



ESSENTIALLY MIDIRS

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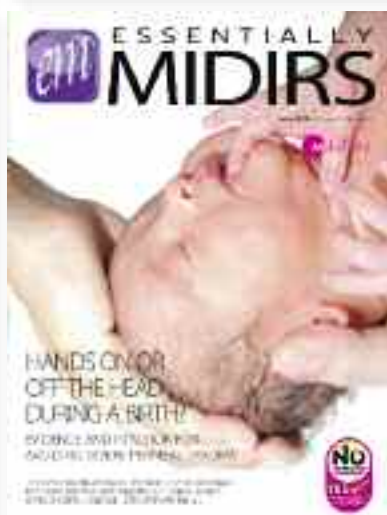
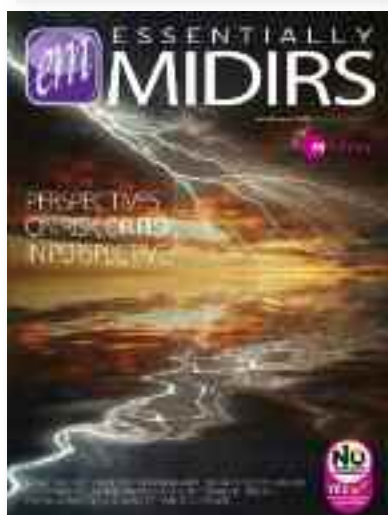
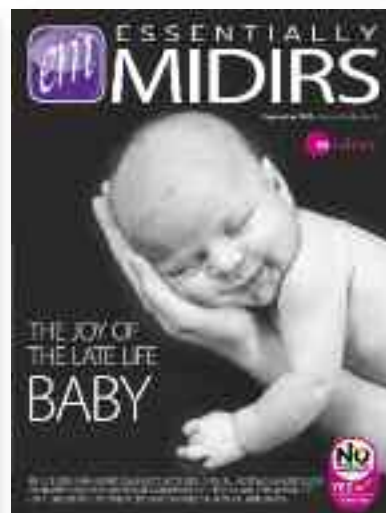
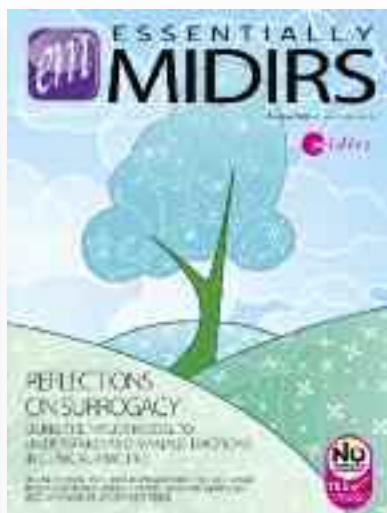
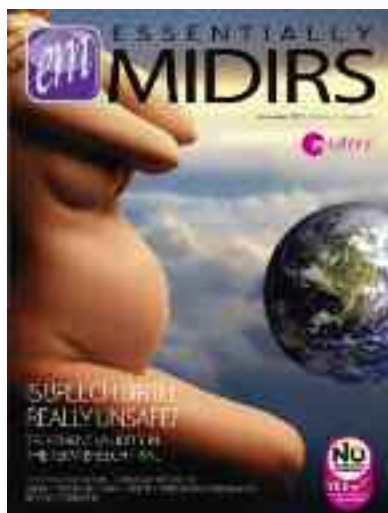
UNDERSTANDING PHYSIOLOGICAL BREECH BIRTH



MANAGEMENT OF SICKLE CELL DISEASE IN PREGNANCY ... USING ART AS REFLECTION IN PRACTICE: A MIDWIFERY STUDENT'S EXPERIENCE OF UNCONSCIOUS REFLECTION, MADE CONSCIOUS AND TRANSFERABLE ... INFORMED CHOICE UPDATE ON POSITIONS FOR LABOUR AND BIRTH ... I AM HERE: REFLECTIVE LEARNING AND A POEM ABOUT A MIDWIFE, MOTHER AND A BABY ... LOVE, KISSES, AND OTHER WAYS OF KNOWING...



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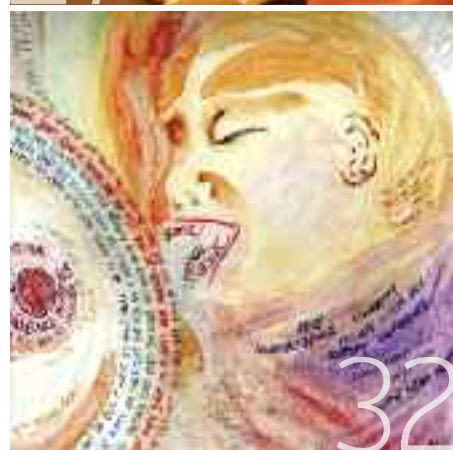
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Do women's ideas of 'normal' birth match those held by professionals?

Aim:

To explore the definitions of normal birth held by women who have not given birth, what influences that perspective, and compare it with those of health professionals.

Background:

Available evidence provides conflicting definitions of normal childbirth. The majority of available evidence encapsulates the views of the health professionals themselves or women who have experienced childbirth. Little evidence exists that reflects the views of women yet to experience childbirth.

Method:

Six participants were identified via purposive sampling to undertake a small exploratory qualitative study utilizing semi-structured interviews and thematic analysis. Ethical approval was obtained.

Results:

The definition of normal birth is individual and complex. The absence of complications and use of interventions influenced this definition, which in part agrees with health professionals' current definitions. Birth was perceived as a scary prospect; a view largely constructed from negative stories from friends and family.

Conclusions:

The findings suggest that working within the confines of a definition of 'normal' childbirth is far from straightforward. It highlights a need to encourage women to view birth more positively. Expanding this research further would explore these issues in more detail, providing more conclusive evidence to support practice.

Issues arising from the topic of this study are featured in this month's 'For Your Portfolio' section; see page 52 for questions to reflect upon in relation to the notion of normal birth.

Edwards A, Conduit J (2011). Do women's ideas of 'normal' birth match those held by professionals?
British Journal of Midwifery 19(11):720-2, 724, 726-8.



Maternal goals for childbirth associated with planned vaginal and planned cesarean birth

We describe maternal childbirth goals among women planning either cesarean or vaginal birth. Women in the third trimester planning cesarean or vaginal birth were asked to report up to five childbirth goals. Goal achievement was assessed postpartum. Based on free-text responses, discrete goal categories were identified. Goals and goal achievement were compared between the two groups. Satisfaction was rated on a visual analogue scale and was compared with goal achievement. The sample included 163 women planning vaginal birth and 69 women planning cesarean. Twelve goal categories were identified. Only women planning vaginal birth reported a desire to achieve fulfillment related to childbirth. Women planning cesarean were less likely to express a desire to maintain control over their own responses during childbirth and more likely to report a desire to avoid complications. The 72 women who achieved all stated goals reported significantly higher mean satisfaction scores than the 94 women reporting that at least one goal was not achieved ($P = 0.001$). Goal achievement was higher among women planning cesarean than among those planning vaginal birth (52.2% versus 23.1%, $P < 0.001$). This research furthers our understanding of women's attitudes regarding cesarean childbirth and definitions of a successful birth experience.

Quiroz LH, Blomquist JL, Macmillan D *et al* (2011). Maternal goals for childbirth associated with planned vaginal and planned cesarean birth. *American Journal of Perinatology* 28(9):695-702.

Myth: babies would choose prelabour caesarean section

Interest in rising caesarean section (CS) rates focuses on the putative relative effects on maternal health and perinatal mortality, especially in 'non-medical', 'request' or 'repeat' planned prelabour CS (PLCS). Shortening pregnancy and avoiding labour affect fetal maturity. Babies who do not experience labour have significantly increased respiratory and other morbidities that may have profound effects on development, determining immediate and potentially life-long disease. It is thus surprising that obstetricians do not advocate awaiting or inducing labour even in women considering CS. Mothers must be fully informed of all the evidence before they can give valid consent and make decisions on their baby's behalf. New evidence about immunological and metabolic differences induced by obstetric interventions continues to emerge, but large knowledge gaps exist. Although all modes of delivery carry potential risk of neonatal morbidity or mortality, we conclude that normal babies would indeed 'choose' labour.

Sinha A, Bewley S, McIntosh T (2011). Myth: babies would choose prelabour caesarean section. *Seminars in Fetal and Neonatal Medicine* 16(5):247-53.



Care of the migrant obstetric population

Care of pregnant migrants is a considerable challenge for all health care workers and health systems. Maternal mortality and serious morbidity are both greatly increased among migrants in western countries, particularly in Africans and asylum seekers. While in many instances, migrants are healthier than native populations and have better perinatal outcomes, this is inconsistent and poorer outcomes are described in many groups. The causes of suboptimal outcomes are numerous and are strongly influenced by the health-seeking behaviour of the parturients. Accordingly, improvement in outcome requires a multifaceted approach with a focus on early access to antenatal services and enhanced medical screening and surveillance for detection and optimisation of comorbid conditions. Provision and/or acceptance of analgesia in labour have not been well researched but existing data are sufficient to suggest that some migrant groups do not receive equivalent pain relief during labour. Provision of information and translation services are important components in improvement of standards of care.

Hayes I, Enohumah K, McCaul C (2011). Care of the migrant obstetric population. *International Journal of Obstetric Anesthesia* 20(4):321-9.

Interventions for preventing gestational diabetes mellitus: a systematic review and meta-analysis

Background:

The prevalence of gestational diabetes mellitus (GDM) is increasing worldwide. GDM is associated with increased risks for mother and child during pregnancy and in later life. The aim of this article is to systematically review literature on the effectiveness of interventions to prevent GDM.

Methods:

Controlled trials found in PubMed, EMBASE, or CENTRAL were selected. The primary outcome was GDM, and relevant secondary outcomes were maternal fasting blood glucose and large-for-gestational age (LGA) or macrosomia. Data were combined in meta-analyses, and the quality of evidence for the effectiveness of the interventions was assessed in a GRADE approach.

Results:

Nineteen studies evaluating six types of interventions were included. Dietary counseling significantly reduced GDM incidence compared to standard care. None of the interventions was effective in lowering maternal fasting blood glucose. Low glycemic index (LGI) diet advice and an exercise program significantly reduced the risk of macrosomia. The quality of evidence for these outcomes was low.

Conclusions:

The results indicate that there may be some benefits of dietary counseling, an LGI diet advice, or an exercise program. However, better-designed studies are required to generate higher quality evidence. At the moment, no strong conclusions can be drawn with regard to the best intervention for prevention of GDM.

