwives sent out to enquirers also increased my workload.

### Organisation

We established a business relationship from the onset. We discussed the money issues which have always been clear. We set up a rota so there were definite periods when we were not available to clients or each other. This worked well. There are very few practices that operate this rota system. We had a secretary to do our office work and she worked at Melody's house. I took the responsibility of sorting out lab results. We set up classes and advertised our practice quite widely.

Childcare has always been a major concern and I have never found it easy. When we first started in practice together, often one of us would be at the birth and the other would have all the children. We both had 18 month olds and I had a 3 year old. Sometimes we would both be at a birth and Steve, my husband, would have them all. It was not easy. Now I have an extremely flexible childminder and a good network of friends. I do talk to the clients about the importance of keeping in touch and to inform us early of their labour so that we can organise ourselves. They are fantastic at respecting this.

It has been important to plan the workload so there is clear time off. This has meant thinking carefully about income so it can be spread to cover holiday times. Only in extraordinary circumstances do I do bookings, normal antenatals or late postnatal visits in the evenings or at weekends. I would never have any free time if I did, I would probably be burnt out and a single parent by now.

The classes on natural childbirth and parenting are open to all women/couples rather than just our clients and this has been a good source of referrals. We have placed advertisements in the local National Childbirth Trust newsletters and also go to speak to various groups. I teach ante and postnatal water exercise classes in the local community. I would say though, most referrals come via word of mouth. The IMA is starting to have stands at various exhibitions where we give out lists of

all our members and have found this to be effective.

The main challenge I found in working this way was to acquire the necessary skills and experience to work with home birth, especially first labours. I realised I had never seen a really natural birth until I witnessed Melody working. Gradually as I acquired more confidence and experience, I began to push out my parameters of the normal and my 'transfer in' rate began to drop.

Other independents have reported the same phenomenon. On the other hand, I was so relieved to be away from the restrictive practice of the hospital setting, that at first I was so anxious to give every woman the experience of the best chance possible of a natural homebirth. I have discovered not all women necessarily want a natural homebirth really - they have booked me more for the continuity of care and on the first opportunity, they will choose to transfer in and have the works.

I have learnt this is their choice and I have no right to impose on it. Having had two caesarians myself and never having experienced a labour, I realised at times I was trying to enforce my desires unfairly onto others.

There were many things I had to unlearn from my hospital days. Women taught me a lot. Melody who had never been a nurse and had very little hospital experience showed me so many other ways of tackling situations. The other Independent midwives taught me invaluable lessons, skill-sharing sessions and phone calls help tremendously.

I try to attend study days regularly and subscribe to MIDIRs, the digest for midwives. At the IMA meetings information on new practices is shared. Melody is doing the first audit on independent midwifery practice in the country. I hope this will give us valuable insight into our practices. Our women are usually very well informed and if we have missed the latest news on an issue, one of the clients would have found it and told us about it! I also ask the supervisors to inform us of any study sessions in their areas.

Working independently is stressful in good and bad ways. It is wonderful to be able to share the news of a lovely birth experience but it is also important to seek support for the difficult ones. Just as women need to debrief their birth experience with me, so I need this facility with other midwives. If I don't use this, I find myself getting very ratty with the family.

This is a very difficult one. I have made mistakes and at times find it is hard to own up to them. I have some wonderful colleagues with whom I can share these problems and work out solutions or learn for next time.

Generally, independent midwives are very much in the limelight and their prac-

tice is closely scrutinised. We have to help and support each other or we just couldn't practise.

### Looking to the Future

The future for midwives in the UK is very uncertain. A few years ago midwifery was brought under the same umbrella as nursing and health visiting. I believe that this was a grave mistake. Midwifery should be a separate profession, as it is in Holland. Those with the interests of nurses at heart have little or no understanding of midwifery and use the medical model or obstetrics as their guide. Education has also been lumped in with nursing as well, to our detriment. With the reorganisation of the health services there is now 'fund holding' GP practices and hospitals, with a 'trust status', which means they are also budget holding and self-regulating. They can buy in services and ask for tenders. This could be to our advantage. Administrators are only just starting to work out the costs of giving birth in a hospital. I feel, it is a conflict of interest for a midwife to be employed by a GP practice, a view shared by many of the Dutch midwives. Both GPs and obstetricians are currently lobbying hard to protect their interests.

The select committee report, published in February this year, made some excellent recommendations which include:

*Provision of continuity of care for women.  
Midwives holding their own caseloads.  
Much wider availability of home birth.  
Midwifery beds in consultant units.  
Midwife-led units.*

Unfortunately the MP who chaired the committee, Nicholas Winterton, lost his position and the government is telling us the care we have at this time is pretty good. It is going to set up a working party to see what needs to be done. We are not very hopeful. GPs and obstetricians have protested strongly against the select committee's findings. If the recommendations were implemented, many would be out of a job and women would be much more empowered to protest against unsatisfactory and inappropriate care.

The Association of Radical Midwives (ARM) document 'The Vision' and the IMA's aims are to set up community based practices as you have here, and to be paid at source. One of the main problems is the de-skilling of midwives. Many are not confident or competent to work in this way. They need mentors to work with until they acquire the necessary skills to practice safely. I believe the midwife needs to be confident to work both at home or hospital. Just as the progress over the last few years has been brought about from weight of consumer pressure, I believe this is still the real way forward. Women are voting with their feet and we as midwives need to support them. ■



# Te Awhi Whaanautanga

W.M. Timutimu

Midwife - Taranaki Area Health Board  
National Committee Member (COM)  
for National Council of Maori Nurses

*This article is entitled 'Te Awhi Whaanautanga', The midwife, drawing together Maori culture and Birthing from a Maori perspective.*

**M**aori culture, like any other is dynamic and complex. These are some aspects of it that stand out for me.

## Dramatic

Firstly it is dramatic. People are encouraged to convey what they think and feel by their actions. You might not hear many Maori say, when a relative dies "I'm sorry, please accept my condolences." They will embrace you and their tears say it all.

## Oral

Secondly it is oral. Many forms of oral communication have been developed within Maori culture. These include the:-

1. *Whaikorero* or speeches
2. *Karanga* or calls of welcome
3. *Poroporoaki* or speeches of farewell
4. *Waiata koroua* or traditional songs.

## Holistic

Finally Maori culture is holistic. Within Maori culture, an individual's relationship with his or her family, the elements and spiritual forces are more important than the individual. Thus, to understand a Maori person it may be necessary to know their family, their tribal homeland or *turangawaewae* and their religious beliefs.

The holistic nature of Maori culture, the oral nature of Maori culture and the dramatic nature of Maori culture are all important when we care for Maori mothers.

## MAORI CULTURE IS DRAMATIC

Within Maori culture, actions are so important that some body movements, hand movements and facial gestures have been developed into performance arts. These include the *haka*, the *wero*, and the *poi*.

Other actions have become part of the way people interact with one another. Most Maori will greet each other by some kind of touch. In formal occasions this will involve the *hongi* or pressing of noses.

Some meetings may be tinged with a lot of emotion; for instance, the return of a relative after a lengthy absence. Many Maori will show this by their hugs and tears. They may prefer to let their physical actions speak for them. The relationship between actions and emotions is also conveyed in the word *pukuriri*. *Puku* meaning stomach and *riri* meaning angry. Being angry then, is something that is explained in a physical way. Emotions are physical and therefore expressed through actions.

Maori art is particularly symbolic. Artists and carvers continue to use the *koru* design in their work to symbolise continuity and growth. Maori performance arts have developed a number of forms all of which include symbolism. Action songs which talk about the hauling in and rowing of canoes may include these kinds of actions. *Poi* dances which indicate the flight of birds include an action with two long *poi*.

To understand Maori, given that their culture is an active one in which ideas and emotion are conveyed through gestures some of which will be symbolic, it is imperative to listen to Maori with our eyes, our ears, and our hearts.

Understanding then comes from:-

- listening with your eyes
- seeing with your ears
- feeling with your hearts

## MAORI CULTURE IS ORAL

Maori is the cultural language of the Maori people. The Maori language was widely appreciated because of its beauty of expression, flowing naturally in similes, metaphors and figures of speech. But not only is it beautiful in thought pictures it is beautiful in euphony.

The Maori is famed as an orator. This accomplishment issues from the fact that the art of speech and the adequate mastery of speech is a recognised and a valued attainment of the Maori people. All these things denote the fact that language in its comprehensiveness, fullness and beauty is one of the treasured possessions of the Maori race and corner stone of Maori culture.

*Te reo* or language is the essence and foundation of being Maori.

## MAORI CULTURE IS HOLISTIC

A Maori perspective sees health as a four sided concept representing four basic tenets of life:

- Taha Wairua* - spiritual health
- Taha Hinengaro* - mental health



- Taha Tinana* - physical health  
*Taha Whanau* - family health

### Te Taha Wairua

This aspect is generally acknowledged to be the most basic and essential requirement for health. Without a spiritual awareness the individual is considered to be lacking in wellbeing and more prone to disability or misfortune. A spiritual dimension includes religious beliefs and practices but is not synonymous with regular church going or strong adherence to a particular denomination. Belief in God is acknowledged in prayer, both formal and informal. Spiritual wellbeing enables spiritual communication with the environment; land, lakes, mountains, trees. All have a spiritual significance, and all are commemorated in song and formal oratory.

Without access to traditional or tribal land, Maori elders would diagnose poor health and the health history of Maori people would confirm the central importance of land to health. Land is the symbol of continuity with those who have passed on to the spiritual world, therefore respect for land augments one's spiritual strength.

*Te Taha Wairua* also accounts for a vital ingredient in the lives of some people, the presence of 'Mana'. *Mana* has been variously translated as self esteem, charisma. Maori people do not regard this as a personal attainment, rather that it is a state conferred by the gods, a state of spiritual authority and power, denoting a high level of health, without an egocentric core.

**To possess Mana is to know health.**

### Te Taha Hinengaro

In the second concept, the psychic side, thoughts and feelings are vital to health. It is often said that Maori thinking differs from Western style in several aspects. These differences are more evident when scientific method and thinking is compared to Maori cognition. A characteristic of Western thinking is in its analytical capacity. The whole is dissected into smaller parts so that greater understanding might occur. Individual properties are used to distinguish one object from another, one person from another. By contrast, Maori thinking could be described as holistic. Understanding occurs less by division into smaller parts, than by synthesis into a wider, contextual system. Consistent with this style of thinking, health is viewed as an inter-related phenomenon rather than intrapersonal one. Health thinking, in Maori terms, is integrative not analytical.

The distinction between thoughts and feelings, cognition and affect, is less evident within Maoridom. A situation may be simply felt rather than described. At a funeral, Maori mourners, other than the chosen orators, are likely to say nothing but to express their feelings openly, rendering any words unnecessary.

### Te Taha Tinana

The care of the body and the subsequent advancement of health are longstanding concerns of Maori people, albeit from different perspectives. Physical health leans heavily on ritualised procedures concerning most bodily functions. There is a clear separation of the sacred (*tapu*) and common (*noa*). One is careful in Maori society to regard the head as very special, even sacred. By the same token, bodily parts, including hair and nails cannot be cut and disposed of.

During pregnancy a Maori mother is discouraged from cutting her hair, lest some harm may occur to the growing fetus.

### Taha Whanau

Is a family health dimension. It is a widely held belief that ill-health in an individual is likely to be a reflection of family ill-health. The family provides not only support and nurturance, for the individual, but it gives a sense of identity and purpose. The Western belief that a healthy person is one able to stand on their own two feet, as an independent individual, is in total contrast to a Maori perspective where independence is seen as poor health, and the search for self is seen as an unhealthy, self-centred mission. **Interdependence rather than independence is seen as the healthier goal.**

## A MAORI HEALTH PERSPECTIVE

- Focuses on the spiritual.**  
This is a base and is more experiential, and less objective. An experiential quality is associated with events, persons, places and relationships.
- Is holistic.**  
There is no distinction between mind and body. This same holistic notion is found in other countries particularly non-Western.
- Is integrative.**  
A Maori perspective seeks to understand by using specifics or details in the context of larger patterns.
- Makes no distinction between feeling and thinking.**  
The word '*Hinengaro*' concerns the seat of emotions and feelings. No English word adequately translates it. The emotions are included as part of speech, as in oratory, for example.
- Focuses on experience.**  
It does not matter how objective things may be, what is important is what a person experiences.
- Focuses on the collective.**  
A Maori is concerned about his or her origins and relationships within a collective group. A typical question is 'who are your family?' so that individual identity is less important.
- Sees all things and people as interdependent.**  
Independence is not necessarily regarded as a positive or healthy way to live.

## MAORI CULTURE AND THE BIRTHING PROCESS

It is vital that those who work with Maori women acknowledge the spiritual dimension which is an essential part of the equilibrium, the well-being of Maori women. In terms of realising the dignity and self-determination of Maori women and our cultural integrity, the spiritual dimension cannot be ignored. Implicit in this dimension is the understanding that Maori women are *Papatuanuku*, Mother Earth.

Maori stories of the different stages of creation are revealing the place of Maori women in our society. The roots of *mana wahine* are to be found within the Maori creation legends. It is here that the strength and creativeness in the authority and power vested within our Atua-goddesses and gods is shown.

Our great earth mother, *Papatuanuku* gave us the power of birth and rebirth. In our creation story, spiritual and human life began with the female element.

*Whenua* is not only land, it is also placenta. The *whenua* (placenta) is the lining of the womb during pregnancy, by which the fetus is nourished, and is expelled following the birth of the baby. *Whenua* is also the term used for land, the body of *Papatuanuku*, the provider of nourishment and sustenance to humanity. The proverbial saying, '*He Wahine, He Whenua, a ngaro ai te tangata*' is often interpreted in English as, 'by women and land men are lost,' but it can also mean, women and land both carry the same role in terms of providing nourishment, and without them humanity is lost. It is Maori practice to return the *whenua* to the earth to provide a spiritual and physical bond between the newborn and his/her *turanga-waewae* or birth place. The planting of the *whenua* and *pito* is to cement the relationship with *Papatuanuku*.

It is helpful if this information is confirmed during labour. After delivery, the *whenua*, can be given to the parents or grandparents in an appropriate container, for burial at their own time and place.

### Stillbirth

It is the desire of all *whanau* that a stillborn infant be given appropriate burial rights. Initially the minister of religion for the family should be contacted to baptise the baby. If there is no Maori staff available contact Maori Community Health workers urgently to contact relatives. In some communities it is a wish to bury the stillborn baby before sundown. In our hospital we offer a supportive environment to the grieving *whanau* by converting a room into a *Wharenui*. All staff are welcomed to share with the *whanau* particularly those who have cared for the Maori mother during her labour.

Throughout my career I would have to say that this act of sharing and caring has been the most profound. ■

## BOOK REVIEW

**Author:** Gerlinde Wilberg  
**Book Title:** Preparing for Birth and Parenthood  
**Publishers:** Butterworth Heinmann  
**Date Published:** 1992  
**Country Published:** Oxford, U.K.  
**ISBN No.:** 07506 00462  
**Price:** \$75.00

This book, written for the person who seeks inspiration on how to teach those preparing for birth and parenthood, is full of fresh, creative ideas. The author includes in the appendix her credo, which she states reflects her beliefs about pregnancy, antenatal teaching, birth and parenthood.

The credo concludes:

- \* I believe that we create our own reality.
- \* That we influence it by our unconscious wishes, fears and attitudes.
- \* That all that happens is connected.

The reader needs to consider this philosophy carefully before reading the book. A lot of the book talks of feelings, self-awareness, reflection. It engages the reader in a very personal way, and promotes an intimate trust in teacher-parent relationship. My caution is that the reader does not enthusiastically put these many ideas into practice without first thinking through the possible consequences, and the underlying messages. It is so easy to give the woman who has a caesarian section the belief that her birth experience has been a failure, and her unconscious feelings have influenced that outcome.

This book is well structured and easy to read. It is different, with many new ideas from how to recognise your own strengths, to 'day-dreaming - a method of preparation for birth.' It reminds the reader of how many different ways there are of working with parents as they prepare for birth and parenthood.

Reviewed by:

E.A.Smythe  
Midwife Teacher. AIT.

## COMING EVENT

Manawatu Polytechnic,  
Palmerston North.  
Midwifery Workshop - 3 & 4 April 1993  
Details will be available late January -  
make a note in your diary now!!!!

# Midwife to Midwife

Ruth Martis

Midwife

Registered Smear Taker

## Midwives and Cervical Smears

In New Zealand there have been significant developments towards the implementation of a National Cervical Screening Programme (N.C.S.P.).

Overseas experience has shown that well organised, centrally coordinated programmes, are the most efficient method for organising screening. Such a centrally organised programme was a recommendation of the Cartwright Inquiry (1988), consistent pressure from the women of New Zealand and publicity by the media.

### The Objectives of the National Cervical Screening Register are:

- to ensure women with abnormalities are identified and adequately treated
- to provide information about past cervical smears to laboratories assisting them to interpret smears and make recommendations about treatment
- to ensure all women screened will be recalled at appropriate intervals
- to monitor the smear taking process, and the quality of smear reading
- to measure the achieved population coverage
- to identify women and population subgroups who have never had a smear taken and invite them to participate in the NCSP

### Is it really appropriate for Midwives to take smears?

The Nurses Amendment Act 1990 defines the professional scope of a midwife as 'taking responsibility for the care of a woman throughout her pregnancy, childbirth and postnatal period - (which is recognised as six weeks postpartum).

Cytologists comment that the effect of pregnancy hormones on cervical cells, often make assessment difficult and repeat smears often necessary<sup>1</sup>.

This also applies to other situations where women are oestrogen deficient e.g. while breastfeeding, and/or taking progesterone-only contraception, where endocer-

vical cells are frequently not found. In these situations, spatula and brushes will have to be used to have an optimum chance of reaching endocervical cells. During pregnancy it also carries a risk of causing the woman to abort. It also pays to bear in mind, pregnant women presenting with abnormal smears are seldom treated.

Postnatally it is recommended to wait until at least 3 months, or until the woman stops breastfeeding or starts her menstrual cycle again, to have a cervical smear taken. This could be quite appropriate, if she has had regular 3 yearly smears. I am discussing a standard approach to smear taking practice, not the exceptions, as some people may point out at this stage, they may never see the woman again, (I have found in my practice, this is not true).

Also, at 3 months postpartum, women would have to pay for a cervical smear, as midwives will be unable to claim the maternity benefit. It is therefore important, to define whether taking cervical smears belongs in midwifery practice or not.

Certification of the smear taker is another issue. Having been on a course and gained some experience running a cervical smear clinic, I am in favour of certification. This gives any woman interested in womens' health issues opportunity to be trained, which can be very important when addressing cultural barriers.

In this area, smear takers have regular meetings to share valuable experiences and pass on knowledge gained.

I believe it is time for College members to debate this issue and publish the recommendations.

### Reference:

- 1 Cervical Screening Bulletin No. 5 Dec. (1991). Manawatu-Wanganui Area Health Board

## REGISTERED MIDWIVES

### Otago Polytechnic Department of Nursing and Midwifery

Registered Midwives are invited to apply for enrolment in a Bachelor of Midwifery part-time study commencing March 1993.

Brochures and application forms are available from:

The Secretary  
Department of Nursing and Midwifery  
Private Bag 1910  
DUNEDIN

or phone 4773-014 extension 8135  
CLOSING DATE FOR APPLICATIONS:  
Friday 4 December 1992.

# New Zealand College of Midwives

## Membership Form

B.O.M.  
P.O. Box 21-106  
Christchurch

### Regional Information

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Place of Work \_\_\_\_\_

### Subscription Enables:

- \* Establishment of an office and a National Midwifery Centre
- \* Employment of a Co-ordinator for the College
- \* Professional Indemnity Insurance

### Type of Membership

Full Member (Registered Midwife Full or Part-time)	\$120.00
Full Member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged)	\$40.00
Associate Member (Other interested individual)	\$25.00
Affiliated Member (Other groups e.g. Parent Centre, La Leche League, etc)	\$25.00

### Method of Payment

Please tick your choice of payment method.

- Subscription payable to College Treasurer (Please enclose cheque or money order)
- Deduction from salary (Please arrange with your pay office)



### National Information

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Date of birth \_\_\_\_\_ NZNA MEMBER: YES/NO [Delete One]

### Type of Membership



Place of Work \_\_\_\_\_

*Please return completed form (together with money if applicable) to the National Committee member for your area.*

*Northland*  
SUE BREE  
Bay of Islands Hospital,  
Maternity Annex, Kawakawa

*Auckland*  
GLENDA STIMPSON  
P.O. Box 24-403  
Royal Oak, Auckland

*Waikato/Bay of Plenty*  
VIOLET STOCK  
c/- Tauranga Maternity Annex  
Tauranga

*Eastern/Central Districts*  
ANDREA GILKISON  
43 Rangitane Street  
Palmerston North

*Wanganui/Taranaki*  
AILSA STEWART  
Women's Unit, Base Hospital  
Wanganui

*Wellington*  
VIV McENNES  
P.O. Box 7063  
Wellington

*Nelson*  
BRONWEN PELVIN  
P.O. Box 672  
Nelson

*Canterbury/West Coast*  
JULIE RICHARDS  
P.O. Box 21-106  
Christchurch

*Otago*  
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