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SID: 8996312

SON lecturer

Identifying the needs and wants of midwifery clients for the design of midwifery curriculum

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Dr Mike King
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TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

ABSTRACT

GLOSSARY

CHAPTER ONE: BACKGROUND 1

Introduction and Need for the Study 1

Editorial Method 4

CHAPTER TWO: METHODOLOGY and CONTEXT of the STUDY 5

The Research Method 5

The Reference Group 5

The Study Milieu 5

Refining the Format of the Data Collection 6

Consent for the Study 7

Collecting the Data 7

Hidden Agenda 8

Hidden Agenda Items 9

Debriefing 9

Self-esteem 10

Context in Which the Study was Carried Out 11

Why Research? 11

Avondale College 12

Holistic Health 13

Sydney Adventist Hospital 14

Avondale College Bachelor Degree 14

Developing the Caring Theme for a Model of Midwifery 16

A Midwifery Model 17

Profile of the Student Midwife 18

CHAPTER THREE: LITERATURE REVIEW 21

The Culture of Childbirth 21

Historical Developments 21

The Contemporary Culture of Childbirth 22

Changes Occurring in the Expectations and Delivery of Maternity Care 24

Challenges to the Structure of Obstetric Care 24

Women's Changing Needs 26

Women Taking Responsibility 26

Maintaining Safety While Meeting Women's Needs 27

Consumer Group Expectations 27

Quality Control 28

The Culture of Midwifery 29

The Midwife's Role 29

Midwives' Action on Reflection 30

A Consumer Oriented Model of Caring 31

Midwifery Philosophy 33

Midwifery Education 35

Educational Philosophy 37

Definition of a Midwife 38

Nursing Theory 40

Theory Development in Nursing 40

Historical Development

Nursing Theories Generated 40

The Behaviourist Model 41

Qualitative Research and Phenomenology 43

Meeting Others' Needs 44

CHAPTER FOUR: THE RESEARCH STUDY 47

The Experiences 47

Childbirth Education 47

Implications for Curriculum Development 49

Labour Practices 49

The Experiences 49

Drugs 50

Pain Management 51

Partners in Labour 54

Disruptive Practices 56

Implications for Curriculum Development 57

Social Factors 58

Implications for Curriculum Development 62

Continuity of Care 62

Obstetric Care 63

Choosing an Obstetrician 63

Why an Obstetrician was Chosen 64

Midwifery Care 65

Labour Ward 65

Postnatal Hospital Care 66

Postnatal Care after Discharge 66

Implications for Curriculum Development 68

Breastfeeding 68

Implications for Curriculum Development 71

Discussion of Findings 72 73

Implications 73 74

Process for Implementation into Curriculum 73 74

CHAPTER FIVE: CONCLUSIONS and RECOMMENDATIONS 75 76

Conclusions 75 76

Limitations of the Study 81 82

Summary of Overall Findings 81 82

Recommendations 82 83

Appendix I

References

ABSTRACT

Today's women are demanding a social model of health care for their childbirth experiences. It is important that their views should be incorporated into an educational program that educates the health professional in the needs and wants of the consumer.

This is the cultural ethos that curriculum developers must be aware of because of the implications for curriculum content and the future education of midwives. Awareness of social issues is a requisite for today's midwives in their advocacy role, and in promoting greater involvement of women over decisions about their health.

This research seeks to identify the needs and wants of the childbearing woman and her partner to inform curriculum developers. It will have a focus on the clients at Sydney Adventist Hospital where the researcher is employed as an Educator in the clinical environment.

GLOSSARY

CTG/Corometrics Cardiotocography. A graphical correlation between foetal heart rate patterns and uterine contractions. Corometrics CTGs are relayed on video screen to the nurses' station.

COMPS/Complementary. A complementary feed is an artificial feed given to an infant to make up the deficient amount of a breastfeed.

EPISIOTOMY. An incision made into the thinned-out perineal body (the area between the vagina and anus), to enlarge the vaginal orifice.

FOETAL DISTRESS. When the unborn baby suffers a lack of oxygen.

GESTATION. Pregnancy - approximately 40 weeks.

MULTIPARA. A woman who has borne more than one viable infant.

PCA. Patient Controlled Analgesia administered through an IV when the patient pushes a button.

PLACENTA PRAEVIA. An abnormally situated placenta in the lower segment of the uterus.

PRIMIPARA/PRIMIP. A woman who has given birth to a viable infant whether alive or stillborn.

TINCT BENZ. A lotion mixed with olive oil used to treat cracked nipples.

TRANSITION. The end of the first stage of labour and the beginning of the second. The form of the contractions change as the baby starts the final journey through the birth canal.

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CHAPTER ONE

BACKGROUND

Introduction and Need for the Study

Since the 1970s, women have been expressing dissatisfaction with their care during childbirth in hospitals and have successfully challenged the performing of many unpleasant, routine procedures that were called for under the medical model of health. These interventions might have included pubic shaves, routine enemas, labouring in isolation while incarcerated in remodelled operating theatres. Even extended "lying-in" periods separated the women for most of the day from the people they loved. These interventions were later shown to be unnecessary (Bates and Lapsley, 1987, pp.66-72, 85) and have been taken out of practice in the last few years.

Further, the place of birth has been questioned resulting in an increase in homebirths (Kitzinger, 1991a; Shearman, 1989, p.174) and the development of birthing centres which provide midwife care in a homely setting within the confines of the hospital. Today's women are demanding a social model of health care for their childbirth experiences (National Women's Health Policy, 1989, p.74; Shearman, 1989).

These consumer driven changes, and the deconstruction of many 'official' philosophies have led the researcher to consider what we do or do not understand about the needs and wants of these women and their families (Gaskin 1991, pp.55ff), and what changes, if any, might be required in midwifery education.

> Changes in attitude and policies towards nurse education are having far-reaching consequences on the development of the profession. It is past time that the assumptions on midwifery education were questioned equally stringently and a similar re-examination of attitude and policy made (Barclay, 1991, p.89).

The changing power-base of midwives (Game and Pringle, 1983, Ch.5; Kitzinger, 1991b; Mitford, 1992) must be capitalised on and utilised to promote patient advocacy, and understanding of the psychosocial, cultural and spiritual needs of these women and their partners (Shearman, 1989, pp.174, 176). Much of this has been lost in the hospital-based, illness-oriented culture of childbirth.

Advocacy is enhanced by an awareness of the social issues affecting the contemporary childbearing couple, and is required to promote greater involvement of women over decisions about their health (Biggins, 1992, p.64; National Women's Health Policy, 1989, p.101). The concept of childbirth as a natural, safe body function needs to be reaffirmed (Shearman, 1989, p.174) by the

development of a midwifery conceptual framework to guide midwifery education, practice and research (Sohn, 1990).

Today's women have often had little or no opportunity to observe the delivery and management of the parturient woman and her newborn. At best, many women have observed a number of (clean-cut) deliveries on a video. They have little opportunity to observe feeding and childrearing practices.

Today's midwife must comprehend the needs and wants of these women. It is suggested that the qualitative research method of phenomenology can be used to analyse what these needs are. Bartjes (1991, p.259) describes the "essential task of phenomenology" as revealing phenomena that are the "essence of nursing". The phenomenological paradigm is an essential step toward achieving holistic nursing practice, not only as a method of research but to inform the practice of nursing.

> ... phenomenology becomes essential not only as a research method but also for the actual implementation of holistic, empathetic, individualised delivery of nursing care (Bartjes, 1991, p.260).

This study will aim to clarify some of the needs and wants of today's childbearing women and their partners by undertaking a literature review and a small-scale

phenomenological research exercise. The knowledge gained can be used to inform curriculum developers to ensure the midwife of the future will be skilful in assessing and meeting these needs and wants.

Editorial Method

Chapter Two will describe the methodology of the study and the context in which it was carried out. Chapter Three is a literature review. It examines the culture of childbirth and changes that are occurring in the expectations and delivery of midwifery care.

Chapter Four is a presentation of the research study, firstly examining experiences of the women and their partners, then discussing the findings. Chapter Five brings together the findings of Chapters Three and Four, and presents the conclusions and summary of overall findings. The chapter concludes with recommendations for implementation and further research.

CHAPTER TWO

METHODOLOGY AND CONTEXT OF THE STUDY

The Research Method

The Reference Group

This study was undertaken at Sydney Adventist Hospital Maternity Unit on Sydney's upper north shore. The unit has 50 beds and over 2,300 deliveries per year.

A Postnatal Education Program is offered daily for patients and their partners, while still in hospital, and at no charge. One of these classes is presented as a discussion group, and it is advertised as an opportunity for the women to get together for a chat with other women. It is suggested they might like to discuss the birth, feeding their baby and/or going home and community support networks. If their partner is visiting at that time, they are encouraged to come along too. It was this class which became the focus of this study and a phenomenological research method was chosen as a most appropriate qualitative technique.

The Study Milieu

The study was conducted over eleven weeks (not consecutively because of public holidays). The group

sizes differed between three (3) and nine (9) participants, the average being 5.1. A total of fifty-six (56) people participated. The dynamics of the group differed remarkably according to its size. The larger group was difficult to direct as it seemed everyone wanted the chance to talk about their labour, and what to do once home. Occasionally, a husband attended (two (2) in all). This was a self-selecting group of private patients who attended the program to meet a specific need of theirs.

The class took its usual format with the researcher and, when she could make it, the social worker, leading the group through discussion on topics which appeared important to each individual group. The setting was the conference room where all the classes of the Parent Education Program were held, and the chairs were arranged in a circle. All the participants were identified with a name tag bearing first names. The researcher introduced herself and the social worker, though a considerable number had already met them at the prenatal classes.

Refining the Format of the Data Collection

Initially, the researcher had attempted to devise a structured interview, seeking answers to six specific questions that had been thought to be relevant from previous work in that area. However, this turned into a

question and answer session and did not meet the needs of the individual members of that group. Conversation was stunted and the researcher felt it was her needs that were being met. Thus, the original format was reinstated with the addition of note taking, with the permission of group members. This did not seem to detract from the dynamics of the group. Consideration had been given to taping the interviews, but this can be inhibiting for the participants, difficult to identify the speaker, and time-consuming for interpreting later (Wandsworth, 1989, pp.18, 32).

Consent for the Study

Before discussions got under way, permission of the group participants was requested to use their comments in the text. An explanation was given as to the reason for taking notes. The anonymity of the participants was preserved by changing their names, and the dates of the interviews were erased. The names they gave of the obstetricians have been changed. Permission for the study was obtained from Nursing Administration.

Collecting the Data

In a research interview it is essential to be able to refer accurately to the contents of an interview conversation in order to extract relevant "data", the evidence on which a conclusion is based or an observation made. This need was met by taking brief

notes during the class, completing them immediately after the class, and then typing them up at the earliest opportunity - that was always the following morning.

After all the interviews were complete, the information was examined to ascertain if there were patterns across each participant's comments - a method of categorising the information, called coding.

> CODING: A method of transforming qualitative information into quantifiable information by categorisation. Categorisation is according to particular themes or patterns, so that complex information is simplified into manageable and meaningful groups (Wandsworth, 1989, p.81).

This type of research is asking significant people the nature of their experiences, what is wrong with them, and what can be done to improve them. This gives a voice to those less powerful, who until now, have mostly had professionals decide what will happen to them.

> Most research tends to study "down" - that is, more powerful people, or researchers on behalf of more powerful people, go and study less powerful people. In most cases the effect (even if unintended) is to lead to decisions being made **for** those people (Wandsworth, 1989, p.13).

Hidden agenda

The hidden agenda, developed over the years during which these groups have been conducted is: to enable the

women to talk to the group about their experiences as a form of "debriefing". This agenda is kept hidden to maintain credibility of the participants' experiences. Otherwise, some might think: "She won't be interested in what I have to say as she's heard it all before", or "my birth experience wasn't bad enough or interesting enough to present to the group". Sharing these experiences is, in itself, therapeutic and may help to make bad memories/feelings more tolerable.

Hidden agenda items

The researcher would look for an opportunity to bring up the following issues: the stress of labour, self-esteem, the nature of parenting, postnatal depression. It depended on the response of the group if these topics were aired, as they decided what was relevant. Mental note was kept on who was not contributing and opportunities made to draw them into conversation.

Debriefing

Most women have a need to talk over their birth experience with a health professional. They express feelings of anger, shame, guilt, bewilderment, depression and fear. They need the midwife to validate their feelings and condone any behaviour that the woman alludes to as being unacceptable. This group session provided a therapeutic opportunity for debriefing and clarification on what happened to them during this, or

previous, childbirth experiences. However, this was not the best time or place, and the researcher came to believe that debriefing should be built into the patient's Midwifery Care Plan.

Self-esteem

Some women have a low self-esteem before they become pregnant. Others have been feeling competent in their abilities until this time after the baby is born. Many believe that they have a hidden natural instinct for childrearing simply because they are women and their esteem is shaken in these early days because they did not realise how complicated and/or different life can be with a new born baby. These women begin to feel anxiety at this time about going home and having another human life totally dependent on them. The midwife's role here is one of educator, enabling the woman to share in decision-making; clarifying what learning has taken place, and providing contact with community support services.

The midwife needs to believe in the importance of achievement for the growth of self-esteem, recognising that anxiety and set-backs are part of the learning process. Students, feeling anxious and apprehensive of new experiences and others' expectations of them, may well be able to empathise, even in a small way, with the feelings their clients can be expected to perceive.

Context in Which the Study was Carried Out

Why research?

This research was undertaken to find out if the practice of midwifery meets the client's needs, and if it does not, to identify how it fails. The study seeks to examine if improvements are needed in the education of today's midwives in recognising the needs and wants of the consumer of midwifery. If there are, then this study seeks to understand the implications for a conceptual framework for midwifery curriculum.

Since the 1970s, women have been expressing dissatisfaction with their care during childbirth in hospitals. They have successfully challenged the performing of many unpleasant, routine procedures that were called for under the medical model of health but which were later shown to be unnecessary. These consumer-driven changes, and the influence of family-centred care in deconstructing 'official' philosophies, encouraged midwives to act as patient advocates.

The changing power-base of midwives must be utilised to promote patient advocacy, and to meet the psychosocial, cultural and spiritual needs of women in our care. "Social, emotional and psychological factors are fundamental in understanding how to provide proper perinatal care" (1985 WHO Conference Statement on

Appropriate Technology for Birth, cited by Shearman 1989, p.175). The concept of childbirth as a natural, safe, body function needs to be reaffirmed. The development of a midwifery conceptual framework is required to guide midwifery education, practice and research.

The client should be involved in the process of determining educational needs and evaluating curriculum outcomes. "Educators, clients and community should be involved in the process of determining educational needs and evaluating curriculum outcomes" (Staropoli and Waltz, 1978, p.17). This study aims to explore the experiences of women and their partners and use these to inform future midwifery curricula.

Avondale College

Avondale College is a college of higher education operated by the Seventh-day Adventist Church. It is a private institution, accredited with the Higher Education Council as offering degrees, but it is not gazetted as a university. It has developed an affiliation with Sydney Adventist Hospital since inception of the Diploma of Applied Science (Nursing) in July 1980. Both institutions are owned and administered by the Seventh-day Adventist Church. Consideration will be given to the type of student who might be attracted to midwifery education at Avondale College, and this

will include a brief study of the Avondale College Bachelor program and the development of an appropriate midwifery model.

There are two campuses to Avondale College, one at Cooranbong (120 kms north of Sydney), and one at Wahroonga based in the hospital grounds. The institution offers tertiary level awards in Primary and Secondary Education, Nursing, Business Studies, Music, Science and Theology. Though small in size, the College benefits by placing "particular emphasis on small group instruction" and the rewards of close relations between faculty members and students (Gibbons, 1982, p.3). The nursing courses are designed to encourage a view of nursing as a sub-set of Christian service and to incorporate Christian philosophy and values into all aspects of nursing practice. This reflects the Adventist belief in education which upholds the spiritual dimension.

Holistic Health

Holistic (wholistic) health is one of the Adventist traditions, because the Bible teaches that the "body is the temple of the Holy Spirit". In defining "holistic health", the author gives consideration to all things that impinge on an individual's well-being - health being more than the absence of disease. Therefore, holistic health encompasses psychological, social,

physical, environmental, spiritual and cultural factors in its regard of things that may challenge a person's welfare.

Sydney Adventist Hospital

Sydney Adventist Hospital is one of Australia's leading private general hospitals specialising in most major clinical areas (Gibbons, 1982, p.3). The newly refurbished and re-designed maternity unit has 50 beds, 8 delivery suites in a ten-bed labour ward, and a Level II special-care nursery accredited for 11 cots. The unit is the largest private maternity unit in NSW (Shearman, 1989, p.129), and draws its maternity patients from "a wide spread across the northern and inner western regions, especially from areas served by Ryde, Hornsby, Royal North Shore, Westmead and Mona Vale" hospitals (Shearman, 1989, p.116).

Avondale College Bachelor Degree

Avondale College School of Nursing offers a Bachelor of Nursing degree which is based on a program "to enable nurse practitioners to meet individual and community health needs ... in more effective and creative ways", and has been developed on a conceptual framework of "caring". The philosophy of caring has six elements considered central to the model. These are:

1. Knowledge base - acquired from nursing theory, practice and research, and other disciplines, and believed to be a pre-supposition for caring.
2. Attitudes and values - manifested primarily in interpersonal relationships. The caring ethic is developed with emphasis on "role modelling, by valuing students as individuals, and by making the teaching/learning process itself an avenue for nurturing caring values".
3. Caring actions - covering a wide range of interpersonal and psychomotor skills. "Caring actions are derived from the nurse's desire and capacity to care and have the potential for mutual benefit and growth for both the nurse and the client in the caring process".
4. Holistic caring - seen as nursing's most important contribution to caring. "Holistic health, or the optimum state of wellness in all aspects of the person is the goal of all nursing action and interaction".
5. Factors influencing caring - societal (problems, goals, desires), participants in nursing action (client, client's significant others, nurse, other members of the health care team), environmental (including demographic, organizational, legislative, social and political).
6. Outcomes - health care outcomes can be measured in the nature and quality of the caring experience,

positive experiences being consistent with holistic caring.

In order to achieve the above, it is important to have a full understanding of client perspectives and reflections. It is this need which underpins this study.

Developing the caring theme for a model of midwifery

It would be appropriate to further develop the caring theme through a midwifery curriculum and maintain a focus on holistic caring and factors which influence this. Bevis and Watson (1989, p.53) state:

> Caring ... is a human process, not a product or commodity to be bought and sold as human capital ... Thus, a framework for a caring curriculum is a transformative paradigm that is philosophically and morally consistent with phenomena and practices of human caring in both educational and clinical worlds.

The midwife must be cognisant with the social processes affecting her clients and be able to communicate this fact to them. She should be sensitive to the social skills and psychological requirements of the women under her care and their families, and have teaching skills, communication skills, and decision-making skills to utilise and pass on to the consumer.

> She (the midwife) has an important task in health counselling and education, not only for

the patients, but also within the family and the community (New South Wales Nurses' Registration Board, 1990).

The midwife has a role in assessment, planning, education, communication and counselling, manipulative, technical and problem-solving skills. She must be able to recognise departures from the normal situation and, when necessary, consult appropriately with other members of the health care team. She should develop an advocacy role for the patient.

A Midwifery Model

A midwifery model needs to explore ways for midwives to be ethical and political, and to encourage reflective thinking and critical thinking. It should examine changes in health professions, promote lifelong education for midwives, and health education as a development process through the life-span. The model should address the way women think about themselves and promote effective change and improve self-esteem.

The midwifery model should address ways of developing the role of primary care giver, meeting the needs of our multicultural society, and accepting responsibilities for global communication, sharing education and skills. It should also examine ways of capitalising on the health system which, after school, provides the best "life path" to reach women: women as health-care

providers, and as health-care recipients. It should meet the changing demands of consumers.

Profile of the student midwife

With the move toward professionalisation of midwives and development of academic curricula in universities curriculum can be developed which will promote effective student learning, based on a theme of unifying and midwifery concepts.

Currently, midwives are educated for the comprehensive part of the register in the first instance. Therefore, eligibility for the qualification of midwifery is achieved through a graduate diploma. This system is not totally acceptable (National Women's Health Policy, 1989, p.74; Willis, 1983, p.94), and there have been calls for direct entry midwifery programs (Barclay, 1991, pp.99ff; ACMI, 1992, 2.2.0; National Women's Health Policy, 1989, p.74). Nevertheless, it is expedient to realise that this course leads to a student with higher level entry behaviours, leading to more developed outcomes of reflective thinking and critical analysis.

For students coming through the Bachelor program, it can be assumed that the following has already been addressed: introduction to normal pregnancy, labour and delivery including the mechanism of labour; observation

of normal and abnormal births as well as the anatomy and physiology of the reproductive system; and an introduction to behavioural science, analysis of data, and nursing theory.

The Sydney Adventist Hospital and Avondale College would like to be the vanguard for midwifery education in private hospitals. Many would see this as being revolutionary as it is believed by some that the patients have private health cover so that they can have the obstetrician of their choice assist with the delivery of their baby, whereas a midwifery program would require that students have access to "hands on" experience with helping a woman deliver her baby.

Avondale College has a tradition of successfully meeting the needs of its clients, and has already run a successful Bachelor program developed on a philosophy of caring. This ethos should prevail in any post-graduate program. This study is designed to analyse the needs and wants of the midwifery consumer so that a more caring-centred curriculum might be developed to create a midwifery model which goes further in meeting the individual needs of women and their families.

This focus will encourage a move away from the medical model of obstetric management to a family-centred,

caring, midwifery curriculum, providing an educational framework developed by women for women. The historical exclusion of women from education until late last century has clearly entrenched women's learning within a conceptual framework constructed by men for men (Summers, 1976, pp.323ff).

> Much of what women know about themselves and the world, comes from knowledge constructed by men and does not fully account for their experience as female knowing subjects or for their ways of knowing (Condon, 1992, p.15).

CHAPTER THREE
LITERATURE REVIEW

The Culture of Childbirth

Historical Developments

The increase in medical control of the birthing process took place in the first half of this century. Since then, birthing was increasingly taken out of the home and into hospital, and the subordination of midwifery to the medical profession was complete (Mitford, 1992; Willis, 1983; Davis & George, 1988, pp.158ff). Husbands were excluded from being present in the Labour Ward, as were any other family or friends of the parturient woman. Nurses' education was developed under the wing of the medical model, suppressing early development of its own speciality.

> Nursing had not identified its distinct contribution to health care and, therefore, could not develop its own knowledge base or teach its own theory (Bridges, 1991, p.42).

Society has cultivated a grave concern about the risks of childbirth (Guilliland, 1992, p.6), as a result of the construction of the medical model which views all pregnant women at potential risk until proven otherwise and requires all women to give birth within the "safe" confines of the hospital maternity unit (Bates and Lapsley, 1987, p.67). This has the result of a

developed dependency on the "expert", the holder of knowledge, in this case, the obstetrician.

The Contemporary Culture of Childbirth

The majority of women in Australia today go to a hospital to have their baby. Sydney Adventist Hospital has a large private maternity wing which is staffed by midwives, some mothercraft and enrolled nurses, and a number of ancillary staff. In the Labour Ward, the parturient woman will be attended by a midwife whom she most likely has never met before, and a comprehensive student nurse who works to her/his level of expertise. The parturient woman is allowed to have her husband/partner in the Labour Ward and another support person. If she has other young children, they are allowed to visit in the Labour Ward after the birth of the baby, as are her and her partner's parents.

The use of the word "allow" has been deliberate to emphasise the focus of control here. The woman is not in her territory; the institution exerting power here is the hospital, and some rules have been established to which she must adhere.

The obstetrician will perform an induction of labour if it is believed that is required and otherwise will not visit the woman until he/she is called by the midwife when the delivery of her baby is imminent. Sometimes

obstetrician may not arrive in time and the midwife will assist the woman with the birth of her baby. The obstetrician will suture the woman's perineum if that is necessary. Midwifery practitioners (those working independently of the obstetrician and/or hospital structure) are trained and attend to the suturing themselves, but this is not required of midwives at Sydney Adventist Hospital.

Some obstetricians examine the newborn, though a number refer all their babies to a paediatrician, and the initial examination will be conducted by the midwife as the paediatrician will not see the baby until his next visit, usually the following day. All babies are examined by a midwife routinely after birth.

Some time after the delivery, the woman will be transferred to her private (or shared) room with bathroom facilities, and be looked after by the midwives rostered to the postnatal ward. After discharge, at around five days, she will receive professional help from the Early Childhood Health Sister and will go to her obstetrician for a final check at six weeks post-delivery. If the baby has been seen by a paediatrician (as most are), a final visit at six weeks is required also. There are other community, government and volunteer groups the woman may access for help and support.

This picture shows some considerable fragmentation of care. It also shows the role of the midwife as a competent practitioner only in the absence of the medical officer. It is this state of affairs that is being challenged today by consumers, midwives and other health professionals and interest groups. The researcher's concern is that, in developing the role of the midwife and increasing her/his professional status, we do not once again lose track of what improving maternity services is all about, viz: **improving the experiences of women**, not improving the status of the midwife. Many would argue that the two go together, and the researcher agrees that they are very closely linked, but the goal must maintain its focus on the woman.

Changes Occurring in the Expectations and Delivery of Midwifery Care

Challenges to the Structure of Obstetric Care

There is some doubt that the 'expert' of the medical model, the obstetrician, always practises safely, or in the interests of women at all times. The World Health Organisation has drawn attention to the fact that maternal morbidity is on the increase in some European countries. This is believed to be caused by

intervention factors to save the baby's life - to such an extent that:

> ... approximately 990 out of every 1000 women and their babies are subjected to extensive, intensive and expensive clinical procedures in an attempt to save the ten babies who die (Downe, 1991, p.34).

It is commonly known that this kind of intervention is prevalent also in Australia, as well as other Western societies (see for example: Bates and Lapsley, 1987, Ch. 4; McIntosh, 1989, pp.189-190; Mitford, 1992, Part III; Shearman, 1989, pp.12, 13) and government documents are beginning to show less support for the hitherto favoured universal practice of hospital confinements (House of Commons, 1992; Mitford, 1992, p.181; Shearman, 1989, p.11).

In order to accommodate the changes required by these challenges to our technological, medically-dominated, health care system, "a thorough transformation of the structure of health services is required together with modification of staff attitudes" (Extract from the 1985 WHO Conference Statement on Appropriate Technology for Birth, cited by Shearman, 1989, p.175). Further, the statement calls for "the redistribution of human and physical resources". The examples of this in the field of midwifery will be examined later.

Women's Changing Needs

It is important to realise that women have not been passive recipients to the patriarchal interference of the medical model as evidenced by the growth of the homebirth movement, and women's demands for less intervention and a homely, conducive environment in maternity units and birthing centres (Bates and Lapsley, 1985, pp.66ff; Harkness, 1989; Shearman, 1989, p.11).

This is the situation that we have today, and evidence of the likelihood of it continuing to develop is available.

> Since the mid-1970s ... there has been increasing public awareness of many issues surrounding birthing. Women and their birth supporters have been politically and socially active in working as agents for change, demanding less intervention and more options and choices regarding the range of services available and the way birthing is practised (Griffith, 1991, p.19).

Women Taking Responsibility

There is an increasing market for books on women's rights in childbirth, and expanded childbirth options (see, for example: Beech, 1991; Kitzinger, 1991a; Kitzinger, 1992; Lamprel, 1991 and McDonald, 1991). Women want to be involved in the decision-making. They want to know what is going on, what is happening to their bodies. They want to feel in control of, and they have a high expectation of, the birth process. With the decrease in family size, there has developed an

increasing expectation of a healthy and satisfying process and outcome of childbirth (Griffith, 1991).

Maintaining Safety While Meeting Women's Needs

This concept needs to be well married with that of "safety". How far is it reasonable for women to make decisions when they cannot possibly understand as much as a trained professional can? How far can a health professional go without being made accountable for decisions and practices? Shearer (1990), commenting on two studies assessing women's satisfaction with perinatal care, states that " ... interventions used did not affect women's views of birth as much as whether they believed the right thing had been done".

Consumer Groups' Expectations

Health-care consumers are developing a greater expectation of the services they use, Patient satisfaction, length of hospital stay, and quality of life are now being used as indicators of patient outcome measures, as well as the traditional ones of disability, morbidity and mortality (Moritz, 1991). In the Shearman Report, the Taskforce advocates the following principles for childbirth practice:

> The goal of the maternity services is to promote and ensure the best possible outcome of birth for the mother and baby and the **best possible experience** [emphasis mine] (Shearman, 1989, p.175).

Consumer groups have had extensive representation on government reviews of birth services in Western Australia, Victoria and New South Wales, and via submissions for the development of Australia's National Women's Health Policy (1989). A priority in this latter document is to increase "participation and control by women over decisions about their health and health care at all levels" (p.101).

Quality Control

The Joint Birth Consultative Committee recommends the inclusion of consumers in Quality Assurance programs wherever this is appropriate (1992, p.7).

At Sydney Adventist Hospital, Quality Assurance (QA) measures are being examined and re-written. Currently, the Quality Control Index examines the patient chart, the patient's welfare and comfort, her environment, the quality of her care and the expertise of her carers. These assessments are completed in four areas: two postnatal/antenatal wards, the labour ward and special care nursery. The patient is specifically targeted, and her personal opinions are sought.

The growth of the QA programme at the Sydney Adventist Hospital reflects the community demand to improve the quality of care that consumers receive. In the near future, provision of childbirth services will require

"multidisciplinary review processes that regularly monitor obstetric practices and outcomes, medical intervention rates and **consumer satisfaction** [emphasis mine] (Shearman, 1989, p.176).

The Culture of Midwifery

The Midwife's Role

Given that, as Condon (1992, p.15) asserts, a midwife's knowledge has been developed from men's knowledge, and that "caring" has not traditionally been the role of the male, deconstruction of the medical model is being undertaken by midwives, and the construction of an individualised curriculum of midwifery care is inevitable.

> Because nursing is practised primarily by women, it is in the interest of nurses to explore modes of being ethical and political that reflect the lived experiences of women (Condon, 1992, p.15).

With the eroding of the extended family and the removal of the woman from her support networks at home to the "safe" confines of the hospital, the midwife's education must extend to include health education. The focus on family-centred childbirth which evolved following the activity of consumer groups as far back as the seventies, also calls for the midwife to understand the social milieu of childbearing and parenting today.

Midwives' Action on Reflection

Action to protect women from the morbidity resultant of the medical model as described by Downe (1991, p.34) has been taken by midwives in New South Wales, as well as nationally and internationally. Currently, there are a number of pilot programs being developed or practised to promote an individualised, midwifery program of care. Team Midwifery, a concept developed from Caroline Flint's "Know Your Midwife Scheme" in Britain has been trialled at John Hunter Hospital in Newcastle (Rowley and Saxton, 1992), and a second project is about to begin at Westmead Hospital. Team midwifery is aimed at providing continuity of care (Murphy-Black, 1992, p.115). Other projects, such as Early Discharge programs are utilising the midwife as primary health carer (Brodie, 1992); and Independent Midwives are achieving visiting rights so that they can accompany their clients into hospital and assist the woman with the birth, then continue her care in hospital and at home.

These actions have been based on a critical reflection of the needs and wants of women and their birth partners. Aware of the changing demands of consumers today, midwives who care have been motivated into action. Significant studies have been undertaken to enquire after the thoughts of women, what they think, what they feel, about certain events throughout the childbearing experience (Ball, 1991; Drayton, 1991;

Hillan, 1992; Kirkham, 1991; Lowe, 1991; Morgan, 1990 and Pridham, 1992). We will now examine a study that tested consumer satisfaction with midwifery care, and see how caring that is empathic is most valued (Gibbons, 1991).

A Consumer Oriented Model of Caring

A recent study into the marketable services or products of nursing concomitantly analysed consumer satisfaction with midwifery care. Gibbons (1991) analysed the marketable services or products of nursing, leading to the establishment of a consumer-oriented model of nursing. He established and tested a taxonomy of caring and described the component parts in eight areas: the functions of helper, monitor, technician, protector, communicator, instructor, manager and carer. The "taxonomy of caring" was tested by consumers as to its relevance to their needs and wants. Thirty (30) respondents were midwifery patients from public and private hospitals. It was found that:

> the carer function was both influential and central to the product of nursing and projected that it pervaded throughout and interacted with the other seven (7) nursing functions, to form the nursing product (Gibbons, 1991, p.152).

Empathy (the power of understanding and imaginatively entering into another person's feelings) was the

component of caring given most value by the women respondents (Gibbons, 1991, p.39).

Though the sample was small, and Gibbons states the need for further study in the area, he claims the taxonomy of caring concept " was determined to be contributory and significant to a consumer-oriented nursing model" (p.171). This perspective of caring and patients' requirements is an important one. The Women's Health Unit of the Commonwealth Department of Community Services and Health, calls for further understanding and integration of these concepts into nursing curricula.

> All curriculums should address the issues which can affect the health status and the health care needs of particular groups of women. Specific clinical skills relating to women's health care should be developed along with high level interpersonal skills. The needs of women in relation to acceptance of their lifestyle choices, their wish to participate and the elimination of discriminatory and other practices which undermine their dignity and privacy should also be addressed (National Women's Health Policy, 1989, p.83).

This literature review has led to the development of the author's own philosophy of midwifery, and the construction of an educational philosophy. The following has been developed with a focus on the words of Page (1991, p.250):

> I am advocating that the role of midwifery is to negotiate a definition of birth which

> includes both the medical and family perspectives ... These perspectives and approaches are an amalgamation of the traditions of midwifery and the best of scientific perinatal care.

Midwifery Philosophy

(The author accepts that the words imparting female gender shall include the male in all instances).

The nature and practice of midwifery is undergoing rapid and significant change as we head toward the year 2000 - but one fundamental fact remains unchanged: the concern of midwifery is childbearing as a health event. Midwifery is a profession concerned with caring, enabling self-care and self-actualisation of the childbearing woman. This care encompasses the woman, her infant and her family as well as the community in which they reside.

Midwifery nurtures personal development of the woman and her significant others through education (of an androgogic nature), observing with minimal intervention, and promoting client involvement. Its holistic, caring ethic promotes attention to the physical, psychological, social and spiritual needs of the woman and her family.

Midwifery is also concerned with helping and counselling the woman and her family during the transition to parenthood, and in caring for the neonate. Midwifery

also meets the needs of the family suffering death or morbidity during the childbearing process, supporting and counselling so that health is maintained during the time of stress.

Midwifery is consistent with the caring role of the nurse and obstetric or midwifery nurse, but goes beyond this. Midwifery examines the political stance of women and takes leadership action to improve this. It promotes continuity of care by taking responsibility for administering the total care required by the woman and her family, calling on other health professionals when deemed appropriate. Midwifery is the first line of care and contact for the pre-pregnant and newly-pregnant woman.

Midwifery is built on client needs, research and critical reflection. Midwifery provides advocacy with the childbearing woman and meets her needs, empowering her and promoting confidence, self-esteem, and protection of this most vulnerable human being, through this most natural function of birthing.

In summary, the author believes that:

* the core functional aspect of midwifery is caring

* people are central to the delivery of midwifery care and are valued and respected individuals
* caring interventions are holistic in nature and health education is an imperative of midwifery
* environmental factors influence the caring activities of midwifery
* quality midwifery care contributes to the satisfaction of both the provider and the recipient of care
* the midwife is accountable for:
    * excellence in standards of practice
    * effective communications
    * advocacy, and
    * efficient management of resources
* The midwife is the primary care giver to the parturient woman and her family, involving colleagues and other health care providers as appropriate.
* the midwife needs opportunity to increase professional knowledge, attitudes, skills and an ability to facilitate the education of others.

Midwifery Education

Midwifery is undergoing a change process (Hancock, 1992; Richardson, 1992). Midwives recognise a responsibility

for caring for women undergoing a normal pregnancy, labour and puerperium. Flexibility of rules and innovation of practice will ensure the growth and professionalism of the midwife - to fulfil women's individual choices, as well as their own needs. In 1991, midwives took action to liaise at regular intervals with medical colleagues by participating in a new project aimed at reducing prejudice and mistrust, the Joint Birth Consultative Committee (1992, pp ff).

Education and research are the keys to midwives providing excellence in care and leadership, within the profession and wider community, in midwifery and women's health (Barclay, 1992). Apprenticeship and hospital models of educating midwives no longer fit today's health systems or client needs. This has implications for curriculum developers who might try to change the focus of practice (Print, 1987, p.60) from hospital to community - when the concrete structures are still there, confining women to hospital births. Practice needs to be based on valid, researched data.

Midwives are being called on to demonstrate high standards of professional accountability to their clients and leadership to their nursing and medical colleagues (Barclay, 1992; Townsend, 1992). A midwifery model of care is required to give language and

recognition to the woman's experiences in the childbirth process (Kirkham, 1991).

The traditional task of the midwife is to aid a woman through her pregnancy, labour and the puerperium, and to ensure the safe delivery of her baby in normal circumstances. The term "midwife" means "with woman". This aid is provided by skills development and the education and experience of the midwife, as well as her willingness to refer to other health professionals appropriately, and to understand the needs of the client fully.

Educational Philosophy

The author believes that:

* the student midwife has personal needs and abilities and enters the educational program with a specific body of knowledge
* each student should have opportunity to enquire and think critically through adoption of a problem-solving approach to learning
* the post-graduate student is an adult learner who:
    * needs to know the value of a specific learning experience
    * is self-directed
    * is ready to learn that which complements her/his previous learning

* wants to apply new learning immediately to the real situation
* responds to learning through the stimulation of internal and external motivators
* the teacher functions as a facilitator of learning, while the student assumes accountability for the acquisition of knowledge and the development of values and skills
* nursing education is dynamic, adapting to changes in professional nursing and health care practices
* every student should have opportunity to develop physically, mentally, socially and spiritually to meet their own personal and professional learning needs.

Definition of the Midwife

The researcher's midwifery philosophy embraces the International Confederation of Midwives' definition of a midwife, accepted by the World Health Organisation, the NSW Nurses' Registration Board and the International Federation of Gynaecology and Obstetrics, as follows:

> A midwife is a person who, having been regularly admitted to a midwifery education program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite

> qualifications to be registered and/or legally licensed to practice midwifery.

The midwife's sphere of practice is as follows:

> She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in the mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
>
> She has an important task in health counselling and education, not only for the mothers, but also within their family and their community. This work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service (New South Wales Nurses' Registration Board, 1990).

The marriage described here, between midwifery traditions and the best scientific principles "brings a unique perspective on birth" and paves the way for a different approach to midwifery care (Page, 1991, p.250).

The problems associated with designing a curriculum for midwifery education are many and complex. A curriculum cannot be designed in isolation from its community; in fact, the curriculum "reflects the changing nature of society and its changing themes" (Quinn, 1988, p.234). How best to gain knowledge on, and understand, these

changing themes, is the content of the next section of Nursing Theory and Phenomenology.

Nursing Theory

Introduction

Curriculum is the "raison d'etre" for all educators and so its significance is unquestionable (Print, 1992, p.1). What this chapter seeks to examine is the development of curriculum and this study's relevance to guiding curriculum intent.

Theory Development in Nursing

Historical development

Curriculum content in nursing was derived historically from the medical model (Bevis, 1989, p.20; Meleis, 1991, p.25) until nurses entered other disciplines to study curriculum development and design, and research. At this time, nurses had no higher educational opportunities in nursing. Consequently, the early nursing-focused curricula were developed on theories borrowed from other disciplines (applied theories) (Bevis, 1989, p.20; Sims, 1991, p.54; Sohn, 1991, p.858).

Nursing theories generated

More recently, nursing theories have been generated and

validated and while some may desire nursing to be exclusively developed on nursing theories, others contest the idea (Bevis, 1989, p.20). Meleis suggests that nursing requires more than one theoretical construct because it deals with human beings. She claims that different theories need not compete with each other. Meleis makes a case for "paradigmatic pluralism" where the many different theories "address different relationships and focus on different phenomena, thereby actually complementing each other" (Meleis, 1991, p.79). Sims believes the impetus for creation of theory comes from the "healthy competition" that several well-developed theories would provide (1991, p.66).

The behaviourist model

There have been around forty conceptual models of nursing developed and they represent "the reality of nursing" (Sims, 1991, p.52). The current, legitimate curriculum in nursing, however, is behaviourist (Bevis and Watson, 1989, p.77; Emden, 1991, p.27) and this has had an adverse effect on professional development:

> Being training-oriented and technical, it cannot support professionalism and it is best used for the technical aspects of nursing (Bevis and Watson, 1989, p.77).

The behaviourist curriculum paradigm does not support discussions that are not relevant to the objectives,

and, being teacher selected, these are highly controlled and authoritarian. As a result, these curricula are politically oppressive (Bevis and watson, 1989, p.78).

Maclean (1992, pp.871 ff) claims that changes in the culture of nursing practice have not been reflected in educational content - which continues to be based on a technical curriculum. "Humanistic principles" and "critical reflection" are acknowledged principles in nursing which must be incorporated in program content.

More optimistically, Quinn states that we **are** moving away from the objectives model. The emphasis on the products of learning is being replaced by a more 'process' approach "which views learning experiences as being important variables in the learning process" (Quinn, 1988, p.234).

The nurse needs proficiency in a growing number of skills to meet the demands of increasingly complex technology, but she must also show understanding to meet the needs and wants of the childbearing family (May and Mahlmeister, 1990, p.31-32). This will improve the quality of the experience for the woman and her significant others, as well as the midwife herself/himself.

Qualitative Research and Phenomenology

Qualitative research has been undertaken more frequently in recent times to explore the humanistic dimension to nursing's caring. Phenomenology has been one of the research methods chosen to examine the meanings to individuals of the lived-experience (Wilkes, 1991, pp. 231 ff; Emden, 1991). "Quantitative and qualitative research methods are valuable tools in the search for true knowledge" (Bartjes, 1991, p.249).

Quantitative, statistical data is used to test hypotheses, whereas qualitative research examines the meanings and concepts of things, and in so doing, tends to generate hypotheses. Qualitative research, in examining the nature of things, is examining its quality and as such is a more appropriate method for the study of human beings. Phenomenology is one form of qualitative research.

Phenomenology is the study of all facets of a phenomenon, all the features of reality that can be consciously sensed or experienced (Meleis, 1991, p.12 and 353). For nurses, this kind of study allows a discovery of others' needs, feelings and experiences. It promotes holistic caring as expression is given to significant events in a person's life (from the physical, social, emotional, spiritual and cognitive spectre). This aids the researcher to observe the

dynamic interactions that have meaning to the individual and which constitute humanness (Luckman and Sorensen, 1987, p.4).

> When doing research guided by a phenomenological perspective, researchers search with others for the meaningfulness of our experiences, the communal, and our lived relation with one another in an inter-subjective space (Munhall, 1992, p.259).

Meeting others' needs

Nurses attempt to meet a patient's needs while that person is unable to self-care by offering "support, empathy and a sense of socially responsible care". It is through phenomenological research that we come closer to understanding those needs (Munhall, 1992, p.259).

Qualitative and phenomenological perspectives provide the opportunity to understand what precedes a certain lived episode so that prevention is facilitated if that is appropriate. In any case, the nurses' understanding is at least enhanced so that people's needs can be met and the experiences might become bearable or even improved.

> Our nursing knowledge base **must** include the human experience. We need to become oriented to a world of meaning. Meaning will enlighten and give direction to our nursing practice (Munhall, 1992, p.262).

This study has used phenomenology as a way to illuminate the meanings the patients give to their experiences and suggestions made that future curriculum developers should incorporate phenomenology into the program for student midwives. They, then, may become familiar with it and adapt it as their way of bridging the theory-practice gap.

> Knowledge of the lived-experience of illness, health, and healing are significant points of nursing research which inform practice (Bartjes, 1991, p.261).

Nursing is in a state of continuous change as it seeks to define its unique contribution to society. It is "only beginning to describe and categorize nursing problems or diagnoses" (May and Mahlmeister, 1990, p.52). It requires direction for its practice (Munhall, 1992). It seeks to define the nursing essence (Bartjes, 1991, p.259). It requires to develop and build its theory (Wilkes, 1991, p.235). To enable appropriate research, the required skills should be developed and practised at the student level. As May and Mahlmeister point out " ... nurses in clinical practice are in the best position to identify pressing nursing care problems" (1990, p.52).

The following chapter will describe a study designed to illuminate the reflections of women and their partners about events they experience during the childbearing

year. This will go some way to enable the decision about "what aspects of culture are to be included (in the curriculum) and why" (Print, 1987, p.58).

CHAPTER FOUR

THE RESEARCH STUDY

The Experiences

Introduction

A record of the discussions which took place in each class is contained in Appendix 1. Some of these comments referred back to previous childbirth experiences. Most women made comments on more than one category.

Coding of interview data led the researcher to categorise the information into the following five areas: Childbirth education; Labour practices; Sociological factors; Breastfeeding; Continuity of Care. Each of these areas will be addressed. Implications for future curriculum planners will be dealt with.

References to the women's comments will be shown thus: (I-8 Lidia) meaning the Interview 8 and referring to comments made by Lidia.

Childbirth Education

Most comments were that the prenatal classes held at the hospital were enjoyable with good content:

I-2 Vickie	I-1 Cheryl
I-2 Ellen	I-2 Patsy
I-8 Claire	I-8 Kathy

but that they cannot prepare women, and their partners, having their first baby, for the experience of labour

I-2 Patsy I-10 Sheila.

This statement provides a hypothesis for a literature review and study of teaching methods in prenatal classes. Perhaps it is impossible to transfer the pertinent knowledge by the classroom method, and only **watching** women in labour can provide the appropriate educational experience. With cursory consideration this seems impossible to do for the majority of women.

One man made the suggestion that there could be more focus in the classes on the needs of men and more time for them to discuss things together (I-3 Tony). Women having their second or subsequent baby worried how the first would cope with the new experience (for example, Sarah I-9). Perhaps there is room for more discussion on this in the classes, either pre or postnatally.

One woman (I-3 Sarah) did comment that there was insufficient information on caesarean sections. She had an epidural caesarean and she had felt improperly prepared to cope with this. Although she could not feel any pain, she had not expected to feel so much pulling,

nor to see the actions of the obstetrician beyond the cover of the screen. It is not clear if this was an emergency or elective operation.

Implications for Curriculum Development

Childbirth education has many values but some significant limitations. The student midwife needs to explore the current situation and assess how this meets the needs and wants of women and their partners today. The curriculum should allow further study leading to the development of alternative methods of teaching or content changes.

Labour Practices

The experiences

Many women have bad experiences in labour

I-2 Julie	I-2 Patsy
I-2 Helen	I-4 Kathryn
I-4 Dianne	I-4 Karen
I-5 Chris	I-7 Kerry
I-8 Kathy	I-9 Jody
I-11 Janette	

The fact that labour is painful cannot be denied (May and Mahlmeister, 1990, pp.72gff). It is how best to manage this that seems the profound question. Or, is it management after the event that may relieve these women of some of their stress? Kathy (I-8) felt some dulling of her memory of the experience of labour even only a few days after:

The contractions were excruciating - the worse pain imaginable. But, it's funny, you do forget it. I can remember how to describe it, but I forget the experience of it.

Some other women had experiences that were so bad that talking about it days later reduced them to tears

I-2 Patsy I-9 Jody

Comments such as: "I haven't got over it yet" (I-9 Jody), and "It took me 8 years to get over the first" (I-4 Karen), were made. These experiences are common and are documented elsewhere by women sharing their birth experiences (Kitzinger, 1992; Lamprel, 1991; McDonald, 1992). The researcher believes a debriefing exercise would be therapeutic, and this should be conducted on a one to one basis within 72 hours of the event.

Drugs

The use of nitrous oxide and pethidine was discussed and brought various results. Mostly those using either of these drugs were not happy with their effect

I-8 Kathy I-8 Lisa;

I-9 Cas.

I-2 Julie I-8 Kathy;

I-9 Cas I-9 Betty).

Researcher's Note: three (3) women who had had Pethidine (I-9) were having difficulties feeding their

babies. The relationship to Pethidine has been recorded in the literature (Righard and Alade, 1990).

The five women who discussed their epidural were happy with the results:

I-3 Lindsy	I-8 Kathy
I-8 Lisa	I-9 Cas
I-9 Jody	

The incidence of dissatisfaction with the effects of nitrous oxide and Pethidine suggest the need for further review. These drugs were gratefully introduced late in the 'scientific' era when women thought the best way to manage the pain of labour was to be unconscious and to have no recollection of the labour and delivery at all (Mitford, 1992, pp.12 ff). More and more of today's women, however, are seeking a satisfying, fulfilling experience and these drugs may be becoming outmoded.

Epidural anaesthesia is more acceptable (though there are serious but rare complications) as it meets the need of relieving pain while not distorting the user's mental abilities and perceptions (Reynolds, 1990). That some women need and want to use drugs is a fact, and Radojevic (1991) suggests this has implications for prenatal classes that promote active, drug-free, birthing practices. These are issues of which the student must be aware.

Pain management

Women have different life experiences that give pain a different meaning, perhaps a different feeling (May and Mahlmeister, 1990, pp.729 ff). Below are some of the comments and experiences that were expressed in the interviews.

I-8 Lisa had prepared herself to go through her first labour without using any drugs and achieved her goal. However, she had such a bad experience that by the time the baby was born she "didn't get those nice feelings". She felt that the baby had caused her suffering and she "didn't want to be bothered with it". With her second labour, she had made a decision to use "all drugs", and it was the epidural that gave her the relief she needed. However, she had great fear when her labour started and she thought she was going to die. The epidural did not take away that fear, but she says she was able to relax more. A similar story is recounted in Lamprel's collection of birth stories (1991, pp.218 ff).

Sarah (I-9) had a very quick labour and "didn't have time to use anything". She felt really good and told us, almost in amazement:

> I came in by midnight and everything was really good, in fact, I was laughing at 1 am! ... I was talking all the way through which surprised me. I didn't want to shut up. The midwife would say something to me and I'd give such a long-winded answer so that I could keep talking.

It is important that midwives recognise the value of humour in labour when used appropriately. As long as they're not exhausted (or drugged), women can feel good between contractions, and humour is useful to a certain extent.

Jody (I-9) was very busy talking in the post-natal class. She described many small details of her lead up to labour and her experiences during it. She "ended up having a caesar. The very thing I was determined not to have. As soon as I knew, I went into shock. I wept hysterically ... I was afraid of the pain for a caesarean section". Jody goes on to describe how, although she "had a particular fear of them cutting into me, and didn't want to be awake (for the operation)" she allowed herself to be talked into having an epidural caesar so that her husband could go into the operating theatre with her. (*Many hospitals rule that the woman's partner can go into the theatre for an epidural caesarean but not for one conducted under general anaesthetic*).

> I thought it would be a general (anaesthetic), and John said it doesn't matter, but I could see that it did. I felt I was letting him down because he had wanted to be there (for the birth) (Jody I-9).

Caesarean sections require special prenatal education to a group whose natural instinct is to feel "that won't happen to me". It has significant effect on the woman's well-being months after the event (Barnett, 1991, p.45), and again, the researcher believes in the importance of debriefing with a midwife before discharge from hospital (Fowler and Gornall, 1991, p.38).

One woman described how she had been told by her obstetrician that her delivery was imminent, but then waited another two weeks before being induced. Her labour then lasted only three hours and she felt unable to gain control or to concentrate. "It was all so quick. I found the pushing hard to do. They kept telling me how to push. I got it in the end, but it all felt wrong".

Partners in labour

There were only two men who attended the postnatal parent education group (I-3 Tony and I-8 Frank), but comments were made by their wives in their absence. Most women were very glad to have their husbands or partners with them in the labour ward. Men go through great emotional stress watching their partners in labour, especially on the first occasion as they do not know what the experience will be like. One comment was that there is too much pressure on men to attend (I-10 Judith) and that her husband didn't want to be there at

all. Sheila's husband also did not want to be present in the labour ward, but Sheila says: " ... he had to be - I needed him". Only one woman made a comment about how much her husband enjoyed it (I-8 Lisa). Others have said that they didn't want their husband to touch them or "didn't want him near me" (I-3 Carole) though they seem glad to have them with them in the labour ward.

Little research has been done on the experience for husbands in the labour ward though a few are recounted in anecdotal stories (Kitzinger, 1992; Lamprel, 1991; McDonald, 1992). Frank (I-8) said he felt guilty and helpless during the labour and birth, and further commented that because he was squeamish, he'd been feeling anxious about his ability to cope. After the event he said he has "a special, new respect for his wife" and Kathy (I-8) said her husband had described similar feelings for her. Tony (I-3) said he was very glad to be there.

As has already been described, Jody (I-9) felt she was letting her partner down because she was to have an emergency caesarean under a general anaesthetic, which would have precluded his presence in the operating theatre. "... John said 'it doesn't matter', but I could see that it did".

Tony (I-3) felt there was insufficient information in the classes to meet the needs of men. He suggested there should be more group work for men to improve communication, as well as more information on what it's going to be like for them. He felt they should be able to share their feelings with each other and discuss the strategies they think they would use. With hindsight, he had not realised how tiring it was going to be.

Disruptive practices

Some comments were made through the interviews about practices which had interfered with the labour process. Tony (I-3) commented on how disruptive for his wife was the practice of performing vaginal examinations. His wife had found the most comfortable position for her in labour was bending forward on all fours. The midwife was unable to adequately attend to the examination unless Carolyn, his wife, was on her back. She added that it was really uncomfortable and that she did not like having contractions that way.

Another disruptive practice was described by Judith (I-4). She had a cardiotocograph (CTG) recording throughout the duration of her labour. This is a monitor that assesses foetal well-being by recording its heart rate in comparison to uterine contractions, and was probably being used as Judith's first labour had resulted in an emergency caesarean. She said: "I found

that really uncomfortable. It was on all through labour. My doctor hadn't prepared me to expect that".

Tony and Carolyn (I-3) both felt that it was very difficult to concentrate on instructions given by the midwife as the baby was being delivered. They felt that midwives should clarify their instructions.

> She told Carolyn to do something, then said something else and Carolyn said "What does she want me to do?" And things were happening really fast, but Carolyn had to try and work out what she was supposed to do first! It was very hard to concentrate!

Lynne (I-10) expressed concern that her doctor had hurried her labour along to suit his own social needs. She had a drip and an episiotomy and wonders if either were really necessary.

Implications for Curriculum Development

The curriculum needs to give scope to the student to assess the usefulness or values of the following in labour practices:

* available drugs;
* alternatives under the pain management techniques;
* the use of humour;
* how women feel pain and cope with it - what is best for them;

* how women experience caesarean section and choose anaesthetic
* the role of men in the labour ward and their feelings
* how routines for midwives and obstetricians are experienced by the woman and how disruptive they are to them, eg: vaginal examination, CTG, instructions, drips and episiotomies.

This requires students to understand what the women and their partners need and want during the experience of childbirth.

Social Factors

Social factors are important in considering the needs and wants of the childbearing couple (Fowler and Gornall, 1991, pp.9-13). As seen in Chapter Three, there are many issues which impinge on parenting today. These interviews highlighted a number of them. Many issues such as finances, isolation, husbands away or working long hours, moving house or renovating, making new friends, were all discussed. Further, issues such as the family and family relations frequently came up as a topic in conversation.

Ellen (I-2) had moved house the day before the baby was born. She says: " ... everything's a mess at home. Everything is still in boxes!" In the same interview, Julie, who described her labour as "terrible" and which

eventually progressed to an emergency caesarean section, did not have support at home. Her parents lived in the country and she would be dependent on friends who had not had babies themselves.

Lesley described her experience with her first child as horrendous. She had moved away from her regular home area because of her husband's work. She became isolated and depressed, living in an area with unmade streets making it difficult to wheel a pram, and with an unsupportive partner (I-5). In the same interview, Barbara and Belinda explained how they, too, had no support networks as they both lived away from family. Glenys (I-7) not only lives away from her family, but her husband is away a lot on business. She also has another stress factor as her home is being renovated.

Athena's husband works long hours (I-7) and Judith and Pauline (I-10 and 11 respectively) have both recently moved house. Judith says: "I've not had time to find a GP, let alone make friends". Mary (I-6) may be forced to move because of a new road being built. She has been dependent on her neighbour to look after her little boy while she has been hospitalised for six weeks because of placenta praevia. Her husband takes the responsibility when he gets home from work.

Patsy (I-2), Lindsy (I-3) and Erica (I-6) describe similar situations of stress in the first 5 - 6 weeks at home with a new baby. Patsy and Erica had problems with breastfeeding. Lindsy was very tired and found it "really tough" during that time. She says she realises she expected too much of herself and should have asked for help. Sarah (I-3) agreed with her and said "you feel ... that you should know what to do". Similar comments were made by others

Lesley I-5 Sarah I-9

Pauline I-11.

Janette (I-11) described her overwhelming tiredness following the birth and looking after her baby in hospital. She was concerned as she did not know how to settle her baby.

Patsy (I-2) described the insensitivity of her visitor who brought five children with her and she felt too tired to want to cope. She and her husband put restrictions on visitors and phone calls after that. Kathy (I-8) feels it is important to restrict visitors too, especially because of the busy schedule in the first few days. Alison (I-8) says she got over-tired. "It's a big responsibility looking after two kids", she explained.

Postnatal depression is a serious public health problem affecting up to 40% of all women with young babies, but

SYDNEY ADVENTIST HOSPITAL
LIBRARY

is only recently being recognised as such (Barnett, 1991; Feely, 1992; Fowler and Gornall, 1991). Lesley (I-5) referred to it and Alison (I-8) had been re-admitted to our unit because of it. In I-11, the midwife discussed it with the three participants who had it or could develop it.

Some women spoke of prenatal social factors which caused them difficulties. Barbara (I-5) felt tired, and during the last two weeks of pregnancy became immobile. She did not want to drive and found difficulty shopping. Also, her mother was in hospital in Newcastle and she felt unable to make the journey. Chris (I-5) agreed with her on the difficulties of shopping and being so big with the pregnancy. She did not drive.

Belinda (I-5) was suffering from Chronic Fatigue Syndrome prior to and during most of her pregnancy and says that she got depressed. Mary (I-6) had to be in hospital for six weeks prior to the birth because of placenta praevia and had another child at home to be looked after. Janette (I-11) described thwarted anticipation of an imminent delivery after her doctor had told her the cervix was 5cm dilated at her 38 week check.

> I kept waiting to go into labour. My husband, family and friends all thought I'd soon be having the baby - but nothing happened. I

> felt really low during that time. I was tired and wanted it - expected it to be all over.

The social factors described above are all recognised sources of stress. Tiredness, depression, lack of control or understanding of events, can change a normal episode into an unsatisfactory, distressing situation. These issues are important for midwifery education if we are to support and encourage a quality experience for the childbearing woman and her family.

Implications for Curriculum Development

Many social factors impinge on the childbearing experience of the couple and their families. The student midwife needs to be aware of what social factors affect them and also the sociology of the family today.

Continuity of Care

Continuity of care has become a major issue since childbearing was moved, almost exclusively, into the hospital environment. The birth process has been dissected and compartmentalised so that prenatal care and prenatal education are considered separate entities and probably conducted by different people if not in different buildings. Maternity units may be so built that staffing is split between labour ward, pre and postnatal areas and Special Care Nursery. Shift work means a change of staff every eight hours. Postnatal care is conducted initially in the hospital, later in

the Early Childhood Health Clinics, and by the obstetrician until six weeks after the birth of the baby when the General Practitioner takes over. This results in considerable discontinuity of care for most women.

Obstetric Care

Choosing an obstetrician

It was interesting that, though the women believed they were able to choose their own obstetrician, when they came to talk about it, it didn't seem much of a choice (especially for those in their first pregnancy). Some were given names of local obstetricians from their General Practitioner and were asked to pick a name (I-4 Kathryn; I-6 Mary). Others may have chosen the hospital first then found an obstetrician with visiting rights to that hospital (I-4 Dianne). Anna (I-4) and Mary (I-6) said they would have asked their friends about their experiences, but it is interesting to note that Anna followed on to say she had no friends who had had babies, so it would not have helped her.

Mary (I-6) found her obstetrician of choice had full bookings and so she went to another he recommended. If the obstetrician is not going to be available for the woman's delivery, it is he who elects another obstetrician to take over that woman's case, as happened to Erica (I-6). Alison (I-4) had not been happy with the obstetrician's care for her first pregnancy and so sought out another one the second time. However, it seems she is not entirely happy with the manner of this second doctor.

When Erica (I-6) had her first baby, her doctor of choice, Dr·Bell, was away at the time of delivery and he had contracted another doctor, Dr Sandown, to attend the delivery. Unfortunately, Dr Sandown did not make it to the hospital in time to be present for the delivery. With her second pregnancy, Erica went back to Dr Bell and, as he would be away on holiday by the time Erica's second baby would be born, he induced her two days before her expected date of delivery. After the birth and when Dr Bell was on holiday, Erica was again under the care of Dr Sandown, but he had not been in the hospital to see her, and this was four days later.

Why an obstetrician was chosen

For those having subsequent pregnancies they were very glad to be going back to someone who knew them, and/or they knew him. This continuity of carer is important to women undergoing the childbirth experience. That a midwife can fulfil this role is not in question, just that these women have opted for private health insurance and electing an obstetrician, not a midwife, to provide their care.

Dianne (I-4) had her fifth caesarean section and felt that had been possible because the one obstetrician had performed each operation. Some obstetricians strongly recommend no more than three (3) operations because of the weakness of the scar tissue on the uterus. Another

bonus, she said, is that she doesn't have to join long queues for her prenatal/postnatal checks.

Erica (I-6) agreed it is good to go back to the same doctor who knows her obstetric history. Her doctor went as far as inducing her labour early because he was going away on holiday. Mary (I-6) has a complex obstetric history and said:

> My GP gave me five names (of obstetricians to choose from). You ask friends too. I'd chosen Dr Waters but he was full and he gave me Dr Wall's name. I understand he stands in for him when he's away on holiday. I was happy with him last time so naturally I went back.
>
> I had a "normal" delivery ... my first was a miscarriage, then my live baby, then I had two miscarriages and now I'm expecting this one and have placenta praevia. Well, it's good to have the same doctor through all that.

Midwifery Care

Labour ward

Sheila (I-10) did say that it was a problem having different midwives looking after you in different parts of the maternity unit, but she was happy for the continuity of care given to her in labour ward.

> I was lucky in labour both times, as my midwife stayed on until the baby was born. It was just a half hour with my second and there must have been a change of shift as she'd just introduced me to the second, and the two were in the room when he was born.

Lynne (I-10) followed up with a comment that she had laboured only through one shift so it had not been an issue for her.

Postnatal hospital care

Although steps are taken by Nursing Unit Managers to promote continuity of midwifery care over the days of a woman's stay in hospital, it is often impossible to organise. Kerry (I-4) commented that she had been under the care of a different midwife for every shift except one, and she was going home that day.

In the Interview 11, we were joined by a woman who had been discharged four weeks earlier (Kate). She had been seen three times after discharge, for breastfeeding problems, and came in that day for further assistance, joining the group until I was free for consultation. She told the group:

> It's been great for me to be able to come back here when I've had problems with breastfeeding - and I've had my fair share of that. My clinic sister has been really good, and she's a lovely person, but they understand here what my problem is.

Postnatal care after discharge

In Interview 6, Kay and Mary discussed how some obstetricians are not interested in the baby after the birth, nor in helping with breastfeeding.

Kay: "But his interest stops at the baby. He did ask how it is, but that's all. Their interest seems to stop after the baby's born - except to make sure everything is OK with you, of course".

Mary: "They're not interested in the baby or breastfeeding. They just want you to lie down on the couch and open your legs! (laughing with others). In fact, I think they're a little bit impersonal".

This comment is significant in our society where "both nursing and women's health care [are] subservient to the more powerful patriarchal health care system, where technology and specialization are valued over health promotion" (Archibald, et al, 1990). Freed (1993) picks this up when analyzing the lack of support of the medical profession for breastfeeding. He shows that it is due to inadequate education of the physician in this field.

During this interview, Kay commented on the lack of continuity in the Early Childhood Health Centres:

> Oh, they have different sisters all the time there. You never get to know one, and they all give you different stories on what you should be doing with the baby.

Implications for Curriculum Development

Student midwives need to recognise their special skills in meeting the needs and wants of women in the childbearing year and the curriculum should provide opportunity for them to examine innovative methods of providing continuity of care.

Breastfeeding

The women expressed concern over things that could be grouped in three areas: education, conflicting advice, giving comps. Suzanne (I-1) described her breastfeeding experience as "a disaster" and because Ashlyn (I-1) did not receive the proper support and advice, she gave up breastfeeding, though, she said, "I had really wanted to breastfeed".

Suzanne and Ashlyn (I-1) felt a prenatal breastfeeding class would have been good to give them some starting knowledge for the first few days and Lidia (I-1) thinks it may have helped her with her first baby. She had already made up her mind that with her second baby she wouldn't go through the trauma again.

Ashlyn had had a forceps delivery and had also aggravated an old neck injury which was now stiff and painful. Then when trying to breastfeed, she had very painful nipples and received conflicting advice from the midwives. She said:

> It was all really confusing. Anyway, I've decided to bottlefeed now. But I had really wanted to breastfeed. I thought I would enjoy it, and I know it's best for the baby. But my nipples are very sore and my milk hasn't come in. I just felt I couldn't put up with any more.

Kay and Erica (I-6) also complained of receiving conflicting or different advice. Kay said : "It's very distressing" and has had poor help from the community sisters also.

Patsy (I-2) and Kate (I-11) were given follow-up care by a Lactation Consultant, at the hospital, for breastfeeding difficulties. They felt it was better to be seen by staff who already knew them - or whom they already knew.

Karen (I-4) described her dissatisfaction with her care when having her first baby at a different hospital. When looking for a hospital for her second delivery, she had two questions to ask which reflect her dissatisfaction with the management of her first breastfeeding experience. The questions were: "Do they force you to breastfeed?", and "Do they make you mind the baby all day?"

Dianne and Anna (I-4) did feel that there had been an improvement in continuity of advice at the Sydney Adventist Hospital since their first stay. Dianne added " ... you're asked what you think, what you want".

Judith, however, had not given her permission for her baby to be given a drink of water which had been given in the night. She was particularly concerned about this as her milk was coming in and her breasts now felt full and uncomfortable.

Judith said she had found it best to ignore the information given to her in hospital and to go home and sort it out for herself. Kerry complained of having different staff every shift, except once, and that midwife had given her good breastfeeding advice.

Erica (I-6) described how she had very sore, cracked nipples with her first baby and "spent the first six weeks crying". This condition could have been rectified with proper support and education. She felt Tinct Benz was her "miracle cure" and eventually went on to feed for 16 months.

Betty (I-9) brought her baby with her to the class and was breastfeeding him, but she had not been shown a good technique. The baby was all bundled up in a blanket and had his arm across his chest. Her baby was in Special Care Nursery because he was two weeks early and small for his gestational age. His mother said he was not feeding well yet.

Dianne described a situation with her first baby which showed the orientation of midwives' attitudes. She had not wanted her first baby to have a dummy, so the staff put an appropriate sign on her cot. Dianne said she felt "labelled" for something she thought should have been routine.

There has been an information explosion in human lactation in the last two decades, and with it an "increased awareness of the risks which failure to breastfeed holds for infants ..." (Walker, 1992). New midwives are educated with the latest information, while some of the others are tardy in assimilating this knowledge. This leads to the production of conflicting advice. Midwives are subjected to the same socio-cultural situations as are mothers and the bottlefeeding culture. Exposed to aggressive marketing of formula as equivalent to breastmilk, leaves the uneducated professional with little interest in protecting, promoting and supporting breastfeeding.

> When health workers take a neutral stand on infant feeding, they leave the way open for commercial interests to persuade parents that breastfeeding does not matter (Walker, 1992, p.1).

Implication for Curriculum Development

The implication for curriculum development is for the

student to value breastmilk and develop advocacy for breastfeeding through education.

Discussion of Findings

This study has illuminated some of the meanings of five categories gleaned from the whole childbirth experience from the perspective of the midwifery client and her significant others.

As Bartjes described the "essential task of phenomenology" as revealing phenomena that are the "essence of nursing", this study has presented phenomena that are ***required*** to be met by nursing. This has implications for curriculum developers. The lived experiences of the women and their partners have not always been satisfying and it is the education of midwives that the researcher suggests can be attuned to meet these needs.

> Unless nurses are conscious of the meaning of human struggle experienced by the patient within the health care system, nursing management will find it impossible to fully achieve those service structures and characteristics necessary to meet the needs of the consumer (Bartjes, 1991, p.261).

This step toward achieving holistic nursing practice is dependent on the phenomenological paradigm, not only as a method of research but to inform the practice of nursing.

Implications of Findings

The researcher believes it is imperative that students undertake their own phenomenological research. After completing the writing up of each session, the researcher recognised how a considerable amount of nuance is lost in the telling of these stories. Birth stories make compelling reading as they are interesting and informative (see, for example, Kitzinger, 1992; Lamprel, 1991; McDonald, 1991). However, the researcher now understands the limitations in expressing the feelings and innuendos observed in the groups studied.

At the end of the sessions the researcher felt rather overwhelmed from the group dynamics, but it was not until her notes were read and later typed in the text that she found she could better reflect on their meanings. Much could be forgotten if not for the process of freezing them in the text. These are the feelings and understandings the students themselves should experience as an important learning strategy.

Process for Implementation into Curriculum

Instead of studying, for example, "the management of pain in labour" the author suggests the emphasis should be on "the needs and wants of women experiencing pain in labour". A unique consequence of this focus in the curriculum will be to provide a convergence of patient outcomes with student outcomes.

Another consequence of this focus in the curriculum will be to intertwine the practices in the wards or community with the theoretical component in the educational institution. To be able to study a key learning area of, say, fertility or the postnatal period, the student will first address the needs and wants of the client experiencing that particular aspect of the curriculum.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The conclusions arising from this study related specifically to clarifying the needs and wants of today's childbearing women and their partners. The study was undertaken in order to inform curriculum developers of midwifery programs. It found that that midwifery practice does not meet the needs of all clients. With increasing consumer demands and the introduction of quality assurance programs in hospitals, this has implications for the education of midwives as they must recognise the needs and wants of the women under their care.

Midwives are privileged to work "with woman" during what might be one of the most trying, triumphant and fulfilling experiences of her life - bringing a new life into this world. A woman in labour is a human being at its most vulnerable - a person to be protected, supported, encouraged, soothed and rewarded for the natural phenomenon of suffering and pain inherent in the

labour process. How to understand these needs and wants was the purpose of this study.

The literature review in Chapter Three examined the culture of childbirth and changes occurring in the expectations and delivery of midwifery care. Especially during the past twenty years, childbearing women have had to endure paternalistic attitudes from their carers who, influenced by the medical model of health, created interventions never before heard of. Treating the normal, healthy, childbearing woman as potentially at grave risk until after the event has excused what now seem irrational interventions.

But the childbirth experience is more than a labour/birth event. Women and their partners need education and guidance through the antenatal and postnatal period. This is the unique role of midwifery.

An examination of the culture of midwifery found that the changing role of midwives as patient advocate, and innovator in appropriate maternity care. The study also presented the development of the consumer movement and demands made for quality care, not just a safe event but also a satisfying one. Today's student midwives require an education reflecting the changing needs and demands of the childbearing woman and her family in our present age society.

In investigating the theory of nursing we have seen how **caring** is paramount to the purpose and practice of nursing. It is through this medium that a nurse might help an individual to achieve the highest possible level of health or self-actualization. To promote the highest level of caring, **empathy**, theories of nursing should be based on phenomena depicting the realities of the childbirth experience as expressed by those undergoing the experience - the childbearing couple. Phenomenology has been shown to be an appropriate research method to achieve these aims.

Student midwives today will receive a more liberating education than has ever before been offered, but they will work in the practice area that still has a framework developed on the medical model of health. Maternity units generally divide their staff into specific areas of care - often dictated by the structure of the building and rostering requirements. In this state of flux, it is essential that the theory of education moves into the practice arena of the wards, birthing centres and community. Midwifery education must meet the needs of the midwifery patient client. It is important that student midwives recognise what women value in the care they receive and need, during the whole childbearing episode. It is important that students value what these women value.

This research project described in Chapter Four has uncovered some real needs of midwifery clients. These have been categorised into five areas: childbirth education, labour practices, sociological factors, breastfeeding and continuity of care.

That nursing is dependent on a mix of skills ***and*** humanistic principles has been shown. What this study has attempted to do is increase the available knowledge on client perspectives, in humanistic terms, of being nursed. It increases the value of knowledge that has meaning for solving everyday problems. The researcher, however, has undergone a significant experience in her own right, and has considered how this might affect a student's development.

What has eventually transpired is a desire in the researcher to provide opportunity for the student to undergo the crystallization of ideas when exploring women's experiences. When undertaking this study the researcher was a novice in its methodology but the act of observing these women and men and later reflecting on their comments in the text filled her with the profundity of their experiences. The study was exciting as it felt to the researcher that she was examining a previously untapped source of information to contribute to her own knowledge and understanding of women's experiences, needs and wants. It was the act of

reflection and the writing of the text that encouraged the crystallization of ideas.

Phenomenology has been used as a model for nursing research (Wilkes, 1991, p.243). What this researcher is suggesting is that it can be integrated into a midwifery curriculum to guide the learning of, and understanding in, the post-graduate student - shaping thinking in a phenomenological way.

In midwifery where most care takes the form of education for the client, it is important that the curriculum focuses on methods of teaching and androgogical principles. Midwives must recognise the uniqueness of their role and meet the challenge of sharing their knowledge with their clients, to be articulated in a way that will empower them by promoting confidence, independence and self-esteem.

Part of this recognition should come from a curriculum that frequently addresses the needs and wants of the consumer of the midwifery product. This concept should be seen as a key learning area that infiltrates all disciplines and shows the relationships between the disciplines.

If breastfeeding is the learning area in the current curricula, it should become "the needs and wants of the

breastfeeding woman" in a curriculum using phenomenological principles. If postnatal depression is the learning area for student midwives today, the phenomenological curriculum would call it "the needs and wants of women in preventing postnatal depression".

This focus in a curriculum will move away from the behaviourist model of nursing education. It will bring the student to discover what constitutes the lived experience of their client and they will develop abilities to "interpret what is needed by people". In this way, the client might undergo "tolerable, manageable, or even enhanced" experiences instead of what patients describe as "alienation, abandonment and even horror" (Munhall, 1992).

The researcher recognises the early stage of the conceptualization of her ideas, and that they will require further research and testing for validity before they might become significant in informing curriculum content. Nevertheless, she is confident that phenomenology offers a means of breaking down the theory-practice gap in nursing education as well as improving the ways in which the needs and wants of the childbearing woman and her family will be met. Thereby, midwives are offered the opportunity to enable more women to achieve satisfaction and fulfilment in a major life event.

Limitations of the study

This was a small sample of self-selecting private patients. Therefore, the categories could be different if the study were replicated with other groups.

It is important to consider why such a small number of women attended this class. Further research might ask why they came, and to ask those who didn't: why not? It would have been appropriate to ask the group to evaluate the class afterward to examine if it did meet their needs, whether it improved their self-esteem or changed their way of thinking about themselves. Also, we could enquire if they felt better/different after talking about their birth experience.

Although many issues were extrapolated from the study, there was insufficient opportunity to deal with them here. A number of issues of relevance for further research were highlighted, such as: (a) the value of nitrous oxide and pethidine to women in labour (a retrospective study, preferably, in the first 72 hours), and (b) men's experiences in the labour ward.

Summary of Overall Findings

1. Midwifery practice does not meet the needs and wants of all consumers.

2. Phenomenology is an appropriate method to discover the midwifery client's needs and wants.
3. The midwifery curriculum should be developed on the midwifery client's needs and wants.
4. The curriculum should be researched-based so that the student herself/himself develops the skills necessary to elucidate the needs and wants of her/his clients.

Recommendations

On the basis of the findings in this phenomenological research study, the researcher recommends that:

1. Future post-registration midwifery educational programs be planned on the needs and wants of the childbearing couple.
2. That phenomenology be introduced across a research-based curriculum to aid the student develop her/his own skills in enquiring after the childbearing couple's needs and wants.
3. Further research be undertaken in discovering the midwifery client's needs and wants in order to increase the midwifery knowledge base.

APPENDIX I

THE INTERVIEWS

INTERVIEW I

GROUP SIZE: 5

MEMBERS: Suzanne
Lidia
Ashlyn
Rosemary
Wendy

Suzanne was telling us about her labour experiences and she became tearful. "I haven't got over it yet". Lidia chose to bottlefeed because of her first experience with breastfeeding. Her conversation was peppered with comments that would describe symptoms of postnatal depression plus social isolation. Joined a religious group which gives her strength and companionship. Her face looked "dead-pan".

Ashlyn looked sad and anxious. She had a stiff neck for which she was receiving physiotherapy. It was an old injury, aggravated, she thinks, from positioning in labour. She had a forceps delivery "the doctor decided to put forceps on". "Is that what you wanted?" Ashlyn: "Well, yes, I suppose I was very tired. But I wanted to push the baby out myself".

Breastfeeding class - Ashlyn said it would be a very good idea and she would have come. Rosemary agreed. Lidia said it might have helped her with her first baby as she really hadn't understood how complicated breastfeeding was. But she had already made up her mind with her second baby that she wouldn't go through that again.

Ashlyn complained of receiving conflicting advice on breastfeeding from the midwives. "It was all really confusing. Anyway, I've decided to bottlefeed now. But I had really wanted to breastfeed. I thought I would enjoy it, and I know it's best for the baby. But my nipples are very sore, and my milk hasn't come in. I just felt I couldn't put up with any more".

INTERVIEW 2

GROUP SIZE: 7

MEMBERS: Vickie
Julie
Linda
Cheryl
Ellen
Patsy
Helen

VICKIE: This is my second baby. My first is three years old. I attended classes the first time and they were really good. I didn't go to refresher classes.

JULIE; This is my first baby and my labour was terrible. I just wasn't prepared for what was going to happen. I ended up with a caesarean because my baby was in stress. I had one of those monitors on, at the desk (*corometrics*), but the midwives didn't see the stress and it was my husband who called them. He rang the bell. We could see the baby wasn't well. That really panicked me. I'd had Pethidine but it was awful - I didn't like it at all. I felt sick and I didn't like feeling dizzy - I wasn't in control. Then they couldn't find my doctor. They did eventually but I was really stressed out by then. The contractions were awful and I was really worried about my baby.

MIDWIFE: So you feel you had a really unpleasant experience which could have been avoided?

JULIE: I guess the baby getting stressed would have happened anyway, but I wish I hadn't had the Pethidine. My husband was wrecked by it all.

MIDWIFE: It sounds as though you had a really awful time. How did you feel after the operation?

Interview 2

JULIE: I've really been pretty good. I was very tired but got over that. I didn't have much pain because I had that injection through the drip.

MIDWIFE: The PCA. That's good, it really does help for a quick recovery.

LINDA: I had that. This was my third caesar, and I've recovered a lot better this time, and I'm sure it was because of that.

MIDWIFE: That's good. I'm glad to hear it. Cheryl, how did things go for you?

CHERYL: I found the classes were really good the first time. I had a quick delivery and concentrating on the breathing really helped me. But I didn't go for the refresher this time. I read the book by Janet Balaskas and it was very helpful this time. I had my baby at home, we didn't get in in time!

ELLEN: The classes were great. I came here, with my husband. I had a really quick labour too. The baby was a bit early and we'd moved house the day before and everything's in a mess at home. Everything still in boxes!

PATSY: I enjoyed the classes. Jenny ran ours. But they did not prepare me for labour (*fighting back tears*).

MIDWIFE: Is that because you had a hard time?

PATSY: I was 21 hours in labour.

MIDWIFE: So, quite a different experience to Ellen and Cheryl!

PATSY: (laughing) Yes! I thought it would never end! I wondered how long I'd have to go on (crying now)

MIDWIFE: Do you want to talk about it just now?

PATSY: I don't mind. I had the gas and air and it was good at first but the contractions got

really strong and I (*the cervix)* wasn't dilating, so I had an epidural in the end. I was just really tired. Then a visitor came soon after and brought five children! I just wanted them to go but I couldn't tell them. So after that I had two days without calls. My husband told our friends and relatives and the staff wouldn't put calls through ... but I'd had an easy pregnancy. I'd felt really well, so I guess I was expecting everything to go well in labour.

HELEN: I had a difficult first time too. It was awful, just like yours. But the good news is, it does get easier. My second was a breeze. It took a third of the time. The doctor had told me "Don't worry, it's always easier the second time; it will only last one third as long". And it did! I had Pethidine this time and an induction.

MIDWIFE: We've had quite a mix of deliveries described here today. Unfortunately, we're running out of time, but I really do want to hear more from you. If anyone would like to meet up with me after the class, or before you go home, you know where my room is, or I can come along to your room. What I'd like us to think of now is going home, and how prepared you feel, and if you have help at home. Ellen, how are you going to manage in a new house? Have you moved into a different district, or even State?

ELLEN: No. We've only moved a few streets away. so we'll have our old friends, and my family live locally.

PATSY: I haven't found out yet where the baby clinic is. When do I have to go there? ...

Interview 2

MIDWIFE and SOCIAL WORKER discussed Early Childhood Health Centres and the care they provide.

MIDWIFE: Do you have help at home?

PATSY: My mother lives nearby. I can drive to her place in half an hour.

SOCIAL WORKER: Does your mother drive? Can she get to your place OK?

JULIE: I have friends who will call.

SOCIAL WORKER: They have babies too?

JULIE: No, but they're very keen to help out and want to look after the baby.

(Patsy contacted us three weeks later with feeding problems. She saw Claire once and rang her at home at the weekend, then rang me on the Monday and came in for me to watch a feed. she was very tired (voice on telephone, facial expression - though general appearance was immaculate). We dealt with the feeding problem then I asked her if we could talk about something that was very painful for her. She was emotional and trying to keep under control, but her feelings wouldn't stay under and kept coming out in her tears, which she fought back. We talked through her labour and expectations and personal problems. She expressed a great satisfaction later. I hope it did her some good). Patsy rang to express her gratitude for the care and attention she had received from me and Claire. Her baby was putting on a lot of weight for the second week running, and she was very happy and felt confident. She said she also felt that she was "becoming more like a human being again".

INTERVIEW 3

GROUP SIZE: 6

MEMBERS: Lindsy
Annette
Carole
Tony
Carolyn
Sarah

MIDWIFE: Did you enjoy the prenatal classes? Did they help you?

SARAH: I feel there wasn't enough on caesareans. I had to have one under epidural and although I couldn't feel any pain, I could feel an awful lot of pulling and I wasn't expecting that. I was almost lifted off the table when he was pulling with the forceps, and it was horrible to see him tearing at my skin (*held her hands as the obstetrician would to separate the abdominal muscles*). He had to use a lot of force! 16.11.92, spoke to physiotherapist about this and another couple of incidents mentioned by patients, and she described R Small getting in touch with her and other comments about frightening the patients with these stories. They were all going to the rooms asking about it.

LINDSY: I had an epidural during labour and liked that I could feel the baby coming down. It was nice to push the baby out. But it's true, the epidural, while it takes the pain away, you do still feel everything.

MIDWIFE: I'm interested that you said it was "nice" to push the baby out. Would you tell us a bit more about that?

LINDSY: Well, the midwife had sort of encouraged me not to have a top-up because I wouldn't be able to feel the baby coming out. But I was determined to have my epidural (*laughing*).

Interview 3

I had had one with my first one and they had to use forceps to get it out. But this time I pushed the baby out myself. Well, I could feel it, and I was glad I could because it was ... satisfying. It was nice.

MIDWIFE: Did you have forceps this time as well?

ANNETTE: I know what you mean. I really liked it when I started to push. It was nice. And you know its near the end, but it feels different. You can do something now, you can work at it.

TONY: Does the anaesthetist stay when you have an epidural?

LINDSY: No, he leaves. The midwife gives you a top-up. The anaesthetist puts the first one in and leaves a top-up in a bag over your shoulder. Well, that's the way they did the first one, but they put this one under the pillow. It's in a bag. The midwives are trained to give the top-ups, so they just push it in when you need it.

MIDWIFE: Tony, how did it feel for you while your wife was going through the labour?

TONY: I was really glad to be there. But you asked about the prenatal classes. I feel there wasn't enough for fathers. You know, you go through all the ways you can help in labour but like, that's it. That's all you have to do. It would be good to talk together, the men, in the classes. There's not enough communication between us.

MIDWIFE: Yes, I think I know what you mean. You come along to classes and sit in couples while the physio talks to you.

TONY: Well, we did have group work, but we could have talked about our expectations to each

other. You know, just the men together in a group. Talk about how we might feel, and to keep moving.

CAROLYN: Tony got to feel really tired because he'd been standing up in one position all the time. He wanted to be close to me. My labour was really quick but it was a long time for Tony to be standing in one position.

MIDWIFE: Didn't you know there was a stool then? You could have used that.

TONY: Oh, no. But you need something high up, like a gas chair.

MIDWIFE: You mean something like a bar stool?

TONY: Yes, that's right! But I was really surprised at how tired you could feel. And you feel there's not much you can really do. Another thing that I didn't like the last two weeks say, everyone you talk to has nothing positive to say. They all talk about how bad it is. Like, you can't enjoy it. And when Carolyn was in labour she was on her front, you know, on her hands and knees or over the bean bag, and every time the midwife went to examine her, to do an internal, she had to turn over onto her back. Did she have to do that? Does the examination have to be done with them on their back - because she found it really disruptive.

CAROLYN: Yes, it was really uncomfortable and I didn't like having contractions when I was that way.

MIDWIFE: Well, I guess it's what they get used to. If more women delivered in that position they'd get more used to what they were feeling. Did you delivery in that position?

Interview 3

CAROLYN: No. I had to turn over. I was sitting up. The midwife said something to me but I couldn't understand what she said.

TONY: Yes! They should clarify what they want. She told Carolyn to do something then said something else and Carolyn said, "What does she want me to do?" And things were happening really fast, but Carolyn had to try and work out what she was supposed to do first! It was very hard to concentrate!

MIDWIFE: Did anybody else have an experience like that?

CAROLE: Oh, my midwife was wonderful. I couldn't have asked for better.

LINDSY: Don't get me wrong. My midwife was good.

MIDWIFE: No, that's OK Lindsy, your point was valid. But you had good support then, Carole?

CAROLE: Oh, yes. I felt sorry for my husband because I didn't want him near me! You know, it wasn't that bad, and he was really good. But I wanted to concentrate. I wanted the midwife.

MIDWIFE: What about when you go home? Are you all prepared for that?

LINDSY: When I took my first one home it was really tough for about five to six weeks, then everything came easy. But in the first few weeks I was so tired I could've killed someone to get a sleep. But you know, we expect too much of ourselves. We think we should be able to do everything but when you think about getting a licence to drive a car you have lots and lots of practice. We're just too reluctant to ask for help.

SARAH: Yes, you feel you shouldn't have to, that you should know what to do. I can't believe how

much there is to looking after a baby. Just look at the time. I just got into the shower at 11 am - and that's in here! It's important to let your husband help out or he doesn't understand.

LINDSY: Oh, I don't like my husband doing anything with the baby. I can't trust him.

Social Worker went on to give advice about Early Childhood Health Centre and groups they organise for mothers, especially primiparas.

INTERVIEW 4

GROUP SIZE: 7

MEMBERS: Karen
Alison
Kerry
Dianne
Judith
Anna
Kathryn

MIDWIFE: Did you enjoy the prenatal classes? Did they help you?

KERRY: One thing that I noticed was the position I was in in labour had not been taught in classes. I had my feet on the midwife's waist.

MIDWIFE: I can understand what happened there. The classes are taught mostly by physios and they are not keen on that position. Neither am I in fact. The last place I worked the physio used to emphasise how bad the position was for you and the midwife.

KERRY: Oh! I liked it. It felt very comfortable. It hurt my shoulders having to hold my own legs.

MIDWIFE: But that must mean you were lying on your back, so you were pushing against gravity. You see, if you were leaning forward on your feet (*I get up to show position*) you would have been in the same position but you wouldn't be pushing against gravity. And

there would have been no need to hold onto your legs!

JUDITH: But you can't get out of bed with those wires on can you? (*describing the CTG belts*). I was told I had to say in bed.

MIDWIFE: You had a caesarean though, did you, last time? So in effect, you were having a trial of labour. Maybe that was why your obstetrician wanted continuous monitoring.

JUDITH: I found that really uncomfortable. They were on all through the labour. Dr Carry hadn't prepared me to expect that.

ALISON: I was really surprised at the number of people who came into the room. I thought it would just be the doctor, the midwife and my partner. But my doctor didn't make it and I remember you saying in the prenatal classes, Anne (*talking to midwife*) how, if your doctor doesn't make it there'd be another midwife who comes in. In fact, when I saw her I thought "My doctor's not going to make it!" (*laughing*). But there still seemed to be a lot of staff.

MIDWIFE: Perhaps there were students. Our policy is that students can only come in to watch the birth if they have been working with that women through her labour, so that they are

part of the staff, but we have had a lot of students lately. I'll to talk to Noreen about it. Kathryn, how did your birth go?

KATHRYN: I had a caesarean this time. My other two were born normally, but there was a chance this one may have been caesarean because the head was always high up (*fighting back tears*).

MIDWIFE: So although you were expecting it, you were still shaken. What happened, was there foetal distress?

KATHRYN: I wasn't really expecting it. The doctor had said about it, but I hadn't really thought it would happen. I'd been in labour all day and hadn't dilated, then the baby was distressed. And then everything happened quickly. I didn't have time to think.

MIDWIFE: Yes, that's true. Once the decision for a caesarean has been made, things happen very quickly. That must be a bit of a shock?

KATHRYN: Someone came in and shaved me straight away. Then I had to put a clean gown on. Then the trolley came. My husband couldn't come with me because I had a general (*anaesthetic*). But I realise it had to be done. No-one did anything wrong or anything. It was just a

shock. Then I didn't see her for a long time (*the baby*). Not 'til the following morning. My husband did. He'd been able to hold her and everything.

MIDWIFE: Why was it so long before you saw her?

KATHRYN: She had to stay under the heater, she was cold. I was not 'with it' too, I suppose. I'd had the general. I realise they'd bring her to me if they could.

DIANNE: It is a dreadful experience, an emergency caesar. My first was. This was my fifth. I've had five caesars. My first labour was 26 hours and then I ended up with a caesar. It was dreadful. It took me a long time to get over it. This time I had the PCA and it did make a difference - but I was really worried when the midwife said we could take it down in the morning - I didn't think I'd be ready. I was very glad when the anaesthetist came and said it can stay up until I wanted it off.

KAREN: It took me eight years to get over my first time, and I didn't have a caesar. It was the whole experience. The hospital stay was horrible. It was horrific - and a lot of that was because of the staff. This was at

Interview 4

... (*gives the name of the hospital*). The midwives were horrible, they had a really bad attitude. It's nothing I can really put my finger on - it was the whole thing. But it was that bad I didn't get pregnant again for eight years. Before I booked in here I asked two questions: Do they force you to breastfeed? And: Do they make you mind the baby all day?

MIDWIFE: That's awful. I think you'd find there's been quite a change in attitudes in these last few years. I hate to hear stories like that because I know they are true. (*I sit there squirming because I don't know what to say. I have seen situations like this myself and felt helpless to change things. But now I am hoping midwives are becoming more aware and patient-oriented. I think a lot of those attitudes evolved from midwives being the obstetricians' advocate, and I hope training today, by midwives, for midwives, will help stem those attitudes and reorient values to the patient*).

DIANNE: I've seen big changes here over the years (*meaning at Sydney Adventist Hospital*). They used to use dummies all the time and I didn't

want my baby to have a dummy so they put a label on the cot.

MIDWIFE: Were you happy with that arrangement?

DIANNE: Really, I didn't like it. I felt that I was being labelled. I was surprised it was routine to use them, not to avoid them! But there's much more continuity now, and you're asked what you think, what you want.

JUDITH: I wasn't consulted and they gave my baby a drink of water last night and my boobs were filling up and uncomfortable and I couldn't waken my baby up for a feed!

MIDWIFE: So, you hadn't filled in the form on the feed chart that your baby could have comps? (*pointing to the appropriate place on another baby's cot that was in the room*).

JUDITH: They'd asked me about giving milk comps and I said no, but I didn't think about water comps, and nobody said.

ANNA: With my first baby I needed a lot of help because I didn't know what to do, but everyone said different things. I got really confused. I went home and had to work things out for myself. This time's been much different, there's been a lot of continuity.

JUDITH: Yes, that's right. You just listen to them, ignore what they say and go home and do your

own thing! One midwife said to me, "Don't leave her on too long, you'll wreck your nipples". I didn't like her phrase!

KERRY: I've had different staff every shift, except today. And that midwife has been great. She really helped me with my breastfeeding.

MIDWIFE: That's unfortunate that you've had so many different staff. I know they try and organise the same staff to the same area.

MIDWIFE: Have you been satisfied with your prenatal care?

DIANNE: It's good having one obstetrician. That makes for continuity of care. You don't have to keep explaining the same thing over and over. And you go back if you've been happy. You don't have waiting lists in doctors' rooms. You don't choose the obstetrician. You choose the hospital.

MIDWIFE: How do you choose an obstetrician?

KATHRYN: You don't have a choice. The GP gave me three names and she said to choose one, but I didn't know any names.

ANNA: It's only if you've had a friend who's had a baby and she recommends him, but I didn't know anyone who had a baby!

ALISON: I chose to change my obstetrician, but I'm not so happy now though.

INTERVIEW 5

GROUP SIZE: 4

MEMBERS: Barbara
Chris
Belinda
Lesley

CHRIS: (*keen to talk*). At 36 weeks (*gestation*) I went into false labour, so before I came in this time, I wanted to be sure it was the real thing. I had two nights when I didn't sleep properly because of contractions, but they were not really strong, I guess, but I couldn't rest. They were not regular either. My mother kept telling me to come in, but I wanted to be sure. Anyway, when I did come in, they said it was only early labour, the cervix was only just beginning to dilate. I'd just wanted not to use any pain-killers, and I kept good control with just the gas, but it did get too much for me. In the end, I'd had two shots of Pethidine, but it was transition that was really bad. I couldn't stand it, and I was screaming for the epidural, but when they did an internal, they said it was too late. I was fully dilated. The first twelve hours were OK, I could cope with that, but the transition was terrible.

BARBARA: I had a caesarean. It was planned because the head was high, it just wouldn't come down. But then it turned out I would have had to have one anyway if I'd been in labour because the cord was wrapped twice round the baby's neck and the doctor said there was no way I would have pushed the baby out alive.

MIDWIFE: Perhaps that was why the baby's head stayed high, because the cord was holding the baby back from going into the pelvis?

Interview 5

BARBARA: No. I said that to the doctor, and he said it wasn't that. He didn't know why the baby did not go down but that wouldn't have caused it.

LESLEY: I had my first baby 7 years ago. It was hard then because we had financial problems, and we lived near Albury and there were dirt roads and I never seemed to get out. It was pretty horrendous. But I was lucky, there was the Mercy Hospital Mothers and Baby Unit just opened, and I went there and it was really good. I got depressed really, and you've just got to deal with all the emotional stuff. If you're not used to asking for help, it's really difficult. I had no family, I'd not had time to make friends and my husband was pretty hopeless. He just thought about himself all the time.

My life has been so much better since I left him. I've got a lovely husband now, he's really caring and helps around the house, and this baby is as much his as mine. I've got my family again, now I'm back here in Sydney. I live up at Hornsby Heights. It's really bad to be isolated and depressed.

I'm very scared of the depression coming back, but things are so much different now and my little daughter will be very keen to help. It was good I had a boy, because it's like, her territory isn't being challenged. And we've both had time to settle into our new life. She's had a lot of things to work through. I worked in the country as a counsellor, and you feel like you should know

it all, being a nurse. But it's so different. You've got the knowledge, but not the experience.

BARBARA: I know what you mean. I'm a nurse too! I'm psych. (*psychiatric*) trained, but you still think it'll help. And I live up at Hornsby Heights too. I don't know anyone up there. I see a couple of women occasionally pushing a pram or collecting their kiddy at the bus, but you really don't get to know much about what it's like having a kid.

SOCIAL WORKER: What my group did when my kids were young was, on those horrible wet, wet days when there's nowhere to go, we'd take turns at meeting at one house and use up her electricity to dry the washing and we'd take our lunch and stay for the day and have a good chat! (*laughing*)

BELINDA: I've given myself one treat out of all this and booked up for a month's nappy wash service. I have no family here, but I was very careful to go to antenatal classes at Narabeen, near where I live, so that I'd get to meet up with other women having babies, because I know no-one either, and it was pretty scary getting used to that! But I work in the city so you never get to know your neighbours even. Anyway, it worked really well, and the husbands came along too, so we already feel much happier, and it was good to see we're all in the same boat! Now we've got a network.

Interview 5

It was so important because I had a hard pregnancy. I'd had chronic fatigue syndrome, and I got depressed (*looking at Margaret-Anne*). My husband got tired of it, too. I'd had it over a year before I got pregnant, and it was awful feeling tired all the time, and not having any interests, or energy to do anything. The hardest thing was that no-one knows you're pregnant and you just have to get on with things. You're on your own.

SOCIAL WORKER: It would be much easier if you had a broken leg with a big plaster on it and people would feel really sorry for you. They'd say: sit down while I get you a cup of tea, or: don't struggle with that. Let me help you.

LESLEY: But you also LOOK so well when you're pregnant. As long as you look good, no-one thinks things might be wrong, or that you need help.

BELINDA: You feel guilty yourself, because **you** can't see anything either!

SOCIAL WORKER: You must accept when you need help and make sure you get it. Sometimes making that first call is the hardest thing.

MIDWIFE: Yes, so many women tell us that was how they felt, but once you've made that step, everything else might start to happen.

BARBARA: Most of my family is in Newcastle. My sister will make regular trips. She has a couple of kids herself, and we're really close. She wants to help out. She's just had a hard time because my mother had to go into hospital, and she's in Newcastle, and I've

been in hospital here at the same time and she's been running between the two of us! (*laughing*).

I've felt trapped these last couple of weeks because I didn't feel I wanted to drive with the date being so close, and being 'vagus-maximus'! And you've only got so much energy. You can't even get to the shops. Once you've walked there you feel too tired to do the shopping, let along carry it all the way home.

CHRIS: I know what you mean. I don't drive. I don't think I'll be isolated though. I know one lady with a baby, and there is another baby in the block where I'm living. I live in a unit. And there's another lady in the block pregnant. I'll go and make myself talk to them. And I have a friend. It's sad really because she can't have kids. But she really wants to help. Then my husband is getting three weeks off in December. I know it's not a lot, but he'll be at home to help me then.

BELINDA: I'm an Early Childhood Educator, and I see it all the time how women get too tired and can't cope.

LESLEY: I only finished work two weeks ago, and I think that's wrong. I should have left sooner, because you start out too tired after the baby's born. But my baby came two weeks early. But my husband is good. And I've got my daughter - sometimes you just need someone to hold the baby.

INTERVIEW 6

GROUP SIZE: 3

MEMBERS: Kay
Mary
Erica

(Today, I included a guest - Karen. She is a third year medical student from Newcastle who is thinking she may specialise in obstetrics. When I introduced her to the group they cheered!)

ERICA: That's what we need, more women obstetricians (*Agreement and similar comments from the other two*).

MIDWIFE: Can I ask you how important it is for you to choose your obstetrician?

ERICA: It is important to go back to the same doctor. They know your history and you don't have to keep explaining it to everyone.

MIDWIFE: How do you choose one in the first place (*group looking confused*) - I've been told your GP will give you three names to choose from.

MARY: My GP gave me five. You ask your friends too. I'd chosen Dr Waters, but he was full and he gave me Dr Walls' name. I understand he stands in for him when he's away or on holidays. I was happy with him last time, so naturally went back. I had a "normal" delivery they tell me - a "good" delivery. Well, that's what they say. It wasn't very good to me. (*Others laughing in agreement*). My first was a miscarriage, then my live baby, then I had two miscarriages and now I'm expecting this one and have placenta praevia. Well, it's good to have the same doctor through all that.

Interview 6

KAY: My first was that - placenta praevia. I had to have a caesarean.

ERICA: I like having the same obstetrician. He knows about my previous problems with the episiotomy and feeding problems. I have a good relationship with him. He was due to go on holiday so I had an induction two days early so that he'd be there. I've had to have another episiotomy and I've got more stitches this time. Well, it's not the episiotomy actually but they call it labial tears. I've been in 7 days because of this. (*This is unusual. I wanted to pick this up, and the feeding problems as obstetricians don't usually know much about breastfeeding - certainly not as much as the midwives and clinic sisters, but many patients don't seem to recognise or know that! I'm also not happy about inductions for convenience. Consequently I thought I'd stay on safe ground and go back to Yvonne's comment.*

MIDWIFE: What about your delivery, Kay. Did you have a "trial of labour" as you'd had a previous caesarean?

KAY: Yes. Dr Hadley was very good. That was my last pregnancy. My son is just 12 months old. I had my caesarean 17 years go. He didn't make it for this one. Well, the baby's head was out and the midwife kept telling me not to push, just pant. That was awful. I couldn't wait for him! So he just had time to hold the baby's head as I pushed it out! But his interest stops at the baby! He did ask how it is but that's all. Their interest seems to stop after the baby's

born - except to make sure everything is OK with you, of course.

MARY: They're not interested in the baby or breastfeeding. They just want you to lie down on the couch and open your legs (*laughing with others*). In fact, I think they're a little bit impersonal.

ERICA: Well, my doctor didn't make it for my first one, either! He'd got another appointment. In fact, he wasn't the doctor of my choice then! Dr Bell was in Townsville at the time so his stand-in was Dr Sandown. This was at Hornsby. That's why he decided to induce me early this time because he'd missed the first and I'd had such a bad tear. So at least he'd be there. But now Dr Sandown is looking after me again, and he didn't come in for four days. I've been waiting to know when I can go home, but he's not been in.

MIDWIFE: Do you all know where your Early Child Health Clinics are? Kay, you're probably still going to yours? Did you find the Sister OK?

KAY: Oh, they have different sisters all the time there. You never get to know one and they all give you different stories on what you should be doing with the baby. There was this one "obnoxious little nurse" there. She was talking to someone else, not me, but she was really off. She had a really bad attitude. I had trouble with my feeding but they were no help. I gave up after two weeks. But that's better than nothing isn't it? (*looking to me for approval - I gave it with a nod*). This baby is smaller, so I'll feed her for about a month.

Interview 6

ERICA: I had feeding problems. I had very sore, cracked nipples. I spent the first six weeks crying, then I fed her for 16 months.

KAY: Oh, well done. There's hope for me then?

MIDWIFE: What about support at home? Do you all have someone who can help you?

MARY: I have good support at the moment looking after my toddler, but I don't know how much of that will be around after six weeks antenatally in hospital. I have a fantastic neighbour, but we might have to move.

MIDWIFE: Is that because of your husband's job?

MARY: No. The house is being bulldozed. They're putting the new road right through it!

ERICA: With breastfeeding advice, I've had three different lots of advice over the last three shifts. You can cope with it, but if you were a primip you wouldn't.

KAY: I agree. It's "very distressing", but it hasn't spoilt my stay.

KAREN: (*after end of class*) That was very interesting. I've learnt a lot. It was interesting to hear the views on obstetricians. One thing I've heard a lot of women say that I've been speaking to since my visit here is that they thought they'd have more freedom of choice with the delivery positions.

INTERVIEW 7

GROUP SIZE: 4

MEMBERS: Mary (again)
Glenys
Athena
Kerry

GLENYS: Husband away a lot on business trips. Having an extension built on the house.

SOCIAL WORKER: Not a problem. Lindy's having a main highway built through the front of hers!

GLENYS: Family in Melbourne and mother coming up for a short stay - "but I'm not so sure that's a good idea". It can be a bad time.

MIDWIFE: There are advantages living close to your family sometimes because when they get on your nerves you have the chance to tell them so and sort the problem out, but when they come on a short visit, the pressure is on to make it "quality time". If it doesn't work, you haven't got good communication channels to deal with the problem.

ATHENA: My husband works long hours. This is my second baby and I had a lot of trouble with my first. I think it would have been much easier if my husband had been more help. He just doesn't think, though. He left bottles of chemicals on the side of the bath and I said "Will you be around to take your son to

casualty for a stomach pump?" I have to think of everything, like paying the bills. And he takes too much on. He was running around after this potential client and I asked why. He said he had to treat this man well as he was a potential client, and I said " You'll have no clients if you don't get on and finish the work for your other two definite clients".

KERRY: I didn't have a good experience. My pregnancy had been great. The head engaged really early on and the doctor said I'd go into labour early, but the next visit came and then the next. Then he said he thought it might be a breech and sent me for ultrasound. It was! And he had me in the next day for a caesarean. That really upset me. I hadn't time to think about a caesarean or read up about it. I'd never expected one because everything was going fine. We'd been along to all the classes and planned and practised our technique for labour.

SOCIAL WORKER: Do you think this may have some lasting effect on you and your motherhood?

KERRY: Well, yes! My whole pregnancy had been geared toward having a labour. I feel I let

my husband won - but I had an epidural so he was able to be with me and we could hold the baby straight away. He says he didn't miss out - but it certainly wasn't what we'd practised for.

MARY: Did you not have a chance at vaginal delivery?

KERRY: My obstetrician said emphatically no. He said some will try but there are too many risks.

GLENYS: Well, you have to think of the baby, don't you? If the baby's OK then it's all worth it.

MIDWIFE: How have you been feeling since?

KERRY: OK. Monday I was really sore and had a bad day (Day 3), but I'm really good now. I've been fine.

GLENYS: You have to be sure and not overdo things though. Will you have help at home?

KERRY: Oh, yes. My husband has the weekend off and my mother is coming down to stay with me for a week.

MIDWIFE: That's not a lot of help Kerry in the easiest of situations. I suppose you've been given restrictions on what you can do?

Interview 7

SOCIAL WORKER: A good rule of thumb is that if it hurts, don't do it.

KERRY: Yes. I've been told I can't lift. I'll just have to get my husband to do those things after my mum goes back. And I can't drive for a few weeks. I'm a bit scared about all that. I'm not so sure how I'll manage on my own. And how will I get to the baby clinic. I don't even know where it is. I live at Kellyville.

SOCIAL WORKER: That might be the area where they'll make home visits.

MIDWIFE: Before you leave we'll look up the number for your local clinic and you can give them a call when you get back to your room. They make appointments for women having their first visit with their first baby.

INTERVIEW 8

GROUP SIZE: 9 (no social worker)

MEMBERS: Sandy
Alison (2nd visit)
Suzy
Kathy
Mary
Claire
Frank
Annie
Lisa

MARY: Two weeks more to ultrasound and decision-making.

ALISON: I had my baby four weeks ago. I had to come back in because the doctor said I have postnatal depression. I don't think I'm depressed. It's my incompetent husband who can't help out and at least look after the kids while I get a break. I've just got over tired. It's a big responsibility looking after two kids.

CLAIRE: This is my first baby. I've been lucky really. Just 8-9 hours in labour. My baby weights 8 lbs 11oz. I have to say I think the classes were good.

KATHY: Classes were good. My baby was in a posterior position. The gas made me sick. Pethidine didn't work. Epidural the most fantastic thing. Because the baby was posterior I had the pain in my back and couldn't lie down. The contractions were

excruciating - the worst pain imaginable. But, it's funny, you do forget. I can remember how to describe it, but I forget the experience of it.

FRANK: (in response to my question). I did feel guilty and helpless. Also, I am squeamish, so, afraid of how I would cope.

SUZY: I used the telly, there was a comedy on and I found it distracting. I was much more relaxed this time.

FRANK: I have a special, new respect for my wife.

KATHY: Absolutely.

LISA: My husband really enjoys the experience. it is really important for him to be there. He is sorry about the pain - but matter of fact. He knows it has to happen and there is nothing he can do about it. He's scientific about the whole thing.

ANNIE: I was amazed when they put the baby on my tummy. It feels real then. This was my baby.

LISA: This labour was a different experience to the last. First time I tried without drugs because I thought it was so important, but it was a horrible experience. Now I feel guilty because I didn't get those nice feelings after the baby was born. I didn't

want to be bothered with it. I felt he had caused me this pain. This time I decided I would use all drugs (I was induced). I was so afraid when I went into labour. I thought: "I am going to die". I had an epidural. It was great. I felt nothing. I was still afraid, but I relaxed more. I had tried the gas, but didn't like it. It made me feel dizzy and tired.

ANNIE: I had everything (laughing).

KATHY: I didn't have an induction because I had been told it makes the pains come on quick. Id' be to Ju Ju Sundins classes and had lots of ideas how to help, but I couldn't get out of bed.

Since the baby is born I feel I have a lot to learn. It is too busy in the first few days, what with visitors and sitz baths. I think it is really important to restrict visitors. They don't think and I feel rude asking them to go when they've gone out of their way to get here.

LISA: I'm in here for a rest. I don't want to room in.

CLAIRE: I had a go rooming in and had no problems so I feel good about that.

ANNIE: I tried it but the baby cried and I didn't

get much sleep. I feel I should try and get as much rest as possible while I'm in here.

SANDY: There are too many unnecessary interruptions. I like this nurse call bell better than the others because the nurse doesn't have to come to your room to answer it. You're more likely to use it in that case and call for help when you need it, or to check something before you forget.

LISA: There is a need for a lounge area like in Hornsby. Somewhere you can go to and sit and watch TV if nobody else is there. Coffee tables, magazines.

SANDY: A cosy area where you can go and breastfeed, open your hear out, have refreshments. The area opposite the desk is like a waiting area.

INTERVIEW 9

GROUP SIZE:

MEMBERS: Jody
Sarah
Betty (appeared Japanese and spoke broken English though she could be understood)
Cas

BETTY and I first there. I ask Betty about her baby. It is being looked after in Special Care Nursery as he was born two weeks early and Small for Gestational Age. Not feeding well yet. She's attempting to breastfeed him now, has the baby all bundled up in a blanket, his underarm wrapped around across his chest. Jodie enters, walking cautiously.

MIDWIFE: Do you need a footstool Jody? It might take some weight off your stitches.

JODY: Yes, thank you. It's not my bottom actually. I ended up having a caesar. The very thing I was determined not to have. As soon as I knew, I went into shock. I wept hysterically. I'd been in labour six hours but my blood-pressure went up. I was lucky. I had the best compromise. I had it under epidural. I didn't think that would have been an option. I'd had Pethidine and gas.

MIDWIFE: How is your blood pressure now? Has it settled down?

JODY: No. (She looked frustrated? Ashamed?) I'm on tablets now. My blood pressure was

erratic for the last couple of weeks. My labour started two and a half weeks early.

BETTY: Was your BP OK in your pregnancy?

JODY: Yes. Well, that was the thing. I had such a good pregnancy, I felt really well, that I really believed I wasn't going to have any trouble with the birth. Now I feel I'm having real trouble getting my body back into synch. The rest of my system is all out of order.

MIDWIFE: How? In what say? (Sarah comes in)

JODY: Well, my bowels are not working, and, you know, all that trouble with wind.

MIDWIFE: Welcome, Sarah. We're just talking about Jody's caesar. It's her first baby, and Betty's first too. (Cas has also arrived now). Is this your first?

SARAH: No, this is my second. My first is 2 1/2 years old. A little girl. I was worried how she would be with the baby, but in fact, it's her father who worries me now. She's actually touched him very carefully, and says "Am ony ooking".

MIDWIFE: Why did you say your husband worries you?

SARAH: He's too protective of the baby, and keeps telling Sam (the little girl) not to touch him. And my mother says "Mind the soft spot"

and I say "Mother, it's not that soft!". This labour was much different to my first - that was really long. I was terrified when labour started this time. I thought of everything I had to go through. I hadn't been to refresher classes. But in fact, it was much better.

CAS: This is my first. I wasn't worried at all! I don't know why. I'd queued for tickets that morning. Then my waters broke at 12 midday. I decided I'd better come into hospital at 4.00 pm because nothing was happening, but my contractions started at 4.30. Then it got really hairy. I'd had gas and Pethidine. I didn't like any of those at all. They made me feel sick, and out of control. I ended up with an epidural then the baby was born really quickly by 10.00 pm.

BETTY: I hadn't expected my baby to come early. I started with some bright red bleeding. I put a pad on. My contractions started but they were irregular. By 10.00 pm they had settled down to a pattern and were coming every 10 minutes. By 3.00 am they were irregular again, but like 3, 7, 10 minutely. I rang up and they said you'd better come in. When

they did an examination I was 4 cm dilated. But by 5.00 am I was only 4-5cm dilated. I hadn't wanted to take any drugs unless it was really necessary, but by 8.00 am they ruptured the membranes and I was still only 5cm! Now the pains were intolerable; they hurt more after they'd ruptured the membranes. By 12 midday I thought I cannot take any more and I had Pethidine. It didn't help at all, it just made me feel sleepy. I really felt I wanted to have my bowels open and I called the midwife over. She wouldn't let me go to the toilet, she said "the baby will come", but I really wanted to go. It was overwhelming. She said, OK, push. I didn't want to, I thought I'd have my bowels open! Then I was only pushing 40 minutes and the baby was born.

MIDWIFE: That's the thing with Pethidine. It does affect the way you feel, and I think it does take the edge off your contractions, but it does allow you to sleep, and that's what helps the cervix to dilate. Unfortunately, what you and Debbie were probably feeling is unrelenting contractions because you would fall asleep between the contractions without knowing it, and be woken up with the next

contraction. Now ask your partners about this, because they might tell you that you did fall asleep, even <u>**fast**</u> asleep, even just for a minutes or two - don't forget, that's how frequent your contractions would have been - but during that time your whole body relaxes, and the cervix can dilate up.

SARAH: I didn't have time to use anything! I was really only 1.1/2 hours in labour. I came in by midnight and everything was really good, in fact, I was laughing at 1.00 am! 1.20 am the membranes broke and it was only 20 minutes till the baby was delivered. I shook with the shock. They had to get warm blankets for me (Jody and Cas said this happened to them also - Cas after her epidural. I explained how this is not uncommon in labour, after epidurals, after delivery). What I didn't like was the pushing - that's when I really felt the pain. It's burning.

I was talking all the way through which surprised me. I didn't want to shut up. The midwife would say something to me and I'd give such a long winded answer so that I could keep talking! (laughing)

Interview 9

JODY: My experience was quite different. I'd actually had four days of strong period pain, but it was too early yet and my husband, John, said I was getting too worked up, it was all in my mind because it was much too early - we thought we'd probably have to wait another three weeks yet.

My membranes must have gone at 02.30, but I thought I'd been incontinent and I was so embarrassed, and I'd wet the bed. I was up and down all night and my pads were getting wet, but I couldn't be sure. And then I had some bleeding which I knew wasn't right. But for some strange reason it didn't worry me. And the contractions had started, but they certainly didn't worry me, they weren't too strong. By this time John was propped up in bed looking at our books and he said I had some symptoms of labour but not others.

By 11 am we decided it was time to go in. Yes, my waters had broken but my cervix was very unfavourable. At 1.30 Dr Ball said I should have a drip up and my labour started by 3.00 pm. By 4.30 pm I decided I'd have some Pethidine, and unlike you two, I really liked it. It worked very well. But my blood pressure went up. I was well under control

here. The midwife, Cathy, was absolutely fantastic, and made me feel confident. John and I got into fantastic rhythm, using hand pressure and eye contact and I was happy with this.

But my blood pressure was a problem and the doctor wanted me to have an epidural for that and because I wasn't dilating. Well, that was heaven, and I'd strongly recommend anyone to have one. so I went with it, but I still wasn't dilating, and at 7.00 pm I was still only 1 cm dilated.

Then I noticed a change in Cathy. She was absolutely fantastic, and was saying now that it wouldn't be so terrible if I had to have a caesarean. But I didn't pick up on her cue. At 9.30 Dr Ball said it would have to be caesarean. I fell apart. (She starts crying and said "I haven't got over it yet". I hand her a tissue and she composes herself). I thought it would be a general, and John said it doesn't matter, but I could see that it did. I felt I was letting him down because he had wanted to be there. I had a particular fear of them cutting into me, and didn't want to be awake. I'm 41 and I've

never been into hospital before in my life. I was afraid of the pain.

Anyway, the anaesthetist was tremendous, and took me through step by step what would happen. He made me laugh.. He was very comical and said "Don't you think I can't look after you? I've already given you one good epidural. Do you think I can't do that again? So everything went well - except as Dr Ball was inside, he said something, and it turns out I had had a bleed behind the placenta (concealed APH) so he said my uterus wouldn't have been able to contract properly anyway.

BETTY: That has happened to me, too.

MIDWIFE: Maybe this would explain your bleeding early in labour, and your four days of strong period pain Jody

JODY: I felt to have the operation was all wrong - and now my body's all out of order. I put my day clothes on as soon as I could, so that I wouldn't look sick. I feel strongly that things should work out right. Before the baby was born my mother kept telling me I wasn't resting enough. And I feel guilty because I think if I had been more careful, the waters wouldn't have broken so early. I

feel it's my fault. I should have been more careful.

MIDWIFE: That's not necessarily the case Jody (agreement from Betty) because it can be due to the fragility of the membranes. For an example, one woman I helped with her delivery had such strong membranes that I had a very hard job puncturing them with the forceps, and the baby's head was coming out! being delivered. They were really tough. Whereas others can rupture very early on and the baby has to be delivered prematurely.

I think you expect too much of yourself. This is not uncommon. I feel a lot of women go through this. You've probably all been working until your first baby, earning a wage, feeling authoritative and in control. You probably also get some good feedback on the job you do. When it comes to motherhood, you don't get that. Our society does not hold your tasks in esteem because it does not reward it in the conventional way - with wages. But you expect yourself to know what to do, on your own, no orientation period, no support from colleagues on a day to day basis.

Interview 9

SARAH: Yes, I agree with that! It took me a long time to settle into being a mother. Now I don't worry about looking after the baby - it's my 2 year old and the rest of the family I worry about now!

INTERVIEW 10

GROUP SIZE: 4

MEMBERS: Mavis
Judy
Sheil
Lynne

JUDITH: This is my first baby. I just moved up from Greenwich. I've been here just two months. I went to classes in Greenwich. My childbirth educator came in with me for the labour. I think husbands are put under too much pressure to attend the delivery. My husband didn't want to be there at all.

MIDWIFE: That's a good point. I've had some fathers tell me they feel guilty for having caused their wife such pain - as though they're responsible.

SHEILA: Oh, my husband did. He'd been along to all the classes with me but I don't think any classes could prepare you or anyone for what happens in labour!

MAVIS: I didn't feel prepared as well for labour this time. My membranes had broken in the night so I came in as they tell you to, but nothing happened. I thought I would automatically go into labour, but I didn't and they had to induce me in the morning. I was very well looked after. I had my first

baby here. My mother and sister came in for the labour as well as my husband. It was really good. My husband is squeamish anyway and wouldn't look down the other end! He was great though and it was good to have him with me the second time. There wasn't time for my mother and sister to get in this time. It went so quick.

SHEILA: I had my first baby here. I really like the system. I wouldn't dream of having a baby at home. My husband didn't like being there at all, but then he still came with me this time. He had to. I needed him.

LYNNE: Nor me. It's good to know you're coming somewhere where they've got all the equipment and the theatre's just down the corridor.

SHEILA: Yes, that is a problem. I was lucky in labour both times as my midwife stayed on until the baby was born - it was just a half hour with my second and they must have been on change of shift as she'd just introduced me to the second and the two were in the room when he was born.

LYNNE: Yes, I only laboured through one shift.

MAVIS: And me, well, I'd gone in in the middle of the night and had one midwife, but I wasn't doing anything so I was induced in the

morning and that midwife was with me all day. Things went really quickly then in the end. Dr Symington didn't make it for the delivery.

SHEILA: (laughing) My doctor didn't get there for my first! I made sure he'd be there for this one! It was funny really as I was 7cms dilated when I came in. I hadn't realised I was in labour - it was so different to the first. I'd just felt hot and tired and went to bed early. After a few hours it began to dawn on me that maybe this was labour. I rang up and they said I'd better come in for an examination, and I thought, "Oh, no, they'll probably have to send me home again. Anyway, I was 7cms, I couldn't believe it. I quickly got to 10 and they called the doctor. Then everything stopped! I said to my doctor, "I'm getting you back for the first time!" He just laughed.

MIDWIFE: That is another concern of mine, getting the doctor in on time. I've actually been told off for getting one here too early and then again for getting another one too late! But I prefer not to call them too early. I'm always afraid they get too impatient and will put the forceps on or something!

LYNNE: Well, I think something like that happened to

Interview 10

me. My membranes had gone at home and I came in but wasn't doing anything very much. Dr Summers said he'd give me until 2 o'clock and then he'd put the drip up if he had to. Later on the midwife came in and said one o'clock - Dr Summers had been on the phone and he had a Bar B Que to go to that night! (The group shared looks and laughter). She said: "Maybe I shouldn't be telling you this!" Then I had an episiotomy and I don't think I was ready for that, it didn't feel like I should have one. But then the baby's heart was dipping on the machine, so maybe it was necessary - it turned out the cord was round the baby's neck.

SHEILA: My doctor is really great. He's really laid back. But he shouted at me! He'd said to pant as the baby's head was delivered, but I couldn't, I just had to push and he shouted PANT. It turn out the cord was round the neck twice and he was trying to cut it!

MIDWIFE: (after ascertaining there were no feeding problems in the group) I'm conscious of the time and before we go would like to talk about what support you'll have when you leave hospital. Judith, you've already said you've

Interview 10

moved here from Greenwich. Do you know where your Early Childhood Health Centre is?

JUDITH: (We found her local clinic in the directory). I've not had time to find a GP, let along make friends.

SOCIAL WORKER talked about function of Early Childhood Centres, making friends there, even though the only thing they might have in common is that they all have a baby at around the same age; First Mothers Groups. Information supported by Sheila whose family is in Port Macquarie). MAVIS talked about wanting to go back to work. She enjoys her work and has family who can look after the children, but she has problems reconciling time between children, husband and self. Says she feels guilty that she doesn't put more time to children and husband.

INTERVIEW 11

GROUP SIZE: 3

MEMBERS: Pauline
Janette
Kate

PAULINE: I just arrived from Melbourne 4 weeks before the baby was born. I have my family which is good, but know nothing about what's available for me in the area - child-minding and baby clinic and so-on. (We spent some considerable time talking about that, then Ingrid came in).

JANETTE: This is my first baby. I know where my clinic is as it is held in the school just opposite where I live.

MIDWIFE: The group usually likes to talk about their experiences in labour as sometimes it doesn't go as they expected and they feel the prenatal classes could be different.

JANETTE: I think my experience was quite unusual. I'd had a little bit of backache. It was very uncomfortable but not like labour. Then I went for my regular check to my obstetrician at 38 weeks and he did a vaginal examination and my cervix was 5 cm dilated. He said he'd be seeing me again soon! He was surprised I wasn't already in labour. The next two weeks were awful. I kept waiting to go into labour, my husband, family and friends all

thought I'd soon be having the baby - but nothing happened. I felt really low during that time. I was tired and wanted it - expected it to be all over.

I went back to my next routine check at 40 weeks. My obstetrician was really surprised to see me there! He said he'd do another internal as sometimes the cervix closes up again. But this time I was 7 cm dilated. He told me to come in the next day for induction if I hadn't done anything overnight. So the next morning he ruptured the membranes and I' had the baby three hours later. Everything happened so fast. I couldn't concentrate on anything that we'd been taught in classes. My husband was good. He kept me focussing on the breathing and really helped through transition. He said it lasted about 35 minutes, but it seemed more like five to me. It was all so quick, I found the pushing hard to do. Dr Daley kept telling me how to push. I got it in the end, but it felt all wrong.

MIDWIFE: How do you feel about it all now?

JANETTE: Oh, OK. My bottom's sore.

MIDWIFE: Did you have stitches?

JANETTE: Yes, I tore. (Maybe she wasn't needing to

push at all, then?) And I was on a high the first day and couldn't sleep that night, but the next day I crashed. I was very tired (that was yesterday).

MIDWIFE: (seeing the tears in Janette's eyes) How are you feeling now?

JANETTE: I'm still very tired. I had the baby in with me last night but he wouldn't settle. He cried for three hours before I took him to the nursery. He wants to feed all the time and if I put him down - say in the cot - he just starts crying again!

We talked about her milk coming in, and this not being an unusual time for babies to get unsettled; settling techniques, and how she should expect to need help - how traditionally she would not have been the sole person to look after her baby, that there would have been other, eager, family members wanting to help out.

PAULINE: It is so important not to expect so much of yourself. I had my first baby in Melbourne and stayed off work to look after him. My family were all up here. I think I nearly went mad, literally. He was such a difficult baby to look after. Eventually I went for help but was told it was too late as he'd already developed the bad habits.

MIDWIFE: Who did you go to see?

Interview 11

PAULINE: My doctor who sent me to a paediatrician. He did what he could and we tried all the tablets but nothing worked. He NEVER slept at night for nearly two years, and he was awake a lot during the day,

I told her of my friend who went through a similar thing. Her on is now 16 years old and has never been a problem since. He's bright and pleasant. We talked about Tresillian and the Family Care Cottages.

KATE: (has been seen three times postnatally for breastfeeding problems, and came in today for further assistance, joining the group until I am free for consultation). It's not easy with your first baby. You feel so isolated and unsure of who you are and what you are doing. It's been great for me to be able to come back here when I've had problems with breastfeeding - and I've had my fair share of that (laughing).

My clinic sister has been really good, and she's a lovely person, but they understand here what my problem is. The clinic sister just said she couldn't do anything else for me, and I'm in pain with too much milk! You have to understand that different people can help with different things, so if you don't get an answer that is helpful, or it seems

unreasonable, you have to be prepared to go somewhere else.

MIDWIFE: (I talked about postnatal depression here as these three women seemed as though they had, or could, suffer from it).

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