Oostdam N, van Poppel MN, Wouters MG *et al* (2011). Interventions for preventing gestational diabetes mellitus: a systematic review and meta-analysis. *Journal of Women's Health* 20(10):1551-63.



Interdisciplinary team training identifies discrepancies in institutional policies and practices

The objective of this study was to evaluate the impact of an interdisciplinary team-training program in obstetric emergencies on identifying unsupportive institutional policies and systems-based practices. We implemented a qualitative study design with a purposive sample of interdisciplinary physicians, nurses, and ancillary allied health professionals from 4 specialties ($n = 79$) to conduct a 6-month, weekly simulation-based intervention for managing obstetric emergencies. Debriefing focused on identifying discrepancies between clinical practice and institutional policies. Our data yielded 5 categories of discrepancies between institutional or departmental policy and actual clinical practice. Specific institutional policies and system-based practices were recommended to health system administration for reevaluation. Simulation-based interdisciplinary team training can inform system-wide quality improvement objectives that could lead to increased patient safety.

Andreatta P, Frankel J, Smith SB *et al* (2011). Interdisciplinary team training identifies discrepancies in institutional policies and practices. *American Journal of Obstetrics and Gynecology* 205(4):298-301.



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MIDIRS Comments

In many ways, the conclusion that interdisciplinary team training can lead to improvements in the system is unsurprising, yet the creative way in which the authors of this study expressed their findings is both worthy of note and potentially highly useful in unpacking problems that exist in relation to institutional policies. The '5 categories of discrepancies between institutional or departmental policy and actual clinical practice' (Andreatta *et al* 2011:298) that are noted in the abstract comprise:

Policies *certatim* – those that conflict or compete with each other, with one example in this category being that staff in different departments did not have full knowledge of how staff in other departments used and responded to different systems of paging staff in an emergency situation.

Policies *impossibilia* – those that were impossible to implement, for example the mandate that all 'crash' caesarean sections be performed in an operating theatre was deemed impossible in an area which was ten minutes away from the emergency department, highlighting a conflict between best practice and the directive contained in the institutional policy.

Policies *casualis* – this was the most common category and described those informal, often verbally discussed policies which were specific to one department and not generally understood by others. One example given in the paper was the doctor who requested a 'rainbow'. (Somewhat annoyingly, while this was a great example because it is clearly not a term in common use, the authors

did not explain what the emergency medicine resident actually meant by it!)

Policies *oblivio* – those policies with which staff were unfamiliar, sometimes concerning key and important situations such as the treatment of infection in pregnant women, specific policies relating to unaccompanied minors, and transfer between departments.

Policies *absens* – those that were either vague or inconsistent, for example there were frequent conflicts over whether the emergency department, anaesthetic, or obstetric team was actually 'in charge' of managing the airway of a pregnant woman.

While the tongue-in-cheek nature of the naming of these categories is an excellent way to highlight the points that the authors wished to make, the message in this article is no less serious for this. Such conflicts and discrepancies in the relationship between policy and practice can cause misunderstanding, needless delay, and potentially catastrophic effects in emergency situations, and they should be sought and rectified. It is probable that all of these categories of discrepancy can also be found in relation to guidelines for non-emergency situations, as is highlighted by Liz Stephen's (2011) recent article (see p16) and this may also be a very worthy topic for further exploration.

References

Andreatta P, Frankel J, Smith SB *et al* (2011). Interdisciplinary team training identifies discrepancies in institutional policies and practices. *American Journal of Obstetrics and Gynecology* 205(4):298-301.

Stephens L (2011). The need to support normality over non-evidence-based interventions. *British Journal of Midwifery* 19(11):686.

Timing of umbilical cord clamping: effect on iron endowment of the newborn and later iron status

The optimal timing of umbilical cord clamping has been debated in the scientific literature for at least the last century, when cord clamping practices shifted from delayed towards immediate clamping. Recent research provides evidence for the beneficial effect of delayed cord clamping on infant iron status. The present review describes the physiological basis for the impact of cord clamping time on total body iron at birth and the relationship between birth body iron, as affected by cord clamping time, and iron status later in infancy. This research is discussed in the context of current clamping practices, which tend towards early cord clamping in most settings, as well as the high levels of anemia present in young infants in many countries worldwide.

Chaparro CM (2011). Timing of umbilical cord clamping: effect on iron endowment of the newborn and later iron status. *Nutrition Reviews* 69(s1):S30-6.

Educational Resources

Articles that may be of use in teaching and learning...

Cox M, van Onselen J (2011). Infantile eczema. *Practising Midwife* 14(10):16, 18-21.

Germain S, Nelson-Piercy C (2011). Common symptoms during pregnancy. *Obstetrics, Gynaecology and Reproductive Medicine* 21(11):323-6.

Graves K (2011). Hypnobirthing: keep calm. *Practising Midwife* 14(10):32, 34.

Guistardi A, Stablum M, De Martino A (2011). Mother infant relationship and bonding myths and facts. *Journal of Maternal-Fetal and Neonatal Medicine* 24(s1):59-60.

Harris J (2011). How to... perform an examination of the placenta. *Midwives*, 7:24.

Mobberley T (2011). A topic in 10 questions: how to manage infant constipation. *Journal of Family Health Care*, 21(5):24-5.

Pilcher J (2011). Teaching and learning with concept maps. *Neonatal Network: the Journal of Neonatal Nursing* 30(5):336-9.



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Abdominal palpation to determine fetal position at labor onset: a test accuracy study

Objective:

To examine the accuracy of abdominal palpation for identifying left-occipito-anterior (LOA) fetal position using abdominal ultrasound as the reference standard.

Design:

Classical test accuracy study undertaken in 2005-2007.

Setting:

Birmingham Women's Foundation NHS Trust serving a large, socio-economically and ethnically varied population.

Sample:

All nulliparous women with spontaneous or induced labor before established labor (cervix <4cm dilated), with a singleton live pregnancy of over 37 completed gestational weeks without known fetal abnormalities.

Objective:

Accuracy of abdominal palpation (index test) in identifying LOA fetal position, with abdominal ultrasound as reference. Trained observers blind to the index test results performed the ultrasound independently.

Main outcome measures:

Accuracy of palpation in determining LOA position.

Results:

Midwives' abdominal palpation and ultrasound data were obtained from 629 women. There were 61 (9%) fetuses in LOA position that were verified by ultrasound. The sensitivity and specificity of palpation to detect LOA position were 34% (95%CI 23-46) and 71% (67-74), respectively. Midwives with experience >5 years achieved higher sensitivity compared to those with ≤5 years (odds ratio 4.02; 1.26-12.9; p=0.019). Sensitivity was higher for community compared with hospital midwives (OR 6.59; 1.11-39.11; p=0.038).

Conclusions:

Abdominal palpation to determine LOA position at the onset of labor had poor accuracy in nulliparous women on arrival at the maternity unit with a cervix dilation of <4cm. If future research demonstrates that an optimal fetal position at labor onset exists, ultrasound scan to confirm fetal position on arrival for birth may improve midwives' ability to prognosticate.

Webb SS, Plana MN, Zamora J *et al* (2011). Abdominal palpation to determine fetal position at labor onset: a test accuracy study. *Acta Obstetrica et Gynecologica Scandinavica* 90(11):1259-66.

MIDIRS Comments

While the authors of this study seem to have been most interested by issues surrounding the notion of optimal fetal positioning in labour, this research raises many and wider questions that deserve attention by midwives, as the findings could have a significant impact on the value that is placed on abdominal examination as a core midwifery skill, not to mention the additional interventions that labouring women may be exposed to. One of the key questions raised by the methods used in the study concerns the fact that the researchers measured the accuracy of midwives' palpations using abdominal ultrasound as the reference standard. This implies (a) that abdominal ultrasound is more accurate and (b) that abdominal ultrasound always gets it right. These assumptions in turn beg the questions of what evidence we have to support the idea that ultrasound is more accurate than palpation, and what abdominal ultrasound itself is (or has been) measured against in order to determine this. This is not the only point of methodological concern: the researchers acknowledged that there were delays of up to 60 minutes in some cases between the palpation and the scan, which might not be unreasonable in the context of the 'busyness' of practice areas but this does raise questions about whether babies may have moved between the two assessments of their position. It would also have been interesting to see more detail on how the midwives were 'getting it wrong'; if they were identifying babies in a left-occipito-lateral (LOL) position as being in a left-occipito-anterior (LOA) position then this is rather a different situation than if they were identifying LOA babies as right-occipito-posterior (ROP).

In their discussion, the authors argue that, *'the poor accuracy demonstrated by this study suggests that ultrasound scan would be a valuable supplement to abdominal palpation to improve detection of LOA on the onset of labour'* (Webb *et al* 2011:1264) and go on to question the findings of a Cochrane review (Hunter *et al* 2007), which included studies which used this as a means of identifying fetal position. The speed at which they dismiss the value of palpation is somewhat concerning. Their discussion does not include consideration of the fact that, even if abdominal examination is a poor measure of position, the introduction of ultrasound as an alternative surely needs to be supported by evidence that this is preferable. They have also omitted to mention the potential impact of routine ultrasound to assess fetal position, and this debate would be important in relation to a number of factors, not least of which are potential side effects, the way this will further medicalise labour, and cost. There is no acknowledgement that abdominal examination is about more than determining the position of the baby and, while the authors argue that routine ultrasound scanning on arrival at the labour ward will *'improve midwives' ability to prognosticate'* (Webb *et al* 2011:1259), it may be more likely to further de-skill (not to mention devalue) midwives by removing the need for accurate abdominal examination.

The unanswered questions which exist in this research mean that we cannot know for certain if this is as much of a problem as is being argued. It is entirely possible it is, and the fact that more experienced midwives and those working in the community are better than their less experienced and hospital-based colleagues does seem to suggest there is an issue that needs our urgent attention. Whether this attention should occur in the form of immediately bringing in another unevaluated routine intervention is highly questionable. It may be better to look at how midwives are learning, using, and updating such skills, if and how these are being affected and possibly eroded by the increased use of technologies, and consider if it would be possible and preferable to enhance basic midwifery skills rather than allowing midwifery to become a profession specialising in the operation of machinery rather than the use of hands.

References

Hunter S, Hofmeyr GJ, Kulier R (2007). Hands and knees posture in late pregnancy or labor for fetal malposition (lateral or posterior). *Cochrane Database of Systematic Reviews*, Issue 4.

Webb SS, Plana MN, Zamora J *et al* (2011). Abdominal palpation to determine fetal position at labor onset: a test accuracy study. *Acta Obstetrica et Gynecologica Scandinavica* 90(11):1259-66.



The effectiveness of medical interventions aimed at preventing preterm birth: a literature review

Background:

Preterm birth is a significant global health problem with serious short and long term consequences. This paper reviews the research literature to answer the question how effective are the medical interventions that aim to reduce the rates of preterm birth?

Methods:

A systematic search was carried out in CINAHL, Cochrane, Medline and Embase in relation to following medical treatments aimed at preventing preterm births: anti-infective medications, tocolytics, progesterone and cervical cerclage. The research underpinning each type of intervention is critically analysed in order to establish the validity of knowledge claims that are made for each type of intervention.

Findings:

In relation to reducing the rates of preterm births, anti-infectives are only effective in the presence of known infection. Screening for infections during pregnancy is ineffective. Tocolytic agents are not effective in decreasing the preterm birth rates. Progesterone seems to be effective in a select group of pregnant women at higher risk of preterm birth. Cervical cerclage plays a small and an occasional role in preventing some preterm births.

Conclusions:

This literature review demonstrates that medical interventions aimed at preventing, not just delaying, preterm birth, are not effective at a population level. Providing holistic, antenatal midwifery care for women living in socio-economic disadvantage and/or with an increased risk of preterm birth seems to be a promising strategy to address the negative effects of the social determinants of disease and thus to reduce the rate of preterm births at an individual and a population level.

Wisanskoonwong P, Fahy K, Hastie C (2011).

The effectiveness of medical interventions aimed at preventing preterm birth: a literature review.

Women and Birth: the Journal of the Australian College of Midwives 24(4):141-7.

Recent and Related

Klebanoff MA, Keim SA (2011). Epidemiology: the changing face of preterm birth. *Clinics in Perinatology* 38(3):339-50.



A review of evidence around postnatal care and breastfeeding

Postnatal care and support for breastfeeding has been central to the United Kingdom maternity care provision for over 100 years. Over that time the burden of care has shifted from home to hospital and back to home again. In the last 10 years, an evidence base has been distilled around the key components of optimum postnatal care and breastfeeding support but the implementation of these has been hampered by an ongoing tensions [sic] between a biomedical and social model and by changes in the organization of community postnatal care. These issues are discussed in this paper which concludes with some new developments in care provision.

Walsh D (2011). A review of evidence around postnatal care and breastfeeding. *Obstetrics, Gynaecology and Reproductive Medicine* 21(12):346-50.

Supporting fathering through infant massage

Fathers may feel dissatisfied with their ability to form a close attachment with their infants in the early postpartum period, which, in turn, may increase their parent-related stress. Our study sought to determine if an infant massage intervention assisted fathers with decreasing stress and increasing bonding with their infants during this time. To address the complex father-infant relationship, we conducted a pilot study using a mixed methodology approach. Twelve infant-father dyads participated in the intervention, and 12 infant-father dyads populated a wait-list control group. Paternal stress was measured using the Parenting Stress Index at baseline and at postintervention. We found infant massage instruction significantly decreased paternal stress. Our findings were also supported by the qualitative data and suggest fathers may benefit from applied postnatal education.

Cheng CD, Volk AA, Marini ZA (2011). Supporting fathering through infant massage. *Journal of Perinatal Education* 20(4):200-9.

Recent and Related

Henderson A (2011). Understanding the breast crawl. *Nursing for Women's Health* 15(4):296-307.



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New guidelines for newborn resuscitation - a critical evaluation

The 2010 International Liaison Committee on Resuscitation guidelines for newborn resuscitation represent important progress. The criteria for assessment are simplified based on heart rate and respiration only and there is no timing of stages after the first 60 sec. Instead of giving supplemental oxygen, the guidelines state that 'it is best to start with air'. However, the optimal oxygen concentration later in the process and for premature babies is not yet clear. A description of an adequate heart rate response is not given, and the cut-off of 100 bpm may be arbitrary. There are still no clear recommendations regarding ventilation, inspiratory time, use of positive end expiratory pressure or continuous positive airway pressure. The guidelines do not mention which paCO_2 level might be optimal. As colour pink assessment and routine suctioning of airways are not recommended anymore, there is an urgent need to obtain international consensus and create a new and revised Apgar score without these two variables.

Conclusion:

In spite of improved guidelines for newborn resuscitation, there is still a number of unanswered questions and a need for more delivery room studies.

Saugstad OD (2011). New guidelines for newborn resuscitation - a critical evaluation. *Acta Paediatrica* 100(8):1058-62.

Communication with parents in neonatal intensive care

The psycho-relational problems in Neonatal Intensive Care Units (NICU) are complex and multifaceted and have only recently been properly addressed. Some specific factors make communication in NICU particularly problematic; the baby's clinical condition, the emotional and working conditions of the medical staff, the emotional state of the parents and the setting of the NICU and the interaction of multiple professional figures with the parents. The purpose of communication in NICUs is not only to inform parents of their child's clinical condition; the medical and nursing staff must also educate and guide parents so that they can actively participate in caring for their child and become true "partners" with the medical team in the decision-making process. Furthermore, the staff must also use their communication skills to understand and contain the anxieties and emotions of parents, supporting and comforting them through the most critical moments of their child's illness and possibly even bereavement. Given the number and complexity of the interpersonal exchanges that take place in the NICU, the risk of misunderstanding, misinterpretation and conflict is high. One could say that the interpersonal aspect is an area where the risk of iatrogenesis is elevated. It is recognized that poor staff-family interactions not only reflect negatively on the baby's care and are a source of distress and discontent for the parents, but are also a major cause of medico-legal litigation and increase the incidence of "burnout". Therefore, specific training of the staff in communication is essential if the optimal results, obtained through modern technology, are not to be invalidated.

Orzalesi M, Aite L (2011). Communication with parents in neonatal intensive care.

Journal of Maternal-Fetal and Neonatal Medicine 24(s1):135-7.

Recent and Related

Ludington-Hoe S (2011). Thirty years of kangaroo care. Science and practice. *Neonatal Network: the Journal of Neonatal Nursing* 30(5):357-62.



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Perineal techniques during the second stage of labour for reducing perineal trauma

Background:

Most vaginal births are associated with some form of trauma to the genital tract. The morbidity associated with perineal trauma is significant, especially when it comes to third- and fourth-degree tears. Different perineal techniques and interventions are being used to prevent perineal trauma. These interventions include perineal massage, warm compresses and perineal management techniques.

Objectives:

The objective of this review was to assess the effect of perineal techniques during the second stage of labour on the incidence of perineal trauma.

Search methods:

We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (20 May 2011), the Cochrane Central Register of Controlled Trials (The Cochrane Library 2011, Issue 2 of 4), MEDLINE (January 1966 to 20 May 2011) and CINAHL (January 1983 to 20 May 2011).

Selection criteria:

Published and unpublished randomised and quasi-randomised controlled trials evaluating any described perineal techniques during the second stage.

Data collection and analysis:

Three review authors independently assessed trials [sic] for inclusion, extracted data and evaluated methodological quality. Data were checked for accuracy.

Main results:

We included eight trials involving 11,651 randomised women. There was a significant effect of warm compresses on reduction of third- and fourth-degree tears (risk ratio (RR) 0.48, 95% confidence interval (CI) 0.28 to 0.84 (two studies, 1525 women)). There was also a significant effect towards favouring massage versus hands off to reduce third- and fourth-degree tears (RR 0.52, 95% CI 0.29 to 0.94 (two studies, 2147 women)). Hands off (or poised) versus hand on showed no effect on third- and fourth-degree tears, but we observed a significant effect of hands off on reduced rate of episiotomy (RR 0.69, 95% CI 0.50 to 0.96 (two studies, 6547 women)).

Authors' conclusions:

The use of warm compresses on the perineum is associated with a decreased occurrence of perineal trauma. The procedure has

shown to be acceptable to women and midwives. This procedure may therefore be offered to women.

Plain language summary

Vaginal births are often associated with some form of trauma to the genital tract, which can sometimes be associated with significant short- and long-term problems for the woman. It is especially the third- and fourth-degree tears, that affect the anal sphincter or mucosa, which can cause the most problems. Perineal trauma can occur spontaneously or result from a surgical incision of the perineum, called episiotomy. Different perineal techniques and interventions are being used to slow down the birth, and allow the perineum to stretch slowly to prevent perineal injury. Perineal massage, warm compresses and different perineal management techniques are widely used by midwives and birth attendants. The objective of this review was to assess the effect of perineal techniques during the second stage of labour on the incidence of perineal trauma. We included eight randomised trials (involving 11,651 women) conducted in hospital settings in six countries. The participants in the included studies were women with no medical complications who were expecting a vaginal birth. We conclude that there is sufficient evidence to support the use of warm compresses to prevent perineal tears. The procedure has been shown to be acceptable to both women and midwives. From the meta-analyses we found significant effect of the use of warm compresses compared with hands off or no warm compress on the incidence of third- and fourth-degree tears. We also found a reduction in third- and fourth-degree tears with massage of the perineum versus hands off; and of 'hands off' the perineum versus 'hands on' to reduce the rate of episiotomy. The studies in our systematic review have considerable clinical variation and the terms 'hands on', 'hands off', 'standard care' and 'perineal support' can mean different things and are not always defined sufficiently. The methodological quality of the included studies also varied.

The question of how to prevent the tears is complicated and involves many other factors in addition to the perineal techniques that are evaluated here, e.g. birth position, women's tissue, speed of birth. More research is necessary in this field, to evaluate perineal techniques and also to answer the questions of determinants of perineal trauma.

Aasheim V, Nilsen ABV, Lukasse M *et al* (2011). Perineal techniques during the second stage of labour for reducing perineal trauma. *Cochrane Database of Systematic Reviews*, Issue 12.

Early additional food and fluids for healthy breastfed full-term infants

Background:

Widespread recommendations from health organisations encourage exclusive breastfeeding for six months. However the addition of other fluids or foods before six months is common practice in many countries and communities. This practice suggests perceived benefits of early supplementation or lack of awareness of the possible risks.

Objectives:

To assess the benefits and harms of supplementation for full-term healthy breastfed infants and to examine the timing and type of supplementation.

Search methods:

We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (1 March 2011) and reference lists of all relevant retrieved papers.

Selection criteria:

Randomised or quasi-randomised controlled trials in infants under six months of age comparing exclusive breastfeeding versus breastfeeding with any additional food or fluids.

Data collection and analysis:

Two authors independently selected the trials; three extracted data and assessed risk of bias.

Main results:

We included six trials (814 infants). Two trials in the early days after birth that reported data did not indicate that giving additional fluids was beneficial. For duration of breastfeeding, there was a significant difference favouring exclusive breastfeeding up to and including week 20 (risk ratio (RR) 1.45, 95% confidence interval (CI) 1.05 to 1.99), indicating that supplements may contribute to reducing the duration.

For infant morbidity (three trials), one newborn trial found a statistically, but not clinically, significant difference in temperature at 72 hours (MD 0.10 degrees, 95% CI 0.01 to 0.19), and that serum glucose levels were higher in glucose supplemented infants in the first 24 hours, though not at 48 hours (MD -0.24mmol/l, 95% CI -0.51 to 0.03). Two trials with four- to six-month-old infants did not indicate any benefit to supplemented infants to 26 weeks nor any risks related to morbidity or weight change.

None of the trials reported on the remaining primary outcomes, infant mortality or physiological jaundice.

Authors' conclusions:

We were unable to fully assess the benefits or harms of supplementation or to determine the impact from timing and type of supplementation.

We found no benefit to newborn infants and possible negative effects on the duration of breastfeeding from the brief use of additional water or glucose water. For infants at four to six months,

we found no benefit from additional foods nor any risks related to morbidity or weight change. Future studies should examine the longer term effects on infants and mothers, though randomising infants to receive supplements without medical need may be considered unethical.

We found no evidence for disagreement with the recommendation of international health associations that exclusive breastfeeding should be recommended for healthy infants for the first six months.

Plain language summary

Human milk naturally provides for growth, protection and development for human babies. It is also important to the health and well-being of the mother. Exclusive breastfeeding is an infant's consumption of human milk with no supplementation of any type, including no water, juice, non-human milk or foods. The effect of early supplementation may include decreased milk production due to reduced removal of milk from the breast, difficulties in developing effective breastfeeding and reduced maternal confidence in the ability to successfully breastfeed with reinforcement of a negative belief that human milk is insufficient for an infant. Despite widespread recommendations supporting exclusive breastfeeding for four, and more recently six months, common practice often does not appear to reflect these recommendations, thus suggesting there are perceived benefits from supplementation. We looked at studies on supplementation with additional fluids in the early weeks or supplementation with the addition of foods at four to six months of age. We identified six randomised controlled studies involving 814 women and their infants that looked at exclusive breastfeeding compared with breastfeeding with additional fluids or foods.

From the trials that we found, for the healthy breastfeeding baby in the first few days after birth, two trials involving 200 mothers found no benefit to newborn infants in giving additional water or glucose water and increased risk of early cessation of breastfeeding from the brief use of additional water or glucose water. For infants receiving supplements of food at four to six months, we did not find sufficiently high-quality data from the two trials identified to indicate any benefit to the infant in giving additional foods nor any risks related to morbidity or weight change.

The trials were reported on between 1982 and 1999. Two were carried out in Honduras and one in each of Spain, Nigeria, US and UK. It may now be considered unethical to conduct a trial in which an infant is randomised to receive supplements solely for the purpose of the trial.

This review did not find any evidence for disagreement with the recommendation of the World Health Organization and other international health associations that as a general policy exclusive breastfeeding, without additional foods or fluids, should be recommended for the first six months after birth.

Becker GE, Remington S, Remington T (2011). Early additional food and fluids for healthy breastfed full-term infants.

Cochrane Database of Systematic Reviews, Issue 12.



Snippets and Bits

MIDIRS summarises the best of the latest discussion papers, opinions, editorials and stories...

The need to support normality over non-evidence-based interventions

MIDIRS Summary:

Liz Stephens begins her discussion piece by asserting her belief that *'labour wards are not the place for low risk women, and that our guidelines all-too-frequently do not support normality'* (Stephens 2011:686). She offers examples of this in relation to waterbirth; reflecting on the lack of evidence to support guidelines that suggest a woman's cervix should be 5cm dilated and she should have a 40-minute CTG before entering a pool. Her article also discusses other examples that she feels underline *'the subtle privileging of intervention over non-interventions and the subliminal medicalization that is a key feature of labour wards'* (Stephens 2011:686) and goes on to look at how differences in approaches can have a dramatic impact upon the experiences of midwifery students.

Stephens L (2011). The need to support normality over non-evidence-based interventions. **British Journal of Midwifery** 19(11):686.

Smell's good! Aromatherapy in midwifery

Author Abstract:

This article explores the contemporary enthusiasm amongst midwives for using aromatherapy and massage in their care of women during pregnancy, postnatally and particularly during labour. An exploration of the benefits of aromatherapy is balanced by discussion of the risks, notably of specific essential oils. The accountability of the midwife working with women wishing to use aromatherapy is addressed and a checklist of pertinent issues and safe use of aromatherapy in midwifery practice is given.

Tiran D (2011). Smell's good! Aromatherapy in midwifery. **Practising Midwife** 14(10):11-2, 14-5.

Creating and critiquing knowledge

MIDIRS Summary:

In this editorial, Joan Skinner raises a number of questions about what is valid knowledge and who decides this. She looks at how midwives 'broker' knowledge that arises in research studies in their relationships with women and families and takes some specific examples of recently published research that has been widely criticized. She goes on to consider some of the studies published in the current issue of the New Zealand College of Midwives Journal, arguing that we need to interpret research with caution and bear in mind that participants may not be representative and concluding that *'the key is to claim the validity of different ways of knowing, to be critical and creative users and generators of knowledge'* (Skinner 2011:4).

Skinner J (2011). Creating and critiquing knowledge. **New Zealand College of Midwives Journal** (44):4.



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midirs

Focus



Understanding physiological breech birth

Jane Evans

Since the release of the Term Breech Trial (Hannah *et al* 2000) many women, midwives and obstetricians have been concerned about the increase in caesarean section operations for breech presenting babies, and the apparent lack of choice as the skills required to safely assist a breech birth are lost. The follow-up to the Term Breech Trial (Hannah *et al* 2004, Whyte *et al* 2004) acknowledged that the trial ended before any conclusive evidence was found and yet, still, the original research paper is used, in many units in the UK, as a reason to advise women to have a planned lower segment caesarean section (LSCS) if their baby is in a breech presentation at 38 weeks' gestation.

The skill of the birth attendant has been shown to be the most important factor in the outcomes of vaginal breech birth (Maternal and Child Health Consortium 2000, Hannah *et al* 2000, Robinson 2000/01). As well as planned breech births there will always be undiagnosed breech presentations that deserve knowledgeable practitioners to facilitate safe birth in all circumstances.

I have attended many breech births during my midwifery career, particularly during the 20 years I have practised as an independent midwife, and have observed the spontaneous movements made by the woman and the baby that facilitate a successful vaginal breech birth when they are not sedated and are free to move around during labour. I was taught by older, more experienced midwives to observe and not interfere unless help was required, and that a

breech birth could be 'normal'; an experience that is now hard to replicate within the UK's National Health Service (NHS). With my colleagues I have studied many sets of photographs, and the occasional video of a breech birth, and have again observed the spontaneous movements made by both women and babies. Whilst working with a doll and pelvis, and being aware of the anatomy and physiology of the pelvis and pelvic floor, it became clear that these movements, as the baby travelled through the pelvis, facilitated spontaneous birth. With further research I found that many of these movements had been described previously, some in historical papers (Johnstone 1951, Plentl & Stone 1953, Myles 1975), but that a complete description has not yet been published.

In this article I wish to describe the mechanisms and movements the mother and the baby will employ to achieve a spontaneous vaginal breech birth. This is different to a vaginal breech delivery, where the birth attendant manoeuvres the baby, although the manoeuvres may appear similar in many instances.

In 3–4% of all normal term pregnancies the baby will present in a breech position. There is a clear route for these babies to negotiate the birth canal safely. This applies to a well grown, full-term baby ie 37–42 weeks' gestation. In such an infant the bitrochanteric diameter is likely to be a similar size to the biparietal diameter, unlike a baby who is premature or has intrauterine growth retardation (IUGR).

The onset of labour should be spontaneous with no induction or 'encouragement' of any sort – not even non-invasive or complementary therapies. The progress of labour should be spontaneous and steady with the contractions getting stronger, lasting longer and coming more often. No augmentation should be used to speed up labour. In the second stage of labour the onset of expulsive contractions and descent of the presenting part should, again, be spontaneous, with no augmentation and no directive pushing.

Throughout this article the baby will be referred to as 'he' or 'his' to avoid the impersonal 'its' or the overly-complicated 'their'. The author would like to emphasise that girls are also born in the breech position, as shown by the recent arrival of her grand-daughter!

It is paramount that the labour is completely spontaneous as this allows the baby time to adopt his own optimal position and to progress at his own pace through the various planes of the pelvis. The labour may spontaneously stop. This should be respected as possibly being nature's way of indicating that this labour needs help. It would be unwise to attempt to push a baby, who is in a breech presentation, through a pelvis that it is unable to negotiate naturally. The safest way forward, in a resource-rich country, may well be to consider a caesarean section operation.

Pain relief should be non-pharmaceutical, as the woman needs to be responsive to the signals her body and her baby are sending her. Epidural anaesthesia is precluded as it will block these messages and will also curtail the spontaneous movements the woman may need to make. It is also very important to keep the atmosphere in the labour environment calm, non-stressed and peaceful. This will allow the appropriate hormones to act and for the pelvic floor muscles to relax and open. It is important to remember that the largest of these, the *levator ani* muscle complex, are under subconscious control and that any stress during labour may cause the woman to feel unsafe and subconsciously tighten those muscles, therefore impairing the progress of the birth. Midwives experienced in breech birth have noticed that most successful vaginal breech births progress more rapidly than a cephalic presentation, and a first labour will take an average of 6–8 hours rather than 12–14 hours.

“The onset of labour should be spontaneous with no induction or ‘encouragement’ of any sort – not even non-invasive or complementary therapies”



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Possible positions of a breech presenting baby

There are several positions that a baby in the breech position may adopt which include flexed (complete), extended (frank), footling and, most rarely, knee presentation. Although many of these will slightly change the mechanisms, the basic route and movements should remain the same and, although not all are optimal, all can still be born safely vaginally. The most common of these positions, especially in a primiparous pregnancy, is the extended (frank) breech, with both legs flexed at the hip and straight at the knee and the feet up near the baby's face. This is also the position from which the baby is least likely to spontaneously turn, or for an external cephalic version (ECV) to be successful, as there is less spontaneous leg movement and the legs act as a splint to the body.

As with a cephalic presentation the position of the baby is described in relation to the mother's pelvis with the marker point on the baby being the sacrum. Breech babies can be described as being left sacrum anterior (LSA), left sacrum lateral (LSL), left sacrum posterior (LSP), direct sacrum posterior (DSP), right sacrum posterior (RSP), right sacrum lateral (RSL), right sacrum anterior (RSA) and direct sacrum anterior (DSA). As with cephalic babies favouring the left occipitoanterior (LOA) position, the RSA position appears to be favoured by, and optimal for, breech presenting babies. As the extended (frank) breech in RSA position appears to be the most common, and indeed optimal, presentation and position for a breech presenting baby, I shall employ this to describe the mechanisms for a spontaneous vaginal breech birth.

The mechanisms of an extended (frank) breech presenting baby as it passes through the pelvis in the RSA position

These descriptions are probably easiest when read in conjunction with using a doll and pelvis.

During the latter weeks of pregnancy the baby will usually drop into the brim of the pelvis in the RSA or DSA position. The bitrochanteric diameter, being the largest of the presenting part, will therefore enter the widest (transverse or oblique) diameter of the pelvis (Fig.1).

At the onset of labour the presenting part will be the buttocks. These will descend through the pelvis, gradually rotating clockwise (if viewed from the top of the maternal pelvis) on the internal pelvic floor muscles to RSL, (1/8th of the pelvic radius from RSA to RSL) which brings the right buttock anterior, and the genital cleft into the transverse diameter (Fig.2).

The first stage of labour then continues until full dilatation of the cervix is reached, adjacent soft tissues are compressed and the vaginal wall expands and opens. As with any birth the woman should be encouraged to labour in the position she finds most comfortable. Only when the birth canal is fully prepared will the woman commence **spontaneous** expulsive efforts. It is vitally important not to encourage pushing at any point as the dilatation of the cervix, birth canal and position of the baby may not be optimal. The woman's body will have the best knowledge of when everything is sufficiently prepared to allow the baby to pass through. An internal examination will confirm that the cervix is fully dilated but may also cause the pelvic floor muscles to contract, thus delaying progress into the second stage of labour. If the baby is disturbed by an internal examination it could trigger the startle reflex, which would cause the arms to extend and the head to deflex. It may be advisable to avoid this procedure unless there is a real clinical need for information that may impact on the advice for the management of the birth, and that cannot be gained in any other way.

With the start of the expulsive part of the second stage of labour the baby descends further through the pelvis still in the RSL position. The woman and baby may be seen to make rocking movements of their pelvises, which facilitate the descent and correct positioning for further progress. Most women in western society, where chairs are

used for sitting rather than squatting, will spontaneously adopt an upright, forward leaning, kneeling position at this stage.

The woman may be seen to start actively pushing whilst sitting on her heels. This will still bring the baby down and will encourage flexion of the baby, which is beneficial for a breech birth.

Gradually the *transversus perinei* muscle retracts and the anal sphincter and *bulbocavernosus* muscle relax, allowing the anterior buttock (right buttock) of the baby to descend and appear at the introitus of the vagina; the baby's anus, genitalia and the posterior buttock soon follow. Progress continues and the widest diameter of the baby's buttocks, the bitrochanteric diameter, is born with lateral flexion. This is generally known as 'rumping'.

After rumping and with further descent the baby rotates anti-clockwise (viewed from the top of the maternal pelvis) to bring the sacrum to DSA, with the sacrum rotating under the mother's pubic arch (Fig.3).

While this is occurring the baby's shoulders are coming into the oblique or transverse diameter of the brim of the pelvis, which is the widest diameter in a gynaecoid pelvis (Fig.4).

Descent continues as the baby's thighs, popliteal fossa (knee pit) and lower legs become visible. Once the baby's pelvis has been, born he arches his spine backwards, extending his pelvis, which will cause his lower torso to round the maternal symphysis pubis. This places tension on the extended legs, thus freeing the legs from the introitus. This movement simultaneously causes the baby's head to move back and round the internal sacral prominence of the maternal pelvis (Fig.5). The Rhombus of Michaelis is often clearly visible at this time as the maternal sacrum lifts to maximise the pelvic diameters. The release of the legs is spontaneously and easily accomplished, by



Figure 1



Figure 2



Figure 3

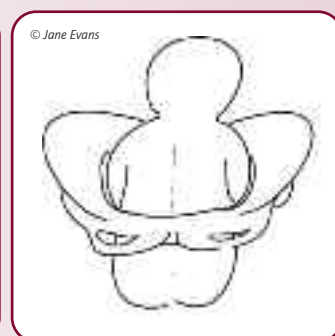


Figure 4

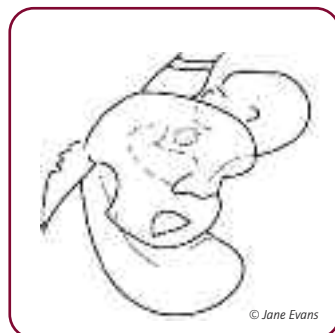


Figure 5

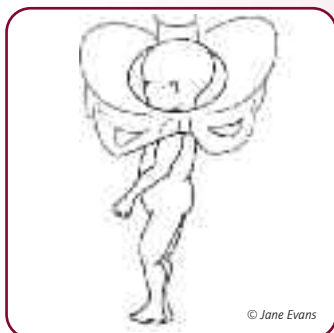


Figure 6

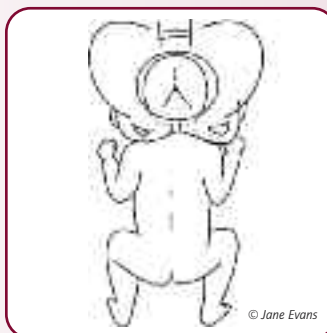


Figure 7



Figure 8

the baby, when the woman is in the upright, kneeling position described earlier. Again the woman may drop her bottom down so the baby is sitting on the floor, which again encourages the baby into flexion.

The baby's legs are now free and the umbilical cord is visible. With further descent and continued anti-clockwise rotation the head is coming into the brim of the pelvis with the sacrum in the LSA position. The shoulders meanwhile are rotating in the mid cavity of the pelvis, guided by the pelvic floor muscles. This continued anti-clockwise rotation facilitates a natural '*Løvset manoeuvre*', which brings the arms down through the mid cavity of the pelvis, again guided by the pelvic floor muscles. The left arm, which started labour in the posterior position, has now rotated to being the anterior arm and releases from under the pubic arch, closely followed by the right arm, which is now posterior. The chest will appear creased if the arms are in an optimal, anterior position, across the chest. Breathing movements may be seen but it is wise to remember the mature baby will have been making such movements in utero.

With the birth of the arms and shoulders the head has come into the brim of the pelvis in the same diameter as if the baby had been head down and LOA position (Fig.6). The baby then restitutes (1/8th of the pelvic radius movement clockwise when viewed from the top of the maternal pelvis) as the head comes through the mid cavity of the pelvis, from LSA to DSA, which brings the occiput directly anterior and onto the internal aspect of the symphysis pubis. External observation of the baby, with the mother in the upright kneeling position, will show the shoulders now in the transverse diameter, and the abdomen and chest facing the maternal spine.

At this point several things occur simultaneously. The baby will flex his legs up towards his abdomen and his arms up towards his shoulders, as if trying to do a sit-up or a tummy scrunch. This movement causes the baby to flex his head, bringing chin down onto chest, and thus pivoting his occiput on the internal aspect of the symphysis pubis (Fig.7). This, in turn, stimulates the mother to spontaneously drop, from an upright kneeling position, to all fours or even a knee-chest position, thus moving her pelvis round the baby's flexing head (Fig.8). This allows the baby's chin, mouth, nose and face, followed by the after-coming head, to smoothly pass the perineum. The birth attendant needs only to be ready to support the baby as the head is spontaneously born.

As can be seen from this description of a spontaneous vaginal breech birth there is normally no need for any handling of the baby and so danger of iatrogenic damage to the baby is negligible. The woman should **never** be asked to drop forward unless the practitioner is physically rotating the head, as described later in the article.

During the birth, with the woman kneeling upwards and forwards, gravity is used to aid the mechanisms and free movement of the maternal pelvis allows maximum space for the baby. The birth attendant has a clear view of progress and can observe, and record, the baby's colour, muscle tone and, after the legs have released, the integrity of the umbilical cord to assess the baby's well-being. There should be steady progress with each contraction. If any of these are giving cause for concern then further action should be considered.

With ALL breech-presenting babies the cord is born before the head. By looking carefully at the mechanisms of breech birth it can be seen that this should not be a problem. The most likely time for cord compression to occur is as the head descends into the pelvic brim. The head is not near the pelvic brim until the shoulders are being born and birth is imminent. The cord is, by this time, clearly visible and the fullness can be observed. With the upright, forward leaning position the baby's body weight is directed away from the cord and is thus less likely to be compressing the cord, which would also be protected by the baby's extended legs.

Although there are some practitioners who support the practice of breech water births, I personally advise against actually giving birth in water when the baby is a breech presentation. This is because the buoyancy of the water works against gravity and impedes the mechanisms. If the breech presentation is undiagnosed and the woman is in the pool already, she will often instinctively adopt a semi-reclining position which allows the buoyancy of the water to lift the baby in a way similar to the '*Burns-Marshall manoeuvre*'. When such a birth is progressing rapidly it is important to keep the birthing room very calm and just observe progress before disturbing the woman, by asking her to exit the pool. It may be better to proceed with an underwater birth than to interrupt it unless help is needed. Water is, however, very good for pain relief in the first stage of labour.

These mechanisms may not always be as clearly defined with the other breech presentations and may appear modified, but the basic moves remain the same. As with cephalic birth there will be variations, which, while not necessarily causing a problem, should be noted by the birth attendant, as they may indicate a less than optimal position for the baby.

A baby in the LSA position will not make the full rotation to bring the arms down through the pelvis, so the birth attendant may need to assist with a modified '*Løvset manoeuvre*' by using the pelvic or shoulder girdle to turn the baby. If any delay occurs in the normal progress of a particular labour, appropriate action may be required before the baby is compromised.

If help is needed it would normally require rotation **not** traction in the direction which would release the obstructed part. The normal mechanisms will usually recommence rapidly once release is obtained.

If there has been no traction on the baby the arms and head are rarely extended as the contractions and progress of the labour would normally flex the baby's head, but, if help is required, with the woman in the upright, kneeling, leaning forward position the whole of the sacral cavity is accessible for any manoeuvre needed. A manoeuvre to reduce an extended head has been described by Louwen (2009); with the shoulders born and the baby in DSA but with an extended head, the practitioner presses their thumbs into the baby's subclavicular space whilst minimally lifting the baby and rotating the shoulders forward. This manoeuvre may need to be repeated until the head flexes sufficiently to allow the '*Mauriceau-Smellie-Veit manoeuvre*' to be performed. The '*Mauriceau-Smellie-Veit manoeuvre*' can easily be performed with the woman in this position should the head need to be helped out; again, using rotation not traction. It is only at this point, with hands on the head, flexing it, that the practitioner may ask the woman to



“ There are still undiagnosed breech births and we must be skilled enough to facilitate a calm, safe birth ”

drop forward to move her pelvis round the baby's head. A baby who has needed help to be born is more likely to need resuscitation but with the cord left intact, the baby will often begin his own resuscitation by flinging his arms above his head, expanding his lungs and crying.

The overriding skill required for supporting a woman to birth her breech presenting baby spontaneously is to quietly support and observe. Women who have a history of abuse may need to be counselled that the spontaneous movements made by the baby during labour and birth may trigger flashbacks but most are able to manage these if they are forewarned. It is imperative to keep the birth area calm and quiet to facilitate the birth.

The skills for ECV were nearly lost, due to equivocal research, but thanks to the Term Breech Trial (Hannah *et al* 2000) these have been rescued. I hope that by gathering and sharing information on facilitating spontaneous breech birth we, as professionals, can similarly keep the skills of safe vaginal breech birth alive so the women we are working with have viable options when their babies present by the breech.

It is our duty not to cause harm and, as the current evidence is still equivocal (Hofmeyr *et al* 2003, Goffinet *et al* 2006, Maier *et al* 2011), and does not appear to indicate any statistical improvements to the women or the babies, there is little to support elective caesarean section operation for every breech presenting baby; particularly when a skilled birth attendant is available. There are still undiagnosed breech births and we must be skilled enough to facilitate a calm, safe birth (RCOG 2006, Kotaska 2009). It is unacceptable to make caesarean section operation the only option for those women whose baby is presenting breech, just because we professionals have lost the knowledge and skills to assist them in a safe, spontaneous, vaginal breech birth.

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Jane has also written a Joined-up Knowing article for *Essentially MIDIRS*, which will be published in the March 2012 edition.



Jane Evans RN, RM

Jane Evans worked in the NHS as a nurse and a midwife for 20 years, and has been working as an independent midwife since 1991. She is co-director of *Sharing the Skills* and has taught about breech birth and midwifery skills both nationally and internationally. She has four children and three grand-daughters, one of whom was a breech presentation, born spontaneously last year.

Serendipity

a fortuitous occurrence or the happy discovery of something, particularly when looking for something altogether different

From the Archives

IN FACT

Most generations born on Leap Day

'The only verified example of a family producing three consecutive generations born on 29 February is that of the Keogh's. Peter Anthony (Ireland) (b.1940), his son Peter Eric (UK) (b. 1964) and his grand-daughter Bethany Wealth (UK) (b. 1996) all celebrate their birthdays infrequently every four years.'

Guinness World Records (2011).

Find a record. <http://www.guinnessworldrecords.com> [Accessed 26 May 2011].



Essentially MIDIRS – Author Guidelines

We welcome submission of original articles for *Essentially MIDIRS*, which is published monthly with a combined July/August issue. As a general guide, full length articles are 2500 words and reflective pieces for the 'Joined-up Knowing' section are 1200-1600 words in length.



Authors should provide a title page including the title of the article, their name, full contact details and details of their title/role/appointment. We welcome colour photographs of authors which can be published alongside the article. Please submit your article as a Word document using 1.5 line spacing in Arial point 12 and email as an attachment to the address below. Please contact us if you are unable to submit material electronically.

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The accuracy of references is the responsibility of the author and full and accurate information must be included for all sources cited in the text. We use the Harvard style of referencing; if you would like a copy of the MIDIRS referencing guidelines, please email us at the address below.

Please contact the EM team on em@midirs.org or 0117 907 7596 with any queries; this is also the email address to which articles should be sent in the first instance. Thank you for considering publication in *Essentially MIDIRS*; we look forward to working with you!

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Feasibility and insurability of independent midwifery in England report

The long and unsuccessful struggle by independent midwives to find insurers to underwrite professional negligence risks has given rise to *The feasibility and insurability of independent midwifery in England* report (Flaxman Partners 2011), commissioned by the Nursing and Midwifery Council (NMC) and the Royal College of Midwives (RCM). The report explores the reasons why independent midwives are currently not able to obtain professional indemnity insurance and identifies possible solutions.

It focuses on the provision of independent midwifery within England — the country in which most of the small number of independent midwives practise in the United Kingdom — and although some of the recommendations would be of relevance to all countries in the UK, possible solutions offered by the report are limited by the differences in provision of maternity services in different countries.

The report draws on recommendations made in a review by Finlay Scott (2010), which recommended that making insurance or indemnity a condition of registration is the most cost effective way to achieve the policy objective that all registered healthcare professionals must have cover. The Finlay Scott review also called for all of the health departments in the UK to consider whether it is necessary to enable the continued availability of the services provided by groups such as independent midwives and, if so, to facilitate a solution.

One possible solution outlined in the Flaxman report is that independent midwives could practise as part of a formally constituted legal entity, such as a social enterprise company, which could be covered by insurance. In addition to this, the NMC has recently reported that a group of midwives may have

managed to secure full professional liability insurance with a commercial insurance provider by forming a limited company.

The NMC also announced that it is to commence a review of *The Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC 2008) which will consider the need for nurses and midwives on its register to have insurance cover. In order to comply with EU regulation, it will become the regulator's responsibility to gain assurances that this cover exists.

Commenting on the report, RCM Deputy General Secretary Louise Silverton said:

"There is simply little appetite in the insurance industry to insure these midwives, and time is running out for them. The report points the way forward and offers possible solutions. It would be a real blow to the midwives, the women they care for, and could care for in the future, if a solution is not found. Independent midwives provide services such as home births that can support and enhance those available in the NHS".

She also stressed that: *"The RCM believe that a solution is achievable. However, it needs the will and commitment from the government and insurers".*

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Views on the News.....

Threatened closure of MLU in Cavan, Ireland

In December 2011, I was alarmed to learn of an impending decision about the future of the midwifery led unit (MLU) in Cavan General Hospital, with closure being considered as a serious option.

Along with Drogheda, Cavan is a flagship project, dating from the recommendations of the Kinder Maternity Services Task Force in 2004 to set up two MLUs in Ireland on a pilot basis. These are our only MLUs and the open and publicly accountable process used to reach decisions to recommend their establishment is precisely what maternity services lack in Ireland. Decisions tend to be made behind closed doors, with minimal 'consumer' representation at regional and national levels.

The commissioned report on the outcomes of the MLUs was published in 2009 (Begley *et al* 2009). Results proved that midwifery led care was at least as safe as births in comparable consultant led units of the two hospitals for women with low-risk pregnancies. Women experienced greater satisfaction and fewer interventions in the MLUs. This was good news, especially given the conservative clinical environment surrounding the report. A leading obstetrician, Professor John Bonnar, stated that, "...midwifery-led care has the potential to provide greater choice for the majority of low-risk women, better continuity of personal antenatal care and a more satisfying birth experience" (O'Regan 2009).

Alas, the era of cutbacks and austerity has provided the rationale - despite evidence to the contrary (RCM 2010, Schroeder *et al* 2011) - that closure of midwifery led care in Ireland is justified because it is 'too costly' (Murphy-Lawless 2011). There has been poor take-up of MLU services in Cavan, but the reason for this is the elephant in the room.

Firstly, the issue of lucrative private practice in a mixed healthcare system where GPs are the first named professional that women see when pregnant and where at least 40% of women opt for private care or mixed obstetric and GP care within public hospitals. There is no framework of national guidelines that might encourage women to seek midwifery led care as their first port of call. If local GPs and obstetric consultants do not wish to support a midwifery led unit, it will show in the figures. The uptake of MLU services in Cavan's sister MLU, 80 kms away in Drogheda, is far higher and even has a waiting list, suggesting that women there have been supported to reach different decisions about their care.

The second issue is cost. The national caesarean section rate is currently 27%, while the rate in Cavan General Hospital is 28.3%. While we have no comparable Irish data, the latest NICE guideline (NICE 2011) states that on average a normal birth costs £1,512, a planned caesarean £2,369, and emergency caesareans £3,042. We know that there is a marked differential between the rates of caesarean sections for women

in the public sector (24%), compared with those who go privately (35%, of which 60% are listed as 'elective' (ESRI 2011)). The new Professor of Midwifery at the National University of Ireland, Galway, Declan Devane, has called for a total reconfiguration of maternity services, moving away from the overcrowded, uneconomic and clinically unjustified concentration of low-risk women in consultant led hospital units (Siggins 2011).

For the moment, Cavan MLU has had a reprieve, but must be seen to increase take-up (Wayman 2011). That will happen only with significantly better local support.

Jo Murphy-Lawless, Sociologist, School of Nursing and Midwifery, Trinity College Dublin

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Winners news from midirs



MIDIRS RCM conference prize draw

The winner of MIDIRS 'Bundle of Goodies' at this year's RCM Conference is Camille Downie, Student Midwife from East Barnet. Camille wins a bottle of sparkling wine, chocolates, an aluminium pinard, a couple of carefully selected midwifery books, and a selection of back issues of *MIDIRS Midwifery Digest* and *Essentially MIDIRS*.

MIDIRS student prize draw 2011

Winner of the MIDIRS Student Prize Draw 2011 is Alison Rodgers from Lisburn, Northern Ireland. Alison wins a brand new iPod touch. Aimee Cannings from Salisbury in Wiltshire, wins the second prize of an iPod Nano.

Breastfeeding flashmob

A group of 40 women joined together to form a breastfeeding flashmob in Brighton city centre in December 2011 to highlight their right to breastfeed in public.

The action was co-ordinated by Claire Jones-Hughes following a confrontation with fellow customers in a restaurant where she was breastfeeding her four month old baby. One woman told her that she was not sufficiently covered up and that it had been 'unpleasant' to watch her feed, whilst another diner at the same table said that she should have used a towel.

Initially she felt upset and bemused, reporting that she had made efforts to be discreet by layering her clothing, but this quickly turned to anger and she decided that she could not let *"the harassment incident pass unmentioned... I have two daughters, and if they in future choose to have kids and breastfeed, I don't want them to feel self-conscious or to be victimised"* (Jones-Hughes 2011).

Flashmobs are rapidly becoming a popular form of protest. Last year gay rights protesters performed a flashmob dance to Madonna's hit single 'Like A Prayer', in front of the California Republican Party convention in September 2011, and it is rumoured that morris dancing flashmobs will infiltrate crowds at this year's

Olympics to protest at the exclusion of morris dancing from the opening ceremony (Condron 2011).

The memorable sight of large groups of breastfeeding women certainly lends itself to this form of protest. In a similar event to the Brighton flashmob, a national 'nurse-in' was organised at over 100 Target stores in the United States on 28th December 2011 following an incident where a mother who had been breastfeeding on the floor of the women's clothing department was asked repeatedly to move to a fitting room.

Such protests may have been inspired by mass public breastfeeding events organised for World Breastfeeding Week in many cities internationally. These are held to raise awareness of and normalise the sight of breastfeeding women rather than in the spirit of protest.

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Jones-Hughes C (2011). New flashmob – breastfeeding mothers come out into the open. *Guardian*, 15 December. <http://tinyurl.com/7zycnsv> [Accessed 3 January 2012].

Strain on midwifery education

The Royal College of Midwives has reported that the number of Higher Education Institutions meeting the Nursing Midwifery Council benchmark ratio of one teacher to ten midwifery students has fallen, with an average of one teacher to 13.5 students. It has also emerged that the teaching workforce is ageing, with over half of 45 teachers surveyed being 50 years old or older and less than six per cent under the age of 40. These figures are the result of a freedom of information request to 76 Higher Education Institutions in the United Kingdom.

MIDIRS resources – New resources and updates from MIDIRS

NEW Standard Search PN158 Physiology of breastfeeding and lactation



This Standard Search covers the physiology of breastfeeding and lactation, including development of the lactating breast before, during and after pregnancy, and throughout the lactation period.

It includes the role of the infant in relation to the physiology of breastfeeding (eg reflexes, cleft lip and palate) and the physiology behind breastfeeding problems such as mastitis, engorgement, and lactation insufficiency.

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MIDIRS ReView

Management of sickle cell disease in pregnancy

Oteng-Ntim E, Howard J (2011).

Management of sickle cell disease in pregnancy (Green-top Guideline 61).

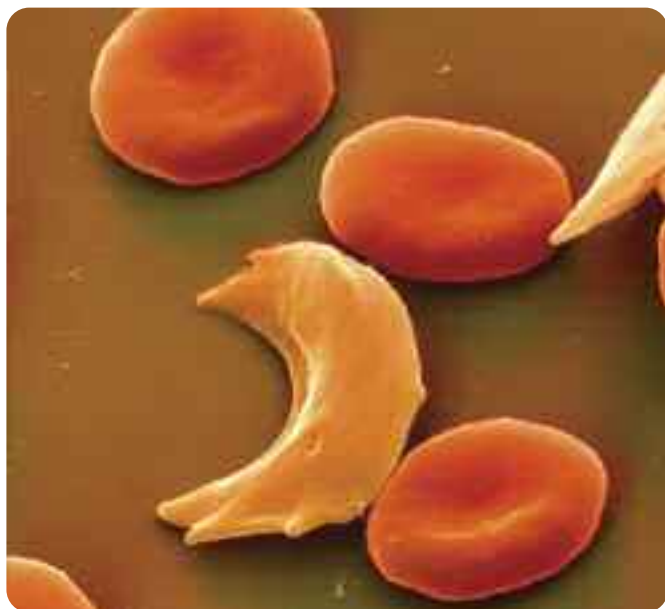
London: Royal College of Obstetricians and Gynaecologists.

Julie Frohlich

Background

This is a new RCOG Green-top Guideline covering the care of women with sickle cell disease (SCD) throughout the pregnancy continuum. It does not cover sickle cell trait. SCD includes the homogygous condition of sickle cell anaemia (HbSS) and the compound heterozygous conditions of haemoglobin S combined with other abnormal haemoglobins including HbSb thalassaemia and the rarer HbSC.

SCD occurs in people of African, Asian and Middle Eastern descent. It is a chronic, lifelong condition that has ongoing implications for care. Functional changes associated with SCD occur in low oxygen conditions (which can be provoked by a cold environment, by over-exertion, dehydration and/or stress). In such conditions, abnormal haemoglobin forms into rigid, sickle-shaped red cells which



are fragile and can easily break down. In turn, this leads to haemolytic anaemia and the occlusion of small blood vessels with all its associated features including painful sickle cell crises. The clinical severity of SCD is variable, but possible serious complications include stroke, pulmonary hypertension, retinal disease and renal dysfunction. Until the second half of the 20th century, women with SCD did not usually survive long enough to reproduce and the first successful pregnancy was only reported in 1931 (Oteng-Ntim *et al* no date). Due to advances in detection and care in the developed world, women with SCD now have an average life expectancy of at least mid-50s and the possibility of pregnancy. This is still a significant (and arguably for those previously unaware of the severity of the condition, quite shocking) reduction in average life expectancy compared with that of a healthy, unaffected adult.

Overview

The RCOG guideline covers the following areas:

- Preconception care** which should be proactive and opportunistic (at every medical consultation from adolescence onwards). Preconception counselling should be provided by a specialist in SCD and should include advice on genetic screening. Women should be given information about how SCD affects pregnancy and how the condition may best be managed to improve outcome for the mother and baby (including antibiotic prophylaxis, vaccination and folic acid supplementation throughout pregnancy). Women taking hydroxycarbamide (a new medication which decreases the incidence of painful crises) should be advised to discontinue this medication for three months prior to conception as it has been shown to be teratogenic in animals. The role of GPs in providing optimum contraception advice and promoting screening is also emphasised.
- Antenatal care** which should be provided by a multidisciplinary team, ideally including obstetricians and midwives with a specialist interest in SCD, a haematologist and a specialist physician. Care is sometimes provided in specialist SCD centres in areas of high prevalence. SCD sufferers should be informed about factors that can provoke a sickle cell crisis (see above) and have a low threshold for seeking medical help. The woman's partner should be offered screening (if this has not already been done) to determine their carrier status at the earliest possible stage of pregnancy. As well as folic acid supplements and antibiotic prophylaxis, 'at risk' women may also be offered low-dose aspirin from 12 weeks' gestation (to reduce the risk of developing pre-eclampsia) and all pregnant women with SCD should be offered prophylactic low-molecular weight heparin during any hospital admission. Monthly midstream urine cultures are advised to enable early detection and treatment of infection. In addition to routine ultrasound scans (USSs), women should also be offered a viability USS at 7-9 weeks and monthly serial USSs from 24 weeks' gestation. Indications for blood transfusion and the management of acute complications are also included in the guideline. There is a section on the optimal management of acute painful crises during pregnancy (see section 5.7, p10) including fluid and oxygen requirements and appropriate analgesia (which should be commenced within 30 minutes of arriving in hospital). Box 1 (p11) summarises the recommended management of acute pain.
- Intrapartum care** including the recommended timing of (38-40 weeks) and mode of birth (it is made clear that on its own, SCD is not an indication for caesarean section). Birth in a hospital able to manage the complexities of SCD pregnancy is advised along with involvement of the multidisciplinary team during labour and birth (which should include a haematologist). The importance of keeping the woman warm and well hydrated during labour is also emphasised. Due to the increased risk of fetal distress during labour and birth, continuous electronic fetal monitoring is recommended. As far as labour analgesia is concerned, the use of pethidine is contraindicated due to the risk of seizures when given to women with SCD; however, other opiates can be used. Regional rather than general anaesthetic (GA) is recommended if operative delivery becomes necessary, as GA carries additional risks for women with SCD. The indications for epidural analgesia during labour are similar to those for women without SCD.
- Postnatal care** which should continue to pay close attention to the condition of the mother as acute crisis and other SCD complications are still a risk. Adequate hydration remains a priority and the use of a fluid balance chart for monitoring this in hospital is recommended. Low-molecular weight heparin for seven days following vaginal birth or six weeks following caesarean section is advised. Contraception is discussed, with

“It is accepted wisdom that sufferers of chronic conditions often struggle to come to terms with their diagnosis and may experience debilitating social and psychological sequelae related to their disease”

progesterone containing methods including oral, intrauterine and injectable progesterone delivery recommended as being particularly safe and effective. For the baby at increased risk of inheriting SCD (where the partner is a carrier or sufferer), early testing is recommended.

- **Clinical governance** which should ensure that every maternity unit should have a guideline for the care of pregnant women with SCD. The importance of the involvement of the multidisciplinary team (either at a specialist centre or linked via a care network) is emphasised. The need for staff training for everyone providing maternity care is also highlighted.

Comments

Despite its worldwide prevalence and despite our awareness in the UK of SCD via the NHS antenatal screening programme (<http://www.screening.nhs.uk/sct-england>), SCD is one of those conditions that most practising midwives in the West do not usually come across on a daily basis. Consequently, it is probably fair to suggest that many midwives may have a somewhat 'hazy' knowledge of the precise detail and complexities of SCD.

Changes in the management of SCD in pregnancy in recent years have contributed to dramatic improvements in pregnancy outcomes, both for the mother (particularly the reduction of maternal mortality to below 1%) and baby, although it is still sobering to realise that even with optimum pregnancy care, maternal and fetal complications remain a distinct possibility. For example, the risk of spontaneous abortion is 19%, the rate of preterm labour is 32% and the rate of stillbirth is around 21% (Oteng-Ntim *et al* no date). It is important and timely therefore that the RCOG has published this new Green-top guideline. As well as evidencing optimum care, the guideline is also a valuable aid to teaching, giving a comprehensive overview of the pathophysiology of the condition in relation to pregnancy, childbirth and the postnatal period.

This is a particularly factual and scientific guideline (even bearing in mind that it is written for professionals), but perhaps this is not surprising given the high-risk and extremely complex nature of SCD pregnancy. As already stated, the guideline provides clear recommendations for the obstetric management of SCD during

the pregnancy and birth continuum. There are some particularly useful summaries in the form of tables and boxes outlining optimum care 'at a glance'. For example, Table 2 summarises specific antenatal care for women with SCD (see p9) and Box 1 outlines the management of acute pain (see p11). However, as well as providing recommendations, it is noteworthy that the authors also consistently provide the rationale to back these up. For example, in the antenatal section (see p5) the guideline states that penicillin prophylaxis is advised during pregnancy. It goes on to explain that this is because women with SCD are hyposplenic and are therefore at increased risk of infection. Understanding the rationale for a recommendation assists us to appreciate exactly why it is made and this in turn enables us to provide better explanations for women in our care. As with other RCOG Green-top Guidelines, the strength of evidence for each recommendation is graded according to a standardised grading scheme (see p19). This further assists professionals in giving appropriate explanations of care choices (based on the best available evidence), and women and their partners in making informed decisions based on their individual needs and preferences.

There is a constant emphasis throughout this guideline as to the advisability and benefits of multidisciplinary working, and the involvement of SCD specialists. There can be no argument that the complexities of SCD are such that optimum care is inevitably best facilitated by a team of clinicians with higher level knowledge. The team should be led by a specialist obstetrician and include a specialist midwife, anaesthetist and haematologist. The guideline recommends that where it is not possible to provide care in a specialist centre (such as in areas of low SCD prevalence), links that enable the sharing of specialist clinical knowledge and guidelines should be established. At present in England there are 26 specialist centres in Greater London and 28 centres outside London, all sited in areas of higher prevalence (Brent Sickle Cell and Thalassaemia Centre 2011). What is clear from looking at the distribution of these specialist centres is that women in dense urban populations with a higher local prevalence of SCD will probably not need to travel too far to obtain specialist care (in England at least). However, women in more remote (particularly rural) areas of lower prevalence could be disadvantaged and this should be a consideration in meeting individual care needs. One personal learning outcome from this guideline, is my realisation that in order to facilitate early booking and referral to enable appropriate screening and counselling, all midwives need to familiarise themselves with referral pathways for specialist care in their own local area.

It is accepted wisdom that sufferers of chronic conditions often struggle to come to terms with their diagnosis and may experience debilitating social and psychological sequelae related to their disease. Given the chronic nature of SCD with its demanding management regime of hospital appointments and investigations, not to mention fears concerning (potentially fatal) pregnancy complications and limited life expectancy, it would be reasonable to assume that having this disease could similarly have profound social and psychological implications for affected women and their families. There is relatively little mention of any social or psychological care (either obstetric or midwifery related) in this particular RCOG guideline. There is a brief mention of reviewing the woman's housing and work circumstances to reduce the possible provocation of crises due to poor living conditions (see p8). There is also a recommendation that couples at risk of having a baby with SCD should receive counselling in early pregnancy (see p4) but this is advised in relation to the methods and risks of prenatal diagnosis and continuation (or otherwise) of the pregnancy. However, there is really nothing else in terms of recommending any particular psychological or social support.

A PubMed search using the terms 'sickle cell disease, pregnancy and psychological' revealed only one article that really considered the psychological implications of SCD during pregnancy (Thomas *et al* 2009). A search of the *MIDIRS Reference Database* using the words 'sickle cell and pregnancy' (having similarly failed with the same PubMed search words) brought up 313 articles, but aside from counselling with regards to screening and prenatal diagnosis, again, there appears to be a complete dearth of articles that examine any psychological, let alone social impact of SCD during pregnancy. This raises the question, is anyone asking women and their families about the impact of SCD on their lives and what do women really feel? If we are to provide sensitive and supportive midwifery care then surely we need to know this?

The Thomas *et al* (2009) paper identified in the PubMed search outlines a specialist health psychology service at Guy's and St Thomas' NHS Foundation Trust (GSTFT) that supports women with SCD. Health psychology focuses on behaviours, beliefs and emotions related to physical health with the aim of bringing about long term health benefits and improved quality of life through behaviour change and self-management strategies. At GSTFT, monthly multidisciplinary SCD clinics are jointly facilitated by an obstetrician and haematologist. The wider team also includes other specialists such as sickle cell nurse

practitioners and community nurses. Although health psychology is not a 'routine' part of the care offered in the clinic, women are referred to a psychologist whenever a need is identified, with the aim of offering appropriate psychological support and intervention. Thomas *et al* (2009) provide a summary of psychological issues raised by women affected by SCD. They include: anxieties around coping with SCD whilst also caring for a young child, lack of support from family regarding SCD, anxiety due to health deterioration, poor coping strategies and concerns about the use of analgesia during pregnancy. These (and other concerns) are important matters for pregnant women who may benefit from professional psychological input. The model of holistic care provided at GSTFT sees and treats women as unique individuals and brings about improvements in quality of life through partnership working and multidisciplinary care. Holistic care should be seen (and aspired to) as a 'gold standard' for all women with SCD around the time of pregnancy.

Without doubt, what this guideline highlights is that pregnancy for women with SCD is very high-risk indeed. Women with this condition need particularly sensitive, supportive and expert care if the risk of adverse outcome is to be minimised. Better knowledge inevitably facilitates better care and this guideline certainly enhanced my knowledge and awareness of SCD during the pregnancy continuum. Aside from those highly specialised clinicians who provide SCD care on a daily basis, I would suggest that there are few of us who would not also benefit from assimilating the information contained in this important guideline. Sadly, there is no cure for SCD, but at least we now have a guideline that provides us with a clear template for optimum pregnancy care for women affected by this condition.

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Sources of further information

- Sickle Cell Society <http://www.sicklecellsociety.org>
- National Coordinating and Evaluation Center - Sickle Cell Disease and Newborn Screening Program <http://www.sicklecelldisease.net>
- NHS Sickle Cell and Thalassemia Screening Programme <http://www.screening.nhs.uk/sct-england>



Julie Frohlich

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Crossword Solution

Words to reconsider in midwifery

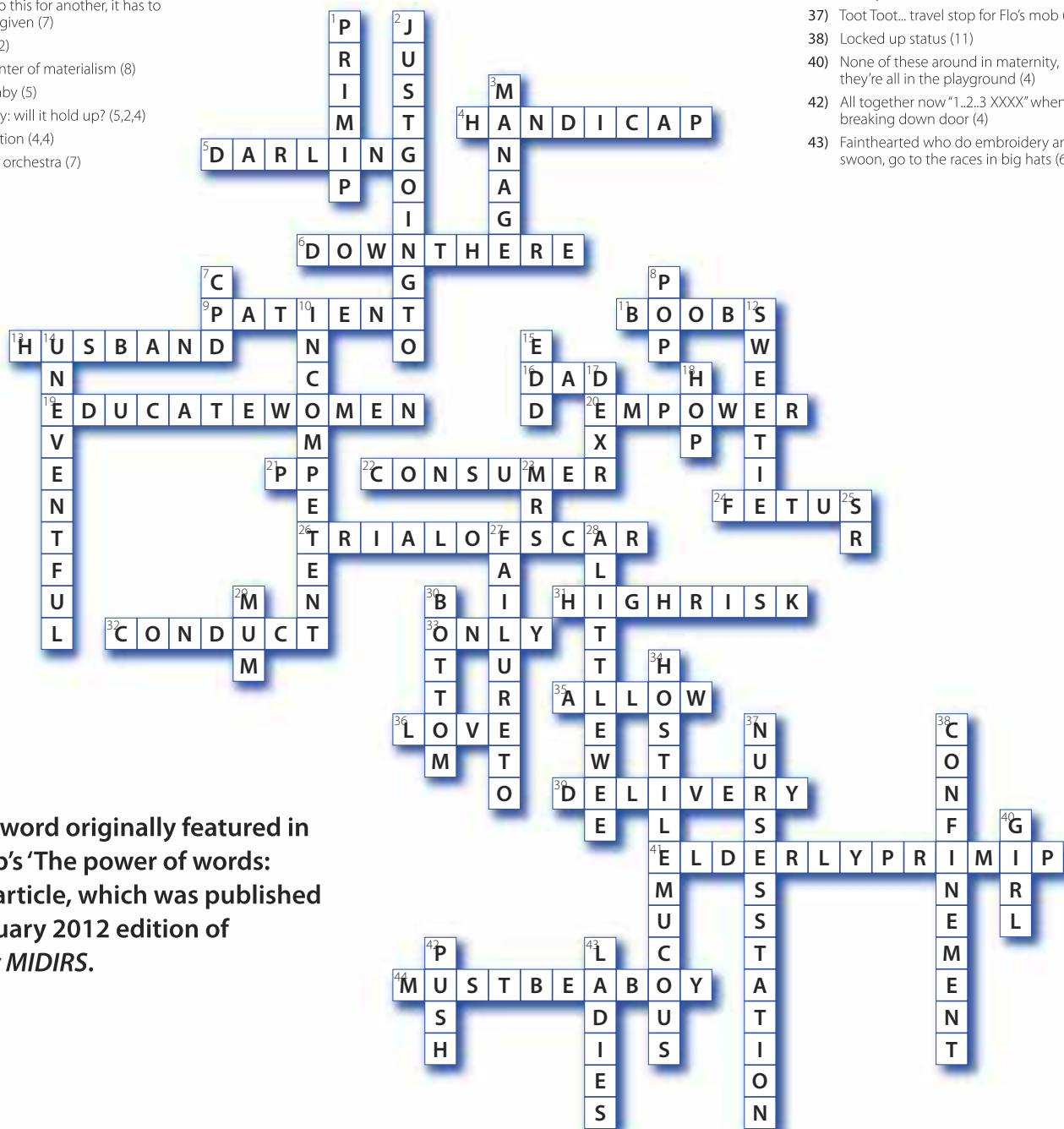
Across

- 4) Label best left for golfers (8)
- 5) Surname of Peter Pan's friend Wendy (7)
- 6) Euphemism for vagina (4,5)
- 9) Lots of these in nursing (7)
- 11) Perfect thermo-regulated source of nourishment (5)
- 13) Don't assume the tied knot (7)
- 16) His kids can call him this (3)
- 19) Share information, not this one-way process (12)
- 20) No one can do this for another, it has to be taken, not given (7)
- 21) Coming first (2)
- 22) Avaricious punter of materialism (8)
- 24) To her it's a baby (5)
- 26) Judge and jury: will it hold up? (5,2,4)
- 31) Fearful prediction (4,4)
- 32) In front of the orchestra (7)

- 33) Undermining reporting of progress, child with no siblings (4)
- 35) The ones who do this have the power (5)
- 36) Is a many splendoured thing, not a way of addressing women in labour (5)
- 39) Of pