

Beginning Journeys - Volume 1

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Introduction

In 1990 the passing of the Education Amendment Act created the opportunity for tertiary institutions, other than universities, to offer degree programmes. Nursing and midwifery moved rapidly from diploma programmes to undergraduate degrees as the standard qualification at pre-registration level. The transition to degree programmes in nursing has been completed this year with all New Zealand comprehensive programmes now at bachelors level.

At Christchurch Polytechnic the nursing degree programme received NZQA approval in 1994. The first groups of degree students are expected to graduate from the three year pre-registration programme and the transition programme for registered nurses at the end of 1996. The three year direct entry Midwifery degree is proposed to commence in 1997 subject to NZQA approval.

For a number of years nursing and midwifery diploma programmes have shared some characteristics of degrees. However the formal introduction of degree programmes has emphasised the need to produce graduates who are critical thinkers and accept the ongoing responsibility to question and extend their knowledge in all practice settings. This is supported by the [NZNA \(1990\) Statement on Research](#) which defines nursing research and presents it as an essential component of the practice of every nurse.

The seemingly constant changes facing the nursing and midwifery professions in the health and education sectors in New Zealand over recent years make it impossible for every practitioner to undertake research. It may be that the actual "doing" of research never becomes a major component of the work of some of those predominantly involved in practice. There is, however, a profession responsibility that all practitioners be consumers of research who seek validation of practice through research to optimise client care. Pre-registration programmes must prepare the practitioners of the future for this role.

[Litchfield \(1993\)](#) states that although research that addresses issues specific to practice in New Zealand is becoming increasingly acknowledged as essential to the nursing profession, to date there has been a reliance on research conducted and published overseas. Research in nursing and midwifery in New Zealand has been undertaken predominantly at graduate level but this has not always been shared with the wider profession. If nurses and midwives are to develop and implement research-based practice there must be a commitment not only to conduct research but to share, critique and discuss the findings with colleagues and peers. A culture where "to talk research" is the norm, must develop.

This journal has been produced with a view to the future and contains a collection of exemplars and discussion papers from students, practitioners and educators. Nurses and midwives in the Canterbury region are developing a culture where research is seen as an integral part of practice. There is recognition of the obligation to share the findings of research and scholarly work with others to promote professional debate. One of the aims of this journal is to provide a forum for sharing in the future while making a statement about some of the issues relevant to education and practice at this time. This first edition of the journal presents a starting point from which sharing of research activities and findings can occur as the language and culture of research are developed.

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Factors Influencing Youth Suicide

Steve Tripp, Bachelor of Nursing Student

One of the more disheartening health issues in New Zealand today is youth suicide. For the 15- 24 year old age bracket it is the second leading cause of death after motor vehicle crashes and it is increasing dramatically. Between the years 1955 and 1989 the male youth rate increased by 630% while there was a 100% increase in the female rate over the same period. New Zealand is not alone in facing this rise in youth suicide rates. It seems to be occurring throughout the western world, but New Zealand and Australia are unique in that our youth suicide rates are higher than our overall suicide rates (Brett, 1993). So what is happening to our young people that is leading them to take their own lives now more than any other time?

In this paper I will address the question of what factors contribute to youth suicide. I will begin by looking at suicide using a sociological perspective and then look at individual psychological factors that appear to be present. Then I will see how these two approaches fit together and how this can apply to us.

To understand the sociological perspective on what influences suicide it is helpful to use the work of Emile Durkheim. In 1897 he published his work on suicide in which he studied the suicide rates in countries of western Europe and found social phenomena which matched the patterns of those rates (Giddens, 1971). He found three social causes for suicide which he called egoism, altruism, and anomie. The first two are concerned with the degree of integration of members of society, that is, the degree to which members share common values. Egoism occurs when the social bonds attaching people to society slacken and so the bond which attaches them to life also slackens. They become isolated from society and Durkheim (as cited in Lukes, 1973) recognised this excessive individualism in highly educated people, unmarried men, and people without families. He also saw this as a result of capitalist ideals.

Altruism occurs at the other end of the scale when people become too attached to society. They lose any individual perspective and their will becomes fused with that of the whole group. The common goal of society then takes over. Durkheim recognised this in the pre-enlightenment societies of the middle ages where the community could be of more importance than the individual. This can also be seen in soldiers in battle especially since military training involves being drilled to place little value on the person (Lukes, 1973).

Anomie is concerned with the degree of regulation in society, that is, the extent to which there are clear and unambiguous norms. When society lacks such regulation it is in a state of anomie which changes the way that people fit into society. Durkheim saw this happening in places experiencing an economic recession as the expectations which people had because of their place in society were no longer attainable (Lukes, 1973). This was seen in the Great Depression as the suicide rate among middle aged men rose with unemployment (Brett, 1993).

Durkheim's theories look as if they could apply to the rise in youth suicide in New Zealand today. The user pays system and aggressive market policies introduced by our governments over the last 10 years have encouraged egoism as society has valued individualism and being able to stick it out on your own more and more over helping those who are worse off. The social bonds are being destroyed. The rapidity with which these changes came about have brought about a state of anomie in our society, which was a relatively stable welfare state. How much is society alienating our young people, leaving them feeling like they don't matter and without hope?

It does seem that using Durkheim's framework there could be strong social factors which have increased the youth suicide rate over the past few years but there are many questions which need to be asked. Why is it that youth rates are climbing and not the suicide rate of the general population? Why is it that for some, life becomes too difficult whereas others can grin and bear it? What factors influence a particular individual to kill themselves and what, apart from writing to our MP or Paul Holmes, can we do about it?

The factors influencing individuals are the issues that psychologists are interested in, and two studies in Christchurch have helped to shine some light on what these factors are. The Canterbury Suicide Project began in 1992 and is to run over a four year period. Over that time they intend to collect data from more than 200 suicide cases in Christchurch by interviewing family, friends, and health professionals to build up a picture of the background circumstances leading up to these suicides (Beautrais, 1992).

In 1994 this project stated that their initial impressions have reiterated what has been found by much overseas research. About 90% of those who die by suicide can be diagnosed with a psychiatric disorder, with the most common being depression, alcohol or drug dependence and conduct disorder or anti-social personality disorder. More often than not they have two or more of these diagnoses. They have also found that a disproportionate number of people came from a family social background that was abusive, chaotic or dysfunctional in some way.

The other Christchurch study is the "Christchurch Health and Development Study" which has been following

the progress of 1265 children born in the city in 1977. [Fergusson and Lynskey](#) (1995) have recently released a report on the prevalence of suicide attempts and the circumstances involved in those situations using the information from this study. This information is particularly useful as data was recorded throughout the individuals' lives and not just after they had attempted suicide. By the age of 16 years 3% of the sample reported having made a suicide attempt and the same factors were found at the same frequency as in the "Canterbury Suicide Projects" findings.

Nearly 90% of those attempting suicide had at least one of the psychiatric disorders mentioned earlier. Those with a psychiatric disorder were 16 times more at risk of suicidal behaviour than those without such problems. 93% of those attempting suicide had at least one problem of social adjustment compared with 37% of the entire sample. Those with problems of adjustment were 22 times more at risk than those without. Adjustment problems included low self-esteem, leaving school early, juvenile offending and police contact. Those with more problems were more at risk.

[Fergusson and Lynskey](#) also report that those who attempted suicide had childhoods which were characterised by disadvantageous circumstances. These included poor economic circumstances, high rates of parental substance abuse and offending behaviours, less responsive early maternal care (they did not mention paternal care), lower levels of childhood experiences, more parental change, family conflict, and more frequent changes of school and residence. Their studies showed the presence of a strong relationship between the measure of childhood circumstances and rates of attempted suicide.

Their conclusion was that there is a common pathway leading to adolescent suicide. This pathway involves early unsatisfactory family and childhood circumstances which increases an individual's vulnerability to problems of adjustment and psychiatric disorders in adolescence and these in turn increase the risk of that individual attempting suicide.

This conclusion throws some light on how social factors and individual psychological factors combine in influencing a youth to attempt suicide. Sociologists and psychologists have often been critical of each others' different approach to understanding suicide and how to deal with it ([Brett, 1993](#)). I believe it is important to understand all these factors for us to address the need adequately. It seems that our family structures have been changing as our society has changed and this has had a direct influence on the youth of today. In 1991 the former Ministry of Youth Affairs senior advisory officer claimed our rising suicide rates were a response to "New Zealand's male macho image,... unemployment, changing family structures, breakdown in traditional systems and a general sense of fatalism about the future" ([Brett, 1993, p 91](#)). We need to be aware of the impact our society has on the family and the impact of the family on the individual.

There seems to be more and more evidence coming out that a predisposition to psychiatric disorders is genetic, however, there still needs to be a number of triggers that determine whether or not one will develop that illness. For example, of two people with a predisposition to depression, one that grows up in disadvantageous childhood circumstances may get depression and attempt suicide whereas the other may not.

Although treating psychiatric disorders is important for those at risk now, [Fergusson and Lynskey](#) (1995) go on to suggest that an important component of any effective suicide prevention programme would be the development of family support programmes to address the needs of high risk families and their offspring. Appropriate family intervention schemes can significantly reduce subsequent adolescent adjustment problems. There is an increasing amount of evidence which supports this ([Garland & Ziglar, 1993](#)).

There is no short term solution to the problem of youth suicide. In fact, if there is any solution then it needs to be multi-faceted. It is not enough to say society must change without working with the youth at risk now. It is not enough to have mental health awareness campaigns if we do not strive to provide a better environment for the youth of tomorrow.

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Reflective Practice and Journalling

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Since its introduction the concept of reflective practice has been widely accepted and discussed. Early work on reflective practice suggested that it was a good thing in itself and the only concerns were how best to promote and implement it. Current literature suggests that several authors are questioning the clarity of the concept and the ways in which it has been defined and put into action. The difficulties seen are mainly in the area of nursing education, in particular, teaching reflective practice and assessing students and practitioners' ability to be reflective.

It is claimed that reflective practice began with the debate as to whether nursing is an art or a science, following what [James and Clarke](#) (1994) describe as "habituated practice" of the 40's and 50's and then the "Research based practice" of the 60's and 70's. [Schon](#) (1983) saw reflective practice as redressing the balance between the science basis and artistry basis within nursing.

[James and Clarke](#) (1994) claim that conceptualisation of reflective practice in nursing is a problem, and skills required for reflective practice remain unclear. In order to explain the process of reflection, [Atkins and Murphy](#) (1993) reviewed the work of several key educational theorists who have proposed reflection as a learning tool and analysed the process of reflection. ([Boud, Keogh, Walker](#) 1985, [Van Manen](#) 1977, [Mezirow](#) 1981, [Schon](#) 1991). They concluded that the lack of definition and clarity of the concept was evident in much of the literature, however an analysis of the works revealed that apparent differences between authors accounts of the reflective process are largely those of terminology, detail and the extent to which they are arranged in a hierarchy. The three stages identified were summarised as 1) Awareness of uncomfortable feelings and thoughts, 2) Critical analysis of feelings and knowledge, and 3) New perspective.

While most authors differ on their definition of the concept of reflection all appear to be pro- reflection as a tool to develop and enhance professionalism. [James and Clarke](#) (1994) claim that reflection leads to the generation of emancipatory knowledge, and autonomy, in professional activity and claims of professional skills. They further state that the relationship between theory and practice in nursing is not merely that of rules, principles, techniques and "know-how" derived from the empirical-analytical research. It must now be considered from the interpretive and critical standpoints in which, through the process of reflection, the practitioner is central.

It is widely acknowledged that the best way for practitioners to reflect on their practice is through a professional journal and that reflective practice and journalling go hand in hand. [Holly](#) (1984) states that reflective writing through keeping a journal can allow nurses to become more sensitive observers, encouraging enquiry, which focuses on the roles and directions of nursing. [Street](#) (1991) believes the paradigm of nursing is shifting toward practice and documenting the reality of nursing can enable nurses to take charge of the critical analysis and decision making. [Budden](#) (1993) claims that during the process of reflective practice it is critical for nurses to participate in professional journalising which can assist in the analysis of their nursing practice. Professional journalling can identify themes in writing which help describe and untangle elements in nursing and therefore contribute to the development of nursing knowledge and theory. Journalling can help the knowledge from reflective practice to be utilised.

Several problems regarding education are discussed in the current literature. [James and Clarke](#) (1994) explore the problem posed to nurse educators faced with the challenge of teaching students and practitioners the art of reflection. Implicit in any course which has reflection as a theme, must be a view that every practitioner can become a reflective nurse. At present, they claim, there is no evidence to support or refute such an idea. Reflection is a very intangible topic to teach, unlike factual knowledge or technical skills. [Atkins and Murphy](#) (1993) summarise the skills required for a practitioner to reflect as self awareness, description, critical analysis, synthesis and evaluation.

[James and Clarke](#) (1994) express concern that educators have no control over the learning outcomes for reflective practice and some of the outcomes may be threatening for students and practitioners alike. They also question how one assesses whether the individual is reflective or otherwise. Nurse educators at present have no means by which they measure reflection and assess that reflection has taken or is taking place. They suggest that more debate and research is needed before reflection in nursing can be truly understood and educational strategies evolved for the development and promotion of reflective skills.

[Greenwood](#) (1993) takes issue with [Schon's](#) identification of the two aspects of reflective practice, reflection-in-action and on-action as this implicitly undervalues reflection-before action. Because all human action is intentional, practitioners have to learn to reason, from their intentions through to their successful execution in action.

Further, [Greenwood](#) claims that in nursing education, unless reflection-on-action is undertaken immediately following action and in the presence of nurse teachers who have shared the relevant clinical experiences,

there is a real risk that student practitioners will activate and articulate the concerns and action they assume nurse teachers will want to hear. This will merely consolidate the theory-practice gap. Unless nurse teachers have actually been in the practice situation with students, they have no way of assessing the veracity of student's accounts.

Greenwood also expresses her concern that by allowing a practitioner to initiate action before checking the conceptual repertoire Schon allows the activation of concepts that may well be inappropriate. Reflection-on-action involves the practitioner reflecting on her experiences, exploring again the understandings she brought to them in the light of the outcome. However student practitioners should be required to articulate their intentions, the rationale behind them and their successful execution before initiating actions.

Greenwood (1993) points out that reflective practice and experimental learning techniques can reinforce rather than eliminate inappropriate action tendencies. If a practitioner is unaware that she is using them, she will be unable to articulate and examine them for adequacy and accuracy. Refinement and modification will therefore be unlikely.

In nurse education an inappropriate stress on reflection could result in a neglect of "content" which could result in decreased competence according to James and Clarke (1994).

Darbyshire (1993) states that reflecting-in-action is not always possible or desirable. Calculative or rational thinking would involve practitioners standing back to consider their actions. Nursing rarely allows for such reflective distancing in the midst of caring for patients. He suggests that in much of nursing there is a non-reflective, intuitive grasp of what we are doing.

All authors reviewed, discussed the attractions of reflective practice. Professional journaling is seen as essential to reflective practice and for practitioners to analyse their nursing practice and contribute to their development of nursing knowledge and theory. The problems of definition and conceptualising reflective practice is reviewed by several authors although this is seen more as a difference in terminology and detail rather than variance of opinions and issues. The main concern in the area of implementation is that of nursing education. Difficulties are seen in the areas of teaching and assessing reflective practice. It is suggested that more debate and research are necessary to develop and promote the reflective skills required by reflective practitioners.

The entries in my journal to this point are varied. However there is one theme consistent in several entries, the feeling of frustration when I am not in control of a situation and the satisfaction of autonomous decision making. It has also become apparent that my first impressions of an event change when I take time to reflect on the circumstances.

I spent several years in a Plastic Surgery Unit, therefore wound care in an area of special interest to me. One entry describes a patient who has a slow healing sinus which we had been treating for several weeks with slow but positive results. This particular day, the Registrar had seen the patient, was concerned with an increase in the exudate from the area and ordered TDS dressings, which the nurse had implemented. I felt annoyed at hearing this, questioning what is to be gained and why put the patient through the discomfort. Literature and my own experience confirm that daily dressings are sufficient. I approached the Registrar and explained the facts. His reasoning was, the patient had mentioned the increased discharge so he felt he should be seen to change things! The patient was concerned that I was changing the doctors orders, however after explaining my reasoning he was happy to continue. I also made him responsible for the care of his skin care, frequent pad changes and cleaning of the surrounding skin to protect it from the exudate. Later when I wrote about this incident in my journal I was aware of several issues; no-one (myself included) had given this patient an explanation of the principles of wound healing, nor had we allowed him the responsibility for some of his own care in this area. The nurse on the morning shift and the patient had both believed the doctor knew best, and when I had explained my reasoning to the doctor he agreed and was willing to hand over the responsibility. I had been irritated by the lack of control I had in the situation until I realised that I did have the ability to change things and feel I have now earned this doctor's respect.

Another entry describes a morning when a patient who was scheduled for a cholecystectomy at about 11.00 am became acutely unwell and was diagnosed as possibly having a perforated gall bladder. To allow time for improvement of his condition and for X-rays, blood tests and anaesthetic assessment the first case went to theatre as scheduled. As I was in charge I was in a position to assist his nurse and was administering his IV therapy. As the morning wore on, the patient's condition continued to deteriorate, and the patient, his family, the nurse who was specialising him and in fact all staff became more distressed. I contacted theatre only to find that a decision had been made to take the second case as arranged and this man had to wait. The feeling of powerlessness was great, more so when we heard there were complications with this case and the wait continued. By the time the man went to theatre, the feeling among the staff was of immense relief, that he had made it this far, now please survive the operation. After theatre and a brief stay in ICU this man returned to our ward and made a very rapid recovery. While writing this incident in my journal I was reminded of my feelings of frustration and anger that morning. However by writing about it as an isolated event, I realised that I had probably done all I could, accurately reporting his condition, ensuring he received adequate pain relief and supporting the patient, his family and the nurse involved. While writing about it and coming to this realisation helped, I know I never want to be in that situation again.

A further entry was about an elderly, confused man who fell attempting to get out of bed. He was found with two large areas of skin loss on his right arm. Once he was settled back in bed, he was examined by his

doctor who said he would send a plastic surgery consult. I felt confident that there was sufficient skin around the area to unroll and strip into place, which I did with very good results. I think the doctor and the nurse with me thought I was a little unbalanced as the areas involved a large part of his arm, but were both impressed with the result. It was when I was writing this in my journal that I realised that I had made a difference because I knew what could be done, my colleagues laughed because they had no experience in this area and therefore felt that surgery would be the only answer. If he had been referred to plastic surgery the nurses there would have done the same as I had providing he had been seen while the skin was still viable. It felt good that I had been confident enough to attempt this despite the doubts of others thus avoiding another transfer for a man who was already disorientated.

I have been surprised to discover that by detailing incidents in my journal, I am aware of different issues than when the event occurred. Reviewing an incident in isolation from other events forces me to look at why I reacted this way and what I could have improved on. I am conscious of each situation or encounter as an important event, where I can make a difference. I am also having to acknowledge my own strengths and as a result identifying my weaknesses and strengths in my colleagues.

It is apparent through journal entries that I prefer to make autonomous decisions, and have felt threatened when these are challenged. Now I am aware of this, I ensure that I can provide the reasoning and have my viewpoint heard. I no longer look at days at work but consider separate events and am more aware of the part I play in decision making, nursing practice and as part of the team. As a result, I am more aware of, and confident in my practice, thus enjoying my profession more than prior to reflecting through journaling.

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Nursing Partnership

A Model for Nursing Practice - Judith Christensen

Melanie Taylor, Bachelor of Nursing Student

Judith Christensen's Nursing Partnership theory, published in 1990 is a model for nursing practice in New Zealand. According to [Churcher](#) (1991), it is "set against a background of theory development and change in practice over the past thirty years. Its message to nurses is energizing by providing a framework for the development of the partnership in their own nursing practice". This paper discusses the development of Christensen's theory, outlining underlying concepts and main points. It also evaluates its application to nursing practice, including factors which could inhibit the use of the theory in the practice setting.

It is possible to see, in the Nursing Partnership that the main points of the theory lie within the interrelated elements of Passage, Mutual Work and Context ([Christensen](#), 1990).

Passage refers to a social process which is used to describe an experience of significant change in a person's circumstances ([Christensen](#), 1990). Within the theory, life is viewed as a continuous series of passages; social passages, from status to status, geographical passages from place to place, even passages from age to age. Christensen broadens the concept of passage to encompass the Nursing Profession. Recovery from illness is seen as a passage, as can be, for example the passage of dying ([Christensen](#), 1990). Giving and receiving of nursing in order to give the patient optimum progress along the journey is seen as the work of the nurse, essential to the patient's passage. It is also important to note that subsequent passages will impact on one another ([Christensen](#), 1990).

The concept of Mutual Work within the partnership is that of interaction between the patient and the nurse, whereby the patient is the passagee and the nurse the agent of nursing. Both parties focus on the patient and the interaction between them is essential to the successful outcome of the passage ([Christensen](#), 1990). Made up of a number of nursing episodes or encounters, the interactions between nurse and patient are the building blocks of the passage ([Benner](#), 1984). It is important, within this element for the nurse to continually ask themselves how they can most beneficially progress the patient through their passage. As Christensen shows, there is a collaborative effort to get through the passage as soon as possible, which brings two relative strangers together in a single purpose ([Christensen](#), 1990). The negotiation process of the theory will affect how successful Mutual Work is. Christensen also notes that not all nursing action will have a positive effect on the patient's passage.

The element of Context, encompasses three "contextual determinants" which bridge the gap between the ideal of the passage and the reality of giving and receiving nursing ([Christensen](#), 1990). The first, Episodic Continuity focuses on the nurse/patient relationship. According to [Watson](#) (1992) this paradox perceives nursing as being continuous when, on examination it is revealed as being a series of episodes in which the nurse and the patient come into contact for short periods of time for a specific purpose. The integration of separate episodes, with different nurses are building blocks contributing to the passage and ensure the ideal of "being nursed" is upheld even when the nurse is not physically present ([Christensen](#), 1990).

Anonymous Intimacy, the second contextual determinant focuses on the patients interaction with the nursing reality. The rotation of nurses determines that care is undertaken by a number of different nurses hence, in a way they are anonymous. Opportunities for close relationships are limited, thus nurses must work as a team, supporting each episode of care and allowing each episode nurse the responsibility of decision making.

Mutual Benevolence, the third contextual determinant refers to the goodwill between nursing and its recipients. The nurse is present as a helper and companion to guide the patient along their journey or help them through their ordeal ([Christensen](#), 1990). This ideal is incompatible with the power relationship of one seeking to dominate the other. Both nurse and patient seek to maintain the Mutual Benevolence of the partnership.

Christensen's Partnership Model was developed following a time of change in nursing practice in New Zealand. The transition from a hospital based training to general education in technical institutes restructured the entire nursing system ([Christensen](#), 1990).

In this time of adaption the move from task orientated practice in the old system to primary care nursing in the new, Christensen saw the need for a theoretical basis whereby the patient would not need to rely on the dependency role often associated with hospitals. Christensen states that "Nursing requires a theoretical shape which encourages its practitioners to apply the full repertoire of nursing knowledge and skills in each encounter, while remaining sensitive to the patients total experience," ([Christensen](#), 1990).

During this time the role of the Registered Nurse underwent dramatic change. Christensen had particular

concern for qualified Staff Nurses and their adjustment to the new roles of primary care, following the removal of nursing students from the hospital work force. As a Nurse Teacher involved in developing programmes for the integration and preparation of nurses into the working environment, Christensen had an awareness of the deficit qualified nurses had when, having previously carried out supervisory roles they were now completing primary roles in a patient orientated system rather than a task orientated one (Christensen, 1990). Christensen's experience in the practice setting was also cause for concern and precipitated her asking such questions as "How do nurses perceive the patient and their work?", "How do they decide what nursing care the patient requires?", "How do they respond to individual differences in patient situations?". Christensen was seeing the need to ensure nurses were ready with knowledge and skills for application at every moment (Christensen, 1990).

Increasingly, Christensen became unhappy with published ideas of nursing which didn't necessarily focus on the nurse/patient relationship. She desired a theory which would bridge the gap between knowledge and real practice care, a theory that would be specific to New Zealand nurses and their changing situations. As Watson (1992) writes in his analysis of Christensen's theory, the Nursing Partnership is a theory in evolution, hence the formulation of the Partnership Model was begun.

Within the Partnership Model, the underlying concept is the partnership between the nurse and patient. This is unique among nursing theories in that it focuses equally on the patient and the nurse (Watson, 1992).

Within Christensen's original model, the patient (or client as they become in the revised version, [Christensen, 1990]) and the nurse each have a part to play in voyaging a successful passage for the patient. This team work is consistent throughout the stages of the theory, Beginning, Settling in, Negotiating the partnership and going home. Within these stages, each member of the partnership has a part to play. The work of the patient centres specifically on managing themselves, affiliating with experts, serving the ordeal and interpreting the experience, while the work of the nurse is focused on attending, enabling, interpreting, responding and anticipating (Christensen, 1990). The idea of partnership between the nurse and the patient is the underlying concept continuous throughout Christensen's theory.

When looking at the viability of the Partnership Model in practice, it is important to note that in chapters nine and ten of the Partnership Model, Christensen revises her theory specifically to better apply it within practice frameworks and in a variety of settings (Kinross, 1990).

The successful application of the theory relies on an environment of team work. In this situation, the Partnership Model would thrive. As Christensen shows, nurses would need to adopt a partnership in which autonomous nurses would work together each making valuable contributions to the progress of a single nursing partnership, building on what has gone before and contributing to what is to become (Christensen, 1990). This ideal would fit in well with the concept of primary nursing currently being practiced, where the total experience of the patient is focused on, rather than the eight hour shift. The Primary Nursing model would need little modification in order to follow the Partnership Model in application to practice (Christensen, 1990).

Another factor supporting the application of the Partnership Model in practice is that, within nursing it is standard procedure for one nurse to attend many patients. Christensen shows that she recognises this factor in her theoretical approach of collegiality, in which she shows that it is the norm for one nurse to attend many patients (Christensen, 1990).

As Christensen summarizes herself in view of the Partnership Model's application to nursing practice, "The nursing partnership may be a helpful conceptual framework for professional practice because it permits, indeed encourages the continuous inclusion of new knowledge and technology without threatening the overall approach to nursing practice" (Christensen, 1990).

When analysing the Nursing Partnership, there are some factors in the New Zealand scene which may inhibit the use of the theory in practice settings.

As was mentioned in application to practice, the Primary Care Model requires modification. This would entail the primary nurse to negotiate and coordinate the partnership, while being responsible for guiding and monitoring the evolving passage (Christensen, 1990). However, this would entail each nurse being accountable for on the spot judgements and, in a professional sense to the primary nurse for actions taken. Thus, up to date detailed care plans would be absolutely essential to this process and, if not followed, could lead to a breakdown in the Partnership Model.

As Christensen herself shows there is a conflict between the ideal and the real within nursing (Christensen, 1990). Nurses often tend to decry the ideal, especially when attempting to use it in practice. Retention of these dichotomies is not helpful and allows nurses to believe that the ideal is unattainable thus, quality of performance is not sought and the ideal is not achieved. The nursing theory however evolving from within nursing practice focuses on the possible. Once nurses realize that the Partnership Model is practical and attainable, the ideal/real dichotomy should be bridged. Factors which may inhibit the application of the Partnership Model should, with understanding and knowledge be relatively easily overcome.

As has been shown, Christensen's Partnership Model is both relevant to, and specifically developed for the New Zealand health sector. The main points of the theory, the underlying concept of an equal partnership between patient and nurse, have been developed to respond to the previous gaps of knowledge in the nursing system of New Zealand. Applications to nursing practice and possible inhibiting factors thereof have

been discussed in relation to the viability of the theory in practice. It can be seen that Christensen's Partnership Model is extremely relevant in New Zealand and is a timely response to the changes of our health system.

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Beginning Journeys - Volume 1

Learning Contracts and Chocolate Fish

Judy Yarwood BHlthSc (Nurs), MCNA (NZ), RGON, Nursing Tutor

Introduction

The integration of theory and practice continues to vex both nursing educators and practitioners. The development of any new and creative teaching strategy which enhances the theory/practice relationship will provide both nursing cohorts with additional knowledge and skills on which to develop and explore new conceptual models. One such teaching strategy is contract learning.

This paper will discuss the literature related to learning contracts which in the main emanates from either America or England, and will then describe the development and use of individual learning contracts in an acute professional practice area.

Definition

Although there is a paucity of up to date material regarding contract learning, material available allows one to explore the concepts inherent in such learning. A number of authors defined learning contracts, with Hammond and Collins (1991) referring to learning contracts as agreements rather than contracts as this could be seen to be less legalistic and a more open association between the parties, while Knowles (1986), a prolific author on learning contracts, has a very clear definition and is frequently quoted by other authors. To him, contract learning is an alternative way of structuring a learning experience. It replaces a content plan with a process plan. Instead of specifying how a body of content will be transmitted (content plan), it specifies how a body of content will be acquired by the learner (process plan).

Grant (1990) views contract learning as enabling students to assess their own learning needs and to also select, implement and evaluate their learning in a way that is acceptable to the student. Grant (1990) also states that contract learning can be used for personal development as the students develop independence in determining their own learning objectives, while Sutcliffe (1993) in a more open and supportive definition, contends that learning is done by individualizing the educational process and recognizes past learning and experiences.

Sutcliffe (1993) acknowledges the importance of the personal development aspect of contract learning. She describes this effective learning strategy as not only promoting cognitive growth, psychomotor skills and positive attitudes, but also promoting independence, self development and boosting creativity and the imagination.

Principles underlying learning contracts

Despite the diverse range of definitions, the majority of authors are in agreement as to what is embodied in a learning contract. Gibbon (1989) states three principles underlying learning contracts as being - adults are individuals, adults are self directing, adults are engaged in lifelong learning.

Others, Knowles (1986) Grant (1990) Sutcliffe (1993) and Lee (1991) are in agreement as to what the learning contract should contain. Typically it should specify;

- knowledge, skills, attitudes and values to be acquired by the learner which may be expressed as a set of learning objectives
- how the learning objectives are to be achieved
- the strategies and resources to be utilized
- the evaluation criteria to be used
- the grades or rewards to be used (if applicable)
- a target date for completion

Whatever is contained in the learning contract and whether it be formal or informal, the pivotal feature of such a contract is the negotiation of learning and the accountability of both parties.

Keyzer (1986) sees the essence of the contract as cooperation and equal partnership in the learning process, while Kreider (1993) views it as a process of mutual negotiation designed to meet the needs of the learner within an agreed and individualized framework.

The beauty of learning contracts is their flexibility, there is no "right way" to form a contract. Knowles

(1986) contends that learning contracts are so flexible a concept that it is practically impossible to organize them into a definitive classification system.

Donaldson (1992) indicated that students using learning contracts placed high value in being treated as adults and in being given control over their learning and that given the choice between future learning contracts or set work, they would choose learning contracts.

Problems

Contract learning is not without its problems, acknowledged by most authors. Donaldson (1992) commented that an overall increase in time spent meeting individually with students and the ongoing constant stream of work involved in implementing and facilitating the contracts was a concern. Riseborough (1994) reported that both teachers and students had commented on the overall increase in time taken over contracts, while Akinsanya (1987) found learning contracts time consuming to set up and keep going.

Dyck (1986) stated that those students not accustomed to learning contracts, found they were anxiety provoking and frustrating and required much time to be spent on them before any productive learning could take place. Riseborough (1994) suggested that such problems could be overcome by the educators taking time to "internalise" the new facilitatory role, by undertaking in-depth instruction in the use of learning contracts and by using collegial support and discussion groups. Donaldson (1992) also suggests that it is vital for the educator to be involved in facilitating the contracts, and to be able to adapt their teaching style to embrace ideas of student centred learning.

Benefits for Nursing Education

The major benefit for nursing education appears to be the links made between the nursing school and the clinical practice area where students were using learning contracts (Akinsanya 1987; Donaldson 1992; Keyzer 1986). These studies reported more educator involvement when visiting students in the clinical area; the educator became more aware of resources available and also saw the "reality" of the students workplace and were therefore able to focus their limited time in the clinical area on important student issues as well as provide quality student contact.

Kreider (1993) contended that the best people to facilitate learning contracts in the clinical setting were clinical instructors rather than educators from the school, who Kreider (1993) suggested had less clinical expertise. The question of clinical expertise is also raised by Keyzer (1986) who believes it is essential that the teacher facilitating the learning contract is "clinically competent" in order to fully understand the demands made on people in the clinical setting.

It is of interest to note that the general consensus from this small group of authors is that while learning contracts can be valuable tools in the clinical area, they are more applicable to registered rather than undergraduate students.

Keyzer (1986) sees registered nurses as being more action orientated in learning based on prior experience, while Gibbon (1989) found registered nurses more self directed than student nurses. However, as Mazhindu (1992) postulates, it is the handing over of learning to the student that challenges the basic assumptions underlying traditional nurse education. The inability to see learning contracts as applicable to student nurses could well be seen as resistance from the establishment, rather than an inability of student nurses to make the successful transition from pedagogy to androgogy.

The success of learning contracts, it could be suggested, is therefore not only dependent on the students own enthusiasm and commitment to the agreement, but also on the ability (knowledge, skills and attitudes) of the educator (Mazhindu 1992).

Learning Contracts in Professional Practice

This was demonstrated quite clearly when I introduced learning contracts into an acute professional practice area. The enthusiasm with which the students embraced new learning tools was so often dependent on tutor enthusiasm and encouragement, which lead me to such question as: How does an educator motivate students to be completely responsible for their learning and is it in fact the educator's role to do so?

Journalling and reflection greatly assisted both my professional and personal learning throughout the introduction of contract learning and journal extracts are incorporated in my attempt to demonstrate the value of such a learning/teaching strategy in nursing education.

The learning contract that I needed to develop for my particular clinical area had to meet certain criteria. It needed to be relatively short and concise and be understood by both the students and the ward staff working in the clinical area. A three day week for six weeks limits the goals the student can set and achieve and it was important that the student did not identify this learning contract as extra work with little positive benefits.

After much reading, research and discussion with colleagues, I developed a relatively simple three page learning contract. It was important that it be immediately understandable, with provision of examples for each area to be filled, for example goals, resources and strategies, assessment, as well as providing brief notes of explanation on learning contracts and capability learning and further references for those students keen to read and learn more.

The introduction of learning contracts in the clinical setting with third year nursing students went very smoothly. I have used learning contracts consistently with varying degrees of success since February 1994, and the students have been happy to use this learning tool, with attention to individuality, flexibility and choice of use being seen as the main advantages.

Orientation Day

Journal entry for Orientation day, the first day I introduced contracts to the students, was very positive. "The students were keen to learn as much as possible about capability learning and learning contracts" ... "they were also keen to discover their abilities and plan their individual goals". They all felt that to date they had been spoon-fed and couldn't think of anything better than to be able to decide for themselves what they need to learn. I commented after this entry that I will be most interested in reading the goals they plan.

I have continued to use the same learning contracts over the last year and have not changed the format. It must be remembered that these contracts have only been used for a six week period, although I have encouraged students to take the contracts with them to their next unit of learning, especially if they have not achieved all their set goals.

The ward staff were interested to hear about this new teaching tool and listened politely to my explanations. I felt their response was similar to other times that I have introduced a new strategy, which is acceptance providing it does not mean an increase in their work load with student teaching. Understandable in a busy acute area, but at least they were prepared, and felt positive about the learning contracts and were willing to be approached and used as resources by the students as they achieved their goals.

Student Responses

After the first week I had interviewed all the students and overall was very pleased with the response. Two of the students had identified their individual goals and were keen to get feedback on their set goals. Slight difficulty had been experienced in the assessment area, with lack of understanding about self assessment being the main concern, but with a little assistance these difficulties were easily rectified. The other two students were not quite as prepared as I'd hoped, although when I discussed their contracts and goals with them they had obviously thought about relevant learning goals they wanted to set. What surprised me was that they had not discussed their contracts with their colleagues, even though I had encouraged them to do so.

Journal entry ... "I get the feeling I may have to direct some of the students rather than leave them to seek out opportunities for themselves; what I think I'll do is ask them at the beginning of the shift which goals they're thinking about for that day". With hindsight, I should have stood back for a week or two. I did comment in my journal that 6 weeks was not very long to achieve what I wanted!

Over the next six weeks I journalled consistently and had both good and bad days, not unlike most clinical blocks! Some entries include ... "I feel the students are much more in control of their learning, they're doing what they individually want to do and because of that feel good about what they're doing". "This week wasn't nearly as good as the last; I sometimes feel really good about my teaching skills and abilities and at other times just awful". Could be more about me than the students.

At this time I wrote a quote in my journal:

A facilitative approach by a tutor causes students to be self directed and autonomous in their approach to learning" (Townsend, 1991)

This quote summed up my feelings about the use of learning contracts with these students.

Positive Feedback

At the end of the six week block I reflected about the use of learning contracts with the students and received only positive feedback. "Learning contracts are a great idea"; "Contracts allowed you to develop the areas you want to develop"; "I felt it was very good as we were made to feel responsible for our own learning"; "For me, it brought my learning needs from the theoretical to a practical base": "It was good to be treated as an individual". This last comment was made by all of the students throughout the six week period, as they really appreciated being treated individually and not as another block of students who had to meet the clinical objectives.

In my reflection I made a couple of interesting points:

1. Not one student was off sick during the six week period, virtually unheard of before, and as a group they were keen, motivated and receptive to new ideas.
2. Both their formative and summative assessments were excellent. Staff feedback commented that the students were friendly, interested, motivated and asking lots of questions.

"From my point of view this has been a most satisfying experience. Sure, it's hard work especially in the beginning, getting it set up, but once the students understood what was required of them they went for it", a journal extract at the end of the first six weeks using learning contracts.

Conclusions

The introduction of learning contracts has been most successful overall. It was greeted very positively, with the individuality of the student being identified as one of the most important aspects for the student. Journal entry ... "just being seen as an individual with individual needs and learning abilities has real appeal".

All the students enjoyed being responsible for their learning and achieving their goals, and their keenness, motivation and pleasure at using learning contracts was satisfying for both students and tutor with the former receiving a well deserved chocolate fish!

The development and use of individual learning contracts for nursing students in a six week clinical placement has been a unique learning/teaching experience. It has allowed me more confidence in the development of creative and new teaching strategies and also demonstrated the importance of student participation, responsibility and accountability in setting clinical learning goals. Innovative clinical teaching strategies such as contract learning, can only enable nursing students to develop both personally and professionally and thus practice more effectively in today's demanding health sector.

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Beginning Journeys - Volume 1

Exercise and Sport During Pregnancy

Hazel Voice and Julia Howell, Diploma of Midwifery Students

The following assignment examines the role of exercise and sport during pregnancy. A short history and then a brief overview of the studies to date will illustrate a convergence of thought between historical beliefs based on "common sense" and current trends in research under this topic. Physiological changes and the postulated risks and benefits that have derived from these studies will be considered. This leads to the discussion of what may preclude a woman from exercise antenatally and the considerations in terms of the type of activity and danger signs to be aware of whilst exercising.

Centuries ago it was recognised that physical exercise and birth outcomes were connected. In biblical times it was found that Hebrew slave women had easier labours than the Egyptian women. Though being physically prepared, the Hebrew women delivered relatively small babies. Conversely the sedentary lifestyle of the Egyptian women predisposed them to the delivery of large babies and associated dystocia (Mittlemark Wisewell & Drinkwater 1991 p 1). In the 19th Century the views toward pregnant women could be interpreted as patronising. The following is a quote from a booklet by Samuel K Jennings (1808) entitled "Married Lady's Companion and Poor Man's Friend".

"It is common opinion that breeding women ought to live indolently and feast luxuriously as they are able, lest by exercise they should injure, or by abstinence debilitate the unborn child ... Those ladies who are accustomed to idleness and who of course cannot take any considerable degree of exercise without consequent soreness or even fever, ought by no means to indulge in riding on horseback, running or romping, in any stage of pregnancy ... The happier class of women, who are the habit of daily labour and continued exercise, may continue their engagements as before, except only, that it may be necessary to abate from their common fatigue in a gradual manner, as they advance in pregnancy. If however, any of the symptoms threatening danger should present themselves, a little blood should be drawn from the arm and repeated as often as necessary."

In the 20th Century, it is recognised that regular exercise plays an important role in the maintenance of a healthy lifestyle. Women of childbearing age make up a large portion of the exercising population (Zeanah and Schlosser 1993). Therefore the issue continues to be raised about exercise and sport during pregnancy. Numerous studies have been conducted to determine the effects of exercise on pregnancy and pregnancy outcomes. Anderson (1987) concluded that even though more information was required, it was reasonable for pregnant women to continue with their chosen exercise or sport, providing there was no adverse history and providing good antenatal care was given. It was also advised that women unaccustomed to exercise should not commence during pregnancy.

Clapp (1989) completed a study to test the hypothesis that vigorous exercise would increase the incidence of abnormal early pregnancy outcome. This was not supported in the results, but this result was limited in that the sample had all been exercising regularly for several years. Hillis (1990) cautioned re the risks of strenuous exercise, to the women and fetus, but also expel the benefits of exercise in moderation after consideration of potential complications and previous exercise history. In 1985 the American College of Obstetricians and Gynaecologists (ACOG) issued a set of guidelines for safe exercise during pregnancy. These guidelines recommended limiting heart rate to 140 bpm and the duration of vigorous exercise to 15 minutes or less. Zeanah and Schlosser (1993) concluded that women who "exercised regularly before conceiving and who had uncomplicated pregnancies did not adversely affect their own or their offsprings health by exercising in excess of the ACOG guidelines" (p 334). Therefore these guidelines are being challenged by such studies involving women who have been participating in vigorous exercise for many years.

A pregnant women undergoes an array of physiological changes during pregnancy and these must be taken into consideration when formulating an exercise programme. In the first trimester there may be nausea, vomiting and increased tiredness. This may decrease the motivation to exercise. The first trimester is also a critical time to avoid elevated maternal temperatures. Increased temperatures above 39°C can occur with intensive exercise and may be associated with birth defects as a result of hyperthermia (Diploma in Sports Studies 1993).

During pregnancy the hormone relaxin is released to loosen the joints in the pelvic region, but it also loosens all other joints in the body. This increased joint laxity increases the potential for joint injury and muscular damage. Hillis (1990) cited cardiovascular complications, for example supine hypotension as a maternal risk and fetally by impeding myometrial blood flow through the redistribution of maternal cardiac output leading to fetal distress. This view continues to cause controversy with some professionals. Pat Kupla, an obstetrician, was quoted as stating that such problems were not as common as implied and also gives the example of many women labouring on their backs (Gauthier 1986).

Hypoglycaemia is considered a maternal risk of exercise. A postulated risk Hillis (1990) considers for both

mother and baby is premature labour.

A fetal risk factor is that of air embolism. Therefore activities that involve changes in pressure or high altitudes such as scuba diving or mountain climbing may affect oxygen supply to the baby (Highet and Robyns).

The benefits of exercise during the pregnancy for both the woman and the baby require more study involving larger trials, but below are some of the currently accepted advantages:

- Maintenance of physical health and self esteem.
- Decreased incidence of the discomforts of pregnancy such as backache, constipation, shortness of breath, varicose veins, morning sickness and fatigue.
- Limitation of weight gain.
- Reduced length of labour, need for intervention, caesarean section rate and analgesic requirements (Highet and Robyns 1990).

Before participating in exercise during pregnancy women are advised to discuss this with their primary care-giver. Some conditions may preclude a woman from exercise. These include a history of miscarriages, placenta praevia, heart disease, severe toxemia, obesity, anaemia, diabetes or thyroid disease (Highet and Robyns 1993). For those women who have not participated in regular exercise, low impact exercise is recommended. Activities commonly prescribed during pregnancy are aerobic exercises, such as aqua-jogging, swimming, cycling and exercise to music classes. One reason for this is that the risk of hyperthermia is lessened at low to moderate exercise and also to prevent the fetus from being subjected to the acidic waste products associated with anaerobic exercise such as sprinting and squash (Diploma in Sports Medicine 1993). As mentioned above it is advised to avoid scuba diving and mountain climbing, but also water skiing, trampolining, gymnastics and contact sports later in pregnancy.

It is recommended if a woman is not already exercising, to build up slowly to approximately three 30 minute sessions per week. If women are already training they should be able to continue at the same level.

Women are encouraged to listen carefully to their bodies. If they experience discomfort during exercise, the nature, duration or intensity of the exercise may need to be changed. The "talk test" is an indication of whether a woman is exercising at a safe level. If she is unable to talk the exercise level is too intense. A recommended pulse rate is 140 bpm, but this is dependent on a woman's previous heart rate and fitness level.

Dangerous signs during pregnancy:

- Any sign of blood discharge from the vagina.
- Any gush of fluid from the vagina.
- Persistent contractions (6-8/hour).
- Unexplained abdominal pain.
- Absence of fetal movement.
- Sudden swelling of ankles, hands and face.
- Persistent, severe headaches and visual disturbances.
- Unexplained spells of fainting or dizziness.
- Elevated pulse or blood pressure after exercise.
- Excessive fatigue, palpitations, and chest pain.
- Low weight gain in the last 6 months (1 kg/month).

It is advised to warm up for at least 5 to 10 minutes before exercising and cool down for a similar period following.

Drink plenty of fluid before, during and after exercise. Exercise in unrestrictive clothing and a pair of supportive shoes.

In conclusion, it seems that further research is required to ascertain the risks and benefits both maternally and fetally, and that comparative studies between those who have and have not exercised pre-conceptually. Education should be available about the current theories of proposed risks and benefits of exercise. Any programme should be developed on an individual needs basis and only after consultation with primary care-giver. Factors that could preclude a woman from exercise and also danger signs should be discussed.

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Beginning Journeys - Volume 1

A Nursing Student's Perspective of Home Birth

Sheryl Gower, Bachelor of Nursing Student

This account of a home birth involves excerpts from a three part assignment, undertaken during the "Family and Community" paper of Stage 3 of the Bachelor of Nursing degree programme.

It was necessary to "find" a pregnant family and journey through the pregnancy, birth and post partum periods with them. The experience was to be documented.

For ease of understanding, I must explain to the reader that the author is one of "the sisters" in this account.

Onset of Labour

Sue and Ted had just finished enjoying a lovely meal, including bacon and egg pie, to which they'd looked forward all afternoon. Having done the dishes and in the process of settling down for the evening, Sue suddenly felt warm water dribbling down her legs.

This was at 1930 hours on 9 May, nine days later than expected. Husband Ted, was up from the city and had been present for the last two weeks. He had arranged time off from his employment.

Sue watched TV for a while and contractions began around 2100 hours. Then, Sue said, things started to move faster than she'd anticipated. She expected to be able to watch a bit more TV, rearrange her bedroom in readiness, phone her sisters in the city and perhaps fit in a bath or shower.

No way! Contractions were 10 minutes, if not less, right from the start and there were small ones in between. She didn't feel like tackling any chores even if there was a little time between them.

Sue phoned her midwife and her sisters at 2130 hours. The midwife suggested that as it may be a long night, she go to bed and rest while she had the chance. Sue should phone when she felt she needed her, (bearing in mind that it would take 45 minutes to get there).

Sue went to bed, but felt she got no rest because the contractions became increasingly intense. She said she was worried she wouldn't know when she needed the midwife. Even with her mother and Ted present, she felt a little vulnerable, (so did they!).

On the arrival of her sisters at midnight, Sue relaxed and felt a little better. She was curled up in bed feeling quite a lot of discomfort and did not feel like getting up. She said she knew she should move around but felt too uncomfortable and sore to bother.

The midwife and her partner, (they always work in a pair), arrived at 0100 hours, after Ted called her at midnight. She commented that Sue was "labouring beautifully". Now things started to get organised. The bed was pushed against the wall and rugs and sheets spread on the thick carpet. A heater was brought in and the thermostat adjusted in order to warm the room in readiness for the baby.

Sue seemed noticeably more confident with the midwife present. She only had to be there, gently comforting and encouraging Sue, to relax her. What a wonderful skill!

Place of Birth

Sue and Ted chose the home of Sue's mother as the place of birth, (where she had been living since they arrived back in New Zealand from overseas). Her bedroom was perfect for the birth; a large, warm room, with two sets of french doors opening onto a two sided verandah overlooking a country flower garden with the Southern Alps in the distance. At this time however, it was cold and dark outside and the heavy drapes were closed. There was ample room for all seven of us; Sue, two midwives, two sisters, her mother and her husband Ted.

On asking later, how she felt having all of us in the room, (especially in regard to her dignity), she reassured us that she felt protected and looked after. She appreciated our care and light conversation through the long hours. Ted said he felt that his heavy responsibilities were being shared.

Comfort Measures

My sister and I kept the midwives supplied with buckets of hot water, in which they wrung out towels. These were placed on Sue's lower back and perineum to soften the area and ease the pain. Sue said it felt really nice every time a fresh, hot towel was replaced, especially on her perineum.

At this stage Sue was either kneeling on all fours or sitting on her haunches and grasping Ted's shoulders to steady herself. Intermittent drinks of cold water kept her hydrated. She was feeling hot and wearing only a

favourite, old thin T-shirt.

Just before 0300 hours, I remember thinking how drawn out and tedious labour can get. I went and made cups of tea and put a loaf of bread in the breadmaker for breakfast.

Ted ran a warm bath for Sue at 0400 hours in which she felt as comfortable as possible. She stayed in the bath for nearly two hours. While they were in the bathroom, the midwife confirmed that the cervix was fully dilated.

Stage Two Labour

By 0430 hours, Sue was feeling increasingly pushy. She had had a couple of small vomits, but was still drinking water and had swallowed a couple of mouthfuls of honey.

Around this time she felt "stuck". She was pushing and the midwife was saying she was doing really well, but she didn't know whether to believe it or not. To her, nothing seemed to be happening.

Amazingly, she recognised this as a decrease in her confidence and told herself to "get stuck in" and work to get this baby out - it was "her job". She said she realized that her body wasn't going to do it on its own, and she had to take charge. What had depressed her most was the severe pain in her lower back, (the midwife explained that the baby's head was coming around and past the coccyx). A few choice swear words seemed to be her only relief. Fetal heartbeat remained strong and steady, at 120 b/m in throughout.

Sue, Ted and the midwife remained in the bathroom where Sue made some progress. She was holding onto the side of the bath and pushing during the contractions.

By now the baby's head was down onto the perineum and Sue could feel some progress. She was beginning to feel the baby move with each contraction and felt elated when she could finally feel the head staying in one place after the contraction had passed. She felt it getting lower and lower; "Things were coming to an end". Sue's back pain had eased a lot now.

0630 hours

At this stage they moved back to the bedroom. Sue crouched by the bed and buried her head between Ted's knees, (who was sitting on the edge of the bed), wrapping her arms around his body and pushing.

0700 hours

The baby's head was now out, just sitting there waiting for another contraction. "Just a couple more, and it's over", reassured the midwife, although by now Sue didn't need reassurance. She was nearly laughing. Baby A gave a cry even before he was fully out.

0705 hours

Baby A gently slid the rest of the way out and lay between Sue's knees on his side. Sue crouched over him enveloping him with her body and her love. There were tears and joy all around the room. "Beautiful boy, welcomed warmly by everyone", recorded the midwife. A ten hour labour, all up.

Stage Three Labour

Sue said to the midwife, "I've more contractions yet, haven't I? To get the placenta out?" We just smiled. "A piece of cake, now", said the midwife while she checked the baby for his apgar score, cleaned up some meconium, and wrapped him up in a warm towel that had been sitting on the heater.

Sue told the midwife that she would be keeping her placenta. She wanted to plant it under a new kowhai tree that she and Ted have bought especially for the occasion.

0715 hours

Delivery of the placenta proceeded with minimal discomfort and bleeding. Ted was surprised at the lack of blood. The midwife recorded the amount of blood loss as approximately 200 ml's. No episiotomy was required, although Sue's perineum was slightly oedematous. There was a small graze on her inner labia. Salt baths were suggested along with lots of rest and good food.

Sue discovered the next day that she had grazes on both elbows and both knees. Ted had an achy body, sore knees and a sore back from supporting Sue on the floor. A birthing stool may have been an advantage here, but it would have taken an important and fulfilling role away from Ted.

Baby's Care

Ted cut the cord of his new son. As soon as the placenta was delivered, Sue climbed up into her soft bed and sat back against the pillows. Baby A was passed to her and suckled at her breast straight away.

Ted curled up in bed beside Sue and they both sat and gazed at babe for ages. The rest of us tidied up. We brought them the phone and they made a call overseas to Ted's parents. His mum cried - her first grandchild.

Baby A weighed in at 3740 g or 8 lb 4 oz. Sue said, "No wonder it hurt so much, I only ordered a six pounder". Apgar score at 1 minute was 9/10 and at 5 minutes 10/10. A vitamin K injection was not administered. Ted and Sue had decided against this injection after doing a lot of reading and discussing it between themselves and with the midwife. Baby A was given a lot of access to colostrum, (high in Vitamin K) as compensation.

My sister and I made breakfast; we'd had a loaf of home-made bread baking throughout the night. We served the hot, freshly buttered bread with hot tea and coffee, and then sat around with Sue, Ted, Baby A, the midwives, and mum (Nana now), de-rolling and talking.

The midwives left at 0900 hours and while Sue, Ted and baby slept peacefully, the rest of us lay down for a kip.

Impact of the Birth on the Family

In this section, I have decided to quote Ted and Sue directly.

"The birth of wee A has had a profound effect on both of our lives. No amount of imagining beforehand compares to the strength of love and adoration he makes us feel. We've moved on to a whole new lifestyle. Naturally, priorities have changed completely" (Father, Ted)

"From traveller to mother, the two don't mix at the moment and I'm thoroughly enjoying it. Our day to day lives have changed for the better." (Mother, Sue)

Summary of Personal Learning

Being part of Sue and Ted's pregnancy and home birth from such a close perspective, has been a privilege and a delightful beginning to my relationship with Baby A, as his oldest Aunt.

Because of this experience, I have bonded closer to this baby than to any of my other nephews or nieces. I feel very fortunate in being able to use this family for my assignment. Our sibling relationship enabled me to experience and write about very personal circumstances in a natural way. This may not have been possible if I had used a family I did not know well.

On the other hand, had I needed to build a therapeutic relationship with a family I did not know so well, I would have had to draw on more communication skills and resources and have made a more conscious effort. I am very impressed with the outcome of the homebirth of Baby A. I feel that the gentleness, relaxation and lack of disruption during this birth, is a major factor in the blooming wellness and demeanour of Baby A. He has surged ahead in growth, has not had one pimple or blemish on his perfect skin and is placid and accepting with other members of his extended family.

Sue has not suffered from postnatal blues and the postpartum period was so restful, smooth and pleasant for her. I was overwhelmed at being able to spend the first three days in such close contact with Sue, Ted and Baby A. It was a vastly different experience from the hospital births I have experienced, for both Sue, Ted and the people surrounding them.

Even though this was not a hospital birth, I believe the concept of Christensen's (1990) theory of partnership was upheld, particularly the "negotiating the partnership" stage. Sue maintained control of her experience, while the midwife enabled her to enjoy this new experience of motherhood.

Leaving the partnership, for both the midwife and the parents, was a gradual process, carried out over the postnatal weeks. Christensen's (1990) constructs of maximising readiness, discovering requisites and resuming control, were evident, (resuming control is not as relevant here, as it would be in a hospital birth, as Sue never truly lost control). The Midwife stood further and further back during this stage, while appraising the family.

Contextual determinants... "Episodic Continuity" was evident in the midwife-client relationship, (postnatally), as the midwife continued to visit for 5-6 weeks after the birth. "Anonymous intimacy" did not play a part in this relationship because, with the home birth, the client and the midwife developed a trusting, intimate closeness. "Mutual benevolence" is the other paradox upheld throughout the relationship, in this assignment, and concludes with Sue and Ted presenting the midwife with a fragrant, flowering rose bush on the second day after the birth.

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Beginning Journeys - Volume 1

A Simple Request?

Susie Herrera, Bachelor of Nursing Student

While giving birth in a foreign country I found myself and my unborn child alone in a hospital theatre for many hours. Every so often a doctor or nurse would come in, examine me and leave.

A couple of hours into labour a doctor came, examined me and then rushed out. A couple of minutes later, four or five nurses came rushing in. They hurriedly opened drawers and put masks on. I was frightened but managed to ask if my baby was okay. I don't remember what the answer was or maybe I didn't understand. This lasted only a few minutes because suddenly every one left and once again I was left without knowing what had happened and feeling very scared.

The hours passed and once again a doctor and some nurses came in. This time, I believe I was ready to give birth.

The doctor, a Chinese man, was the only person I remember trying to communicate with me. A nurse told me to turn onto my left side and gave me an injection. Presumably it was an epidural, because after that there was no pain.

Just before my baby was born, the door of the theatre opened and 6 or 7 young women came in and stood by the door observing the birth. When I asked who they were, I was told they were nursing students.

A day or so later, when I was back in the hospital ward, I requested that my baby have her ears pierced. This is a traditional practice in my country of origin. My request was greeted with much laughter and ridicule and I felt very alone and isolated. It was clear that because my traditions and beliefs were different, they were seen as abnormal. Now many years later, that reaction is still very vivid in my mind. Something traditionally meaningful was simply denied due to the lack of cultural understanding and the cultural disposition of the nurses at the time. To add to my dismay, I discovered soon after that bilingual personnel were available.

My command of the English language at the time was limited so I was unable to express myself fully. However, I knew how to understand caring or lack of caring in any language.

This personal experience highlighted my understanding of the importance of cultural awareness in nursing. This course emphasizes the importance of accepting each individual as unique without the interference of one's own feelings and beliefs. This helps to provide a safe environment for the client.

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Advocacy

Esther Vallance, Nurse Practitioner II, Christchurch Hospital

Mrs A was transferred to our ward accompanied by her daughter and son-in-law. Mrs A was 76 and prior to her admission she had been living in a rest home, was fully ambulant and independent with her activities of daily living. Dementia had impeded her cognition. She was hospitalized to undergo a cholecystectomy and unfortunately a pneumothorax presented as a post-op complication. Following this, and whilst still in hospital, she sustained a brain stem CVA. Whilst I checked the IV fluids, catheter and positioning of Mrs A her daughter chatted to me about her mother. This all assisted my information gathering as part of my initial assessment. Mrs A's cholecystectomy and chest drain wounds seemed to be healing well. Her skin was intact and regular mouth cares had kept her oral mucosa moist.

Mrs A gradually improved and soon we had her sitting in a chair for two hours each morning. Her swallow reflex had also improved and she was commenced on thickened fluids and a pureed diet. IV fluids were discontinued. She could communicate with a word here and there but cognition seemed to be greatly impaired.

One morning, all was not well. Mrs A had had a shower as usual but her balance seemed to have deteriorated and she seemed sleepy. We put her back to bed and had her reassessed by the medical staff. She had had an extension of her CVA. The nil-by-mouth sign went back up, subcut fluids commenced and two hourly comfort care began.

Mrs A's daughter helped me turn her mother and comb her hair. I would cleanse her mouth. Often she required suctioning. I've always been a bit wary of suctioning, but together, her daughter supporting her flaccid neck and I, using the equipment, would free gurgling secretions. I gained great satisfaction in hearing quiet breath sounds.

On one occasion I was off for two days. On my return to work I was asked by the doctors to insert a nasogastric tube for feeding. Two previous attempts had apparently been unsuccessful. Mrs A had to be restrained as she resisted so much and it seemed I could only get it down so far and no further. Mrs A cried out, "No more, no more!" I did not believe she was consenting to the procedure. The doctors were doing their round and arrived in the room. I explained to them what had happened and that it seemed clear that Mrs A did not want the tube and that it was not going in easily anyway. "Would you like me to try?" said the doctor. "Well ... not really", I replied. "You see, I'm convinced Mrs A doesn't want the tube", (this felt scary...). Consequently, the tube stayed out. Being an advocate felt good.

Our next hurdle was the medical staff's wish to insert a gastrostomy tube. Here's our ethical dilemma. Feed or not to feed. Prolong life or allow nature to take its course. I saw before me the agony of a daughter, dedicated to her mother's welfare, tossed to and fro as she prepared herself for a family meeting in which her mother's future (or no future) would be decided. As a nurse, I personally felt extremely unhappy about further medical intervention. What's wrong with a peaceful death?

Mrs A's daughter had very strong religious beliefs and she grappled with, on one hand, the guilt of "allowing her mother to die" whilst on the other, knowing the reality that her Mum had so little left to live for. She had no use of her body, she had dementia and the dying process had apparently already begun. How it struck me again that a nurse cares for the whole family.

Mrs A's daughter decided to "trust in God" for the outcome. The family meeting was to be Monday. Mrs A died peacefully Sunday night, her family surrounding her.

I went to the funeral. Why? For myself mainly. I had been part of that family for five weeks, experienced their joys and pains, their agonizing decision-making and the unity of family members around a hospital bed. It touched them deeply that I came. That felt rewarding. So ... being a nurse is not just giving, it's making connections with people and receiving from them the strength to go on in a profession of caring.

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Arthur

Elizabeth Culverwell, Clinical Nurse Specialist, Christchurch Hospital

Death " *Belongs to life, just as Birth does, The walk is in the raising of the foot as in the laying of it down*" (Tagore', 1916)

Arthur was a 55 year old man who had been a Haematology patient for several years, attending the Outpatients Clinic on a regular basis. During that time I had come to know him rather well. His condition had begun to deteriorate and over the last few months his blood transfusions had become more frequent, progressing from monthly to weekly. He had a very supportive wife and family and was a very cheerful and uncomplaining man.

At 0830 one Wednesday, I received a call to the Day Ward informing me that Arthur was on his way in and would require a 4 unit blood transfusion.

He arrived in a wheelchair, accompanied by his wife. I proceeded to help him into bed and made him as comfortable as possible, then settled his wife in a chair next to his bed. I noted that his abdomen was quite distended and he felt cold and clammy. As I observed him, I knew instinctively that he would not live past this day. I proceeded to commence the transfusion while he and his wife talked together.

While I sat at my desk attending to some paper work I couldn't help but overhear their conversation and as I listened I became quite concerned and decided at the first opportunity to speak with Arthur's wife.

Arthur and his wife were discussing at great length, plans to build a conservatory onto the kitchen. The purpose of this was to provide a sunny room where Arthur could sit and enjoy his garden. It was apparent to me that Mrs A was failing to recognise or accept the gravity of Arthur's condition. My opportunity came a few moments later when she left the Day Ward. I followed her out and asked her to sit down with me for a moment as I wished to speak to her. I expressed my concern for her and sensitively asked her if she was aware of the seriousness of Arthur's condition. She replied that she was aware that he seemed a little worse that day, but the transfusion would "sort that out".

I put my arm around her shoulder and said to her that I believed Arthur was going to die and I would be surprised if he lived through to the evening and if there was anything that needed to be said to one another, perhaps this was the time. There was silence, then Mrs A burst into tears. We sat together for a moment longer, then she told me that she really did feel that Arthur didn't have long to live, but that nobody had really "spelt it out" to her in so many words. So it was easier to pretend than admit to the reality of the situation.

I then suggested that she phone the children and the family while I moved Arthur into the side room in the Day Ward. This would offer more privacy to the family. I also made arrangements to have a bed available in the unit, should the family wish to have Arthur remain in hospital, rather than return home to die. Arthur was quite drowsy as I told him I was going to move him into the side room where it was quiet. He accepted my suggestion, and once settled in there, I waited for his wife to return. I sat on the side of his bed and took his hand in mine and asked him if he was aware how sick he was. The glance he gave me spoke volumes, and I knew in that moment that there would be no need for further explanation.

I then told him that his wife had phoned their children and the rest of the family. He was relieved and content with these arrangements. When his wife returned I asked them both if they would prefer that Arthur go home following his transfusion, where he could be in familiar surroundings. If this was their wish I would arrange for the Cancer Nurse to call and be available to them. However, if they decided Arthur was to remain in hospital, I would confirm the bed state arrangement I had made earlier and we would settle him into the unit following his transfusion. Their mutual decision was that Arthur remain in hospital. At this point, I left to allow them time on their own, while I finalised his transfer into the unit deciding to initiate this for later in the day.

The Day Ward became a hive of activity during that day as family and friends came and went. There were tears and sharing of the family moments spent together. The rest of the Day Ward activities carried on with virtually no disruption to the other patients or to Arthur's family.

As the day past, I watched Arthur visibly relax and let go. It was obvious he realised his struggle was almost over. He no longer had to expend energy on a brave front for his loved ones, he could just "be".

Moments like these are always so special for the nurse.

I transferred Arthur into the unit at 4.00 pm where he was washed, then changed into fresh pyjamas. He was obviously very tired and beginning to experience some pain, so at this point morphine was commenced. Following this he became more settled and relaxed.

Early evening saw a further deterioration in his condition and shortly after, Arthur died peacefully and pain free with family around him. For me this was a poignant moment. To see him surrounded by a loving family, I was mindful of his early life. Arthur was orphaned and then subsequently spent the rest of his childhood and youth in a boys' home. He had never experienced the loving intimacy and care of a family.

It warmed me to reflect on how different this scene was from his early start in life. I felt a sense of satisfaction at being instrumental in drawing this family together in the final moments of Arthur's life. I was aware of the privilege it had been to be part of Arthur's journey. I knew for his family, there would be no regrets or recriminations.

All that needed to be said had been said.

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A Client From Another Culture Admitted Acutely to a Surgical Ward

Boudine Williams, Diploma of Nursing (Accelerated) Student

I chose this topic to show that culture is not always related to colour, creed, nationality or religion, but that there is also a "Culture of Poverty" that is an everyday occurrence in the health system.

In this article I will attempt to demonstrate how poverty can relate to single mothers and the crises they may face when entering hospital either acutely or for planned admissions.

I have been working as an Enrolled Nurse for many years and have continued to do so part time while attending polytech. On a cold wet Saturday night I was sent to Accident and Emergency to escort a patient from another hospital. While I waited for many hours in the department, I overheard a long discussion with a patient in the next cubicle. (My patient was asleep for most of the time.)

The woman who was lying on the next bed was overheard to say that she had been undergoing chemotherapy and was finding it hard to hold down food. She had been vomiting and had some diarrhoea. She was on an IV line to replace fluids and correct the electrolyte imbalance.

The House Surgeon said she would attempt to find a bed for the woman overnight if she wished. The patient asked for a phone and proceeded to ring three different people to see if they could look after her kids for one night. She had no luck; either people were too busy or unavailable for some reason.

She asked her children what they wanted to do. They were approximately 9 and 11. They looked glum and said they were hungry. The mother had no money on her to buy the children something to eat.

The nurses bustled in and out, quickly checking the drip. They did not ask any more than immediate medical questions. The House Surgeon returned an hour later saying there was a bed available if she wished to stay overnight. The woman said she couldn't find anyone to look after the kids so she would go home. The Doctor did not question any further. She did not ask if there was any one at home to help, (apparently there was not) and told the patient she was free to go once the drip was out.

The woman left the hospital at 10.00 pm. I heard her say that the buses were still running. I was so upset by this situation, I asked her, as she left, if I could help. She said abruptly, "I'm alright". She left with two children underdressed for the night temperatures.

I couldn't blame her for feeling animosity towards me. I was wearing a nurse's uniform, and to her, I was probably just another nurse too busy to really care.

I felt angry that she was humiliated by the friends she had asked to help look after her kids. I felt angry at medical and nursing staff for not looking deeper into the situation, and I felt angry at the health system for not being able to deliver a complete health package to those most in need.

If she had been admitted and had been able to recover fully from the vomiting and diarrhoea, and the children had been cared for by someone so as to relieve the mothers anxiety, a whole list of problems may have been curtailed.

Admittedly, I do not know the whole scenario but it was not hard to see that this woman needed help from a whole range of people but nobody wanted to know and nobody showed an interest in the situation.

I am sure this is not an isolated situation. Many woman on their own (or even with partners) put their families before their own health. Cervical smears and breast checks are lower on the priority list when time and money is limited. A mother can not automatically switch off from her role as a care giver just because she is to be admitted to hospital. She must cope with a sick role and a care giving role when she really needs to be nurtured herself.

Reid (1994) discusses how the plight of women and poverty is linked to poor health statistics. She states that health professionals have an important role to play, not only in encouraging women to look after themselves, but in educating them about diet, immunization for children, available services and countless other aspects of health. This is only achieved when we nurse patients in an holistic manner and are aware that their lives extend beyond the walls of the hospital or clinic.

I feel that showing kindness and a real understanding of the impact of poverty would also go a long way. Poverty is not a culture that people strive to be a part of. It is often a result of failed partnerships between couples or lack of choice due to economic recession. Many people come from generations of poverty and see no way out. They may become trapped as a result of motherhood and the cycle repeats itself.

Health is no longer a free commodity, but understanding is still free. We should freely administer understanding and consideration in a non patronizing manner.

In this essay, I have discussed two separate, yet related issues. The first is the ability of nursing and medical professionals to look beyond immediate health problems in order to recognise the conflict a mother faces when entering a hospital. The second, which also involves looking beyond the surface, is the awareness of health issues that are directly linked to, and a part of, the "Culture of Poverty".

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Beginning Journeys - Volume 1

Rose's Story

Elizabeth Griffin BA, Dip Soc Sci, RGON, RM, DipN (SANS), Nursing Tutor

Introduction

Rose is a petite, spunky, 82 year old lady, a long time widow and mother of one daughter and one son. She recently returned to her own home after many months of convalescence following a stroke.

Rose has lived a full and rewarding life with many social, sporting and family activities. The onset and events surrounding her stroke are very vivid in her memory.

Rose speaks

On 20 January last year I took my car to have it oiled and greased and a warrant of fitness, left it at the garage and went around the corner to my sister-in-law to have lunch with her. We were talking across the table, she said something to me, I went to answer and nothing came out, (my arm) just went down like this (lets arm drop) and nothing at all came out. She said to me, "What the hell have you done?" I said, "I don't know."

It came right again and then about quarter of an hour later the arm went, the leg went and then it came back again, and it kept coming and going. Anyway she rang my daughter and she arrived with the doctor. And he said, "Yes, it was a slight stroke." But it was more than a slight one, it was a good one, and they took me off to the hospital, and the doctor examined me and said, "You know you're too fit to be here. There is not a thing wrong with you apart from your stroke." I hadn't been to the doctor for 20 years, and I am going on 82. The doctor said, "I'll give you an injection, it might stop the clot from travelling." He did, but when he came back in the morning he said, "No, it didn't happen." I got (the stroke) down the right side.

I had a very hard time in hospital, with myself, accepting it. It was AWFUL, still you fight through it all. You have to deep accepting it. The Physio's good, the physio can work on you but ... (Rose was moved to tears at this point remembering her struggle. She had a rest, a drink of water, and chose to continue). I cried an awful lot in hospital, and then they gave me a tablet which helped, but I get emotional very easily.

The nurses were marvellous, the matron was lovely, and the doctors were good. No trouble there. I was in there for five months, continued as an outpatient, and then they put me off for a month.

I know a young chap who is a physiotherapist. So, seeing I wasn't going to hospital I rang him and would come and treat me. I was in a (convalescent) home at the time - 13 times he visited me. His treatment was on my shoulder (indicating left shoulder) not the stroke side. When I went back to the hospital the nurse told me off. She said, "I am quite upset with you, you went behind my back and got a physiotherapist." I said, "But I don't think it has got anything to do with you. I'd been given a month off and I wasn't having any treatment from you and he was a friend of mine, and if you can't help yourself it is pretty poor."

So she was never very nice after that. I went back for a month and then she put me off completely. Told me I'd finished at the hospital and if I wanted to come back I would have to go to my doctor who would refer me back. It was a hard way to do it.

How my left should became painful: While I was in hospital I couldn't sit up, I couldn't do anything and they used to put the side of the bed up - here (indicating left side of chair) for me to pull myself up because I couldn't sit up, and by doing that I ruined the shoulder. Pulled all the ligaments - everything in there.

Anyway I had it for four months, and I told the doctors. They said, "Rest it, that's what you have to do, rest it." Well that went on for four months and it was very painful and (tearfully) that one was useless (indicating right arm). They never gave me physio on my shoulder. They used the ultra sound on it, but it never did any good. When I was due to leave hospital, they decided to give me injections into it. Well one doctor put one in the front of my arm here (indicating left shoulder). It didn't do any good. Then about a month later they put three cortisone injections in my back, and the next day two in the front and then I was discharged from hospital.

Well you might as well put water in it. Didn't do a bit of good. I rang Tim (physiotherapist) when I got home and he said, "Well I don't know." Apparently he works for the hospital but he is an outworker, and I thought well it wouldn't hurt him if he was an outworker. I could pay him or whatever, but I think he thought there was too much fuss over the last lot. So I said to him, "I don't want to get you into trouble Tim. I wouldn't have that for anything". So then he said, "I will put you on to another physiotherapist". I said, "Right oh", but then my daughter thought about it and said it was worth an ACC application. It was an accident in the hospital, but they didn't mention it in the hospital. My daughter rang the matron, I knew them all pretty well by this time, and asked her if she could get my papers to see what was on them. Well they can't find my

papers. They've lost them. I've never met such a mess up in my life as there is in there at the moment. The matron said, "We can't find them." So Bev (daughter) said, "We are going for ACC and we will probably get it through the General Practitioner."

Well we did. Went down to see him and he said, "Certainly!" It wasn't treatment or anything, it was an accident, you know. Next door to the doctor is a physiotherapist. I'm having treatment from him now - he's very good. But the hospital did nothing about it. It was neglect on their part. The matron there, she's very nice, but she's soft - she could have done something about this arm. She could have mentioned it to the doctor.

The nurse and the physiotherapist told me they weren't giving me any more treatment. I think the nurse was a bit mad with me for having - for getting Tim. But that shouldn't make her behave like that. I didn't think I should have come out so soon really. I've been completely abandoned from the hospital, unless my doctor sends me back.

Commentary on Rose's Story

Rose is a pseudonym. Her narrative involves reliving aspects of her original experience and her feelings are strongly engaged and apparent as she speaks.

Rose begins her story by describing her personal anguish at the uncontrollable bodily changes she experienced as the stroke occurred. A large part of the narrative concerns her struggle to regain movement and control of her body, and achieve independence again. The events in Rose's story which raise moral issues and caused her special distress relate to Rose's left shoulder and arm, unaffected by the stroke, but injured in the process of developing self care, and compensating for the right sided paralysis, during the process of rehabilitation.

I wish to explore the critical, uncaring and oppressive response of the nurse to Rose's own initiative in organising physiotherapy for herself, and the silence and slowness of the staff in taking seriously Rose's complaints about pain in her left shoulder.

Rose describes her trial leave from the Outpatient Programme as, "They put me off for a month". The mood and feeling from Rose is that she has been working hard and then was, as it were, "made redundant". During this period of leave Rose decided to help herself and engaged a physiotherapist to attend her at the rest home - specifically to treat her left shoulder.

When Rose returned to the Outpatient Service, she recounts how the nurse "told her off", because without reference to the hospital, Rose had organised her own private physiotherapy. Rose quotes the nurse, "You went behind my back", accusing Rose of secrecy and deceit.

The nurse's sense of professional public duty, to be in control of, and to sanction Rose's care leads to an uncaring experience for the patient. By being rule bound the nurse failed to discuss and identify with Rose, her individual needs and desire for ongoing care. The nurse did not demonstrate the ethic of compassionate caring.

Rose explained to the nurse that she did not believe the matter had anything to do with the nurse. Rose was not attending the hospital and therefore there was no conflict of treatment. The idea that there should be any restriction on helping herself is repugnant to Rose. Rose adds that the nurse was never very nice after that. There was no toleration and acceptance of Rose's right to choose and participate in her own care.

Rose also suffered moral distress because she feared her behaviour had caused trouble between the physiotherapist and the nurse. The conflicting perspectives Rose describes may have something to do with Rose as an aged person in our society, in our health service.

Linda Smith had identified habits and behaviours of nurses which need to be changed, "Research has found that nurses frequently exhibit paternalistic behaviour and even when patients try to speak of anxieties they are often ignored ... the nurse knows best is a view held by nurses themselves. What chance is there for an elderly person to make decisions?" (Smith 1993 p 58).

Rose's character, intelligence and experience made it possible for her to act independently and to stand her ground against the negative expressions of the nurse. What Rose shows us is that she had a vision of how she wanted to be and what would make life worthwhile, and she acted to achieve this. Often nurses who care for elderly persons assume that because a patient is unable to carry out a particular task, they are unable to carry out the one relevant to the decision at hand. Nurses become habituated to a health care culture of unquestioning obedience. They begin to suffer from a kind of moral blindness where they deny choices and independence to their patient. In a sense, Rose's nurse seems to exhibit this moral blindness.

The second moral issue raised by Rose's story is the silence of the hospital staff about the error in care which resulted in Rose's strained and painful shoulder. She draws attention to the slowness of staff in attending to this, and the puzzling loss of Rose's medical file when she required ACC for reimbursement of treatment fees.

The faulty acts which produced Rose's painful shoulder do not necessarily mean that someone was at fault although it may mean that. It may or may not indicate professional negligence. "Negligence" is a legal term referring to acts which cause unnecessary and/or irreparable harm.

We can say that medical care is often an uncertain process, involving trial and error, but that does not mean that care is not competent. In Rose's story we note that she never blames the hospital staff for the pain in her shoulder.

The hospital staff focused on treating Rose's disability related to her stroke. They appear to be largely indifferent to her concerns about her painful shoulder until the end of her stay in hospital. The subjective bodily experience of pain which Rose knows for herself has been ignored. Events or behaviours which staff may see as "little" or "trivial", are often the important things for the elderly person in terms of their comfort and independence.

Speaking about errors in care rather than being silent about them, actively involving Rose in the development of her care would have reduced the authority and power of the hospital staff, but would have demonstrated a real ethic of caring.

The loss of Rose's medical file, while it is a factual loss, means that there is a "silence" about the medical facts. Absence of facts may deflect accusations against the staff of poor quality care. Rose is fortunate that her General Practitioner is able to fill this gap in information. We are left feeling that Rose with the support of her daughter continues to work towards freedom and independence, in spite of the hospital staff, rather than with their cooperation.

Rose's story highlights the need for nurses and other carers to take notice of the experience of illness as it is lived by the patient. The experiential or phenomenological way of thinking is necessary for self aware, self critical nurses, in order to attend to the lived experience, and reality of the patient. Only then can nurses respond with sensitivity to the needs of each patient.

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Beginning Journeys - Volume 1

Health Issues Research Team

During 1995 interested members of the Nursing, Midwifery and Health Education Department met to form the health issues research team. Because health issues is a broad topic and our professional interests diverse, we decided to submit a series of abstracts to be published in this journal. Full copies of the following papers can be obtained by contacting the authors.

- [The Sexualisation and Desexualisation of Nurses - Ann Blackie](#)
- [Pain Management in those Labelled Mentally Retarded - Rosemary Pemberton](#)
- [The Effects of Having a Child with a Disability in the Family - Stephen Neville](#)

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Beginning Journeys - Volume 1

The Sexualisation and Desexualisation of Nurses

A study of the process of and attitudes towards preparation for practice

Ann Blackie BA, RGON, Adv Dip N, Academic Leader

The importance of touch and the meaning of touch has different implications for different social and cultural groups. The meaning of touch and the areas of the body which can be touched are also viewed differently within a nursing context from a general view. The nurse is expected to view the body objectively and asexually and is "allowed" to touch areas which would normally be considered taboo except maybe to significant others or family members. During care clients can experience what they may consider violation of their bodies by strangers, causing feelings of invasion and loss of privacy. There are issues relating to power or lack of power, which a client, male or female, will often experience when they move into this role. The way in which touch is used, can therefore be seen as comforting and nurturing or as threatening. Because of this nurses need to have an understanding of the meaning of touch and the need for the creation of a partnership. There is an expectation that the nursing curriculum will enable nurses not only to be able to touch their clients without discomfort but also to be able to discuss matters relating to sexuality. However, in spite of this belief that nurses will be adequately prepared and will behave in an asexual way, much of society does not appear to think about how that might come about.

This study analyses, from a sociologist's point of view, the questions this raised about the perceptions of people who see nurses as desexualised, and who expect them to treat their clients as asexual, but who are unable to acknowledge how this happens. The analysis was also broadened to look at wider issues relating to sexuality and gender and also to consider changes that may have occurred in nursing education. The role of the nurse in providing intimate body care was also examined and an effort made to identify what it is about the context that allows this to happen. It also looked at the process of preparing nursing students for this role and the attitudes of the wider community to the necessity of this preparation.

The study identified the need for nurses and patients to each play a role in order to make the situation safer for the patient. It also showed that experience made managing intimate situations easier for nurses - nursing students may have difficulty with nursing roles initially.

Interviews with nursing tutors demonstrated changes in nursing education which allowed nursing students to develop their skills in a more open and accepting climate compared with the training of 20 years ago.

There is a shortage of literature looking specifically at this topic although issues of touch and sexuality have been researched. This may be because of the private nature of intimate care and/or because of the undervaluing or invisibility of much nurses' work.

Beginning Journeys - Volume 1

Pain Management in Those Labelled "Mentally Retarded"

Rosemary Pemberton RCpN, BHlthSc Nursing Tutor

Nurses are constantly faced with the need to provide comforting care in the presence of pain, however, the clinician in many situations remains unaware of its existence. For the individual with a developmental disability there is created almost insurmountable difficulties that frequently serve to further disable or compromise the individuals quality of life. These difficulties are primarily related to poorly developed expressive language which in some situations is further compounded by extreme physical disability. Further complications arise through the many unsubstantiated claims, myths and misconceptions surrounding issues of pain and those labelled "Mentally Retarded".

Clarification of some misconceptions may be provided by a later contemporary pain theory which suggests endogenous mechanisms can elicit varying degrees of pain relief. Although some debate exists as to the precise mechanism of action, endorphins and enkephalins are thought to have an analgesic action, similar to narcotic medications. As this theory hypothesized, these endogenous opiates are released in response to acute pain, where they produce an inhibitory action. This approach may in fact provide a possible explanation for those with extreme developmental disability who experience acute pain as they have frequently been regarded as unable to experience this phenomenon. This inbuilt physiological coping mechanism suggested by this theory may provide the basis for the belief or phrase, "no brain no pain".

Although specific research in this field is negligible, it can ill afford to be overlooked as those with developmental disability are as likely to suffer a variety of health problems. Further information concedes that in many instances, an illness that would otherwise be minor and quickly cured becomes catastrophic.

Given the advances in pain management it is regrettable that application of formal or systematic approaches to those in pain is not overtly apparent within the context of any institutional environment.

Behavioural indicators are the most effective determinants of the existence of pain in the clinical area, however, clinicians must first examine their own attitudes and stereotyped views before they can begin to acknowledge and respond to an individuals pain experience. Clinicians must also be reliant on their skills as observers together with a sound knowledge of an individuals idiosyncratic signals to identify signs of pain, distress and discomfort. If nurses are unaware of behavioural cues or are unable to correctly interpret them, then pain management may be inappropriate or non existent.

Management strategies are largely dependent on the source of acute pain together with the individuals coping mechanisms. This approach has been subjected to wide varying criticism, as physical indicators bear no quantitative relationship to the intensity of the suffering.

Pharmacological preparations have predominated as the treatment for acute pain, although opioid analgesics are inadequately utilized. This may appear to link with the failure of the system or organisation to ensure appropriate methods are available for pain control. This equates with the outer component of the interactive model of pain which acknowledges the influence a system has on an individuals pain experience.

There is considerable scope for improving pharmacological pain relief for those with developmental disability, however, if institutions are to remain, then continued separation from valued communities and technologies will persist. Further dilemmas exist where diminishing pain behaviours result in the withholding of medications and a shift to a PRN regime.

When medications are required it is vital they be administered with a comforting focus which is likely to engender fewer behaviours that are suggestive of anxiety and pain.

The individuals ability to cope with pain is enhanced by empowering the person to indicate their own comfort zone as they, like others, tend to quickly acquaint the discomfort of pain with situational events.

Perhaps one of the most important considerations is the need to include a variety of distractors in varied settings. Unfortunately the essence of distraction is at times lost in the routinized environment where human resources and time dictates or diminishes the clinicians potential for creative interventions.

Further techniques such as massage and application of heat and cold have met with a modicum of success although, depending on the individual, may do little to lessen the immediate reaction of pain through the anticipatory preparations undertaken by the clinician.

Ultimately the clinician has the ability to shape how individuals cope with the pain experience, therefore careful consideration and planning must be afforded each situation to avoid the person suffering any unnecessary emotional scarring.

Beginning Journeys - Volume 1

The Effects of Having a Child with a Disability in the Family

Stephen Neville RCpN, BA (Nursing), MCNANZ, Nursing Tutor

Nancy got married late in life and decided to have a child. She did not realise the possible risks of having children at her age. Three of Nancy's friends had normal children when they were in their thirties so why should things be any different for her? Lisa was born a very wanted child. Her mother had no idea that she had Down's Syndrome and this did not become apparent for some time. It was only after Nancy obtained a second opinion due to Lisa not doing things that her peers of the same age were doing she discovered the truth. Although she loves Lisa her life is filled with grief and feelings of sorrow that continue to resurface as Lisa gets older.

"She came to us on a bright, crisp, August Morning. I had been full of expectations for her, but almost instantly, instinctively, I knew that these were not to be fulfilled." (National Women's Advisory Council, 1980, p 2) A fundamental part of life is the birth of a child. This event brings a multitude of challenging and changing events for the mother, father and the rest of the family. New feelings are experienced including joy, excitement, expectations, tiredness, sibling reactions, change in financial needs and alterations in family dynamics. "Most families negotiate the adaptations created by a new baby within the first few several months of its arrival given adequate support systems and resources." (Singer and Irvin, 1989, p 207)

In the case of a child born with a disability the feelings and challenges described above may be heightened and the period in which it takes to adjust may increase, that is if adjustment ever truly occurs. Taylor and Hall (1979) as part of a clinical study outlined a range of stressful factors that mothers experienced. These included fears and problems with attachment, babies that were unresponsive, early separation due to the child being in Neonatal Intensive Care Units, feeling incompetent, and issues related to grief, loss, anger, sadness, guilt, rejection and denial. The way professionals involved deal with the situation is a vital and integral part of helping to foster positive family relationships and promote the adaptations required for the family to function with a child who has a disability.

Through research there is now information available in Aotearoa about interactions between the mother and professionals and what approach is most appropriate when communicating the diagnosis and disseminating information. The majority of women want the professional to be open, honest, empathetic, positive and realistic. Research by Halligan (1978), Mitchell (1981) and Pulman (1980) indicates the dissatisfaction women have when informed of the child's diagnosis by obstetricians, paediatricians or family doctors. A lack of sensitivity, dishonesty, the withholding of information, a poor knowledge base on the diagnosed condition or availability of follow up services that may be useful and what are considered to be avoidable delays in receiving the diagnosis were noted. "Surveys of parents have shown that in most cases only one parent has been present during the diagnosis, despite the desire of all but a small minority of parents to be told together." (Mitchell and Singh, 1987, p 119)

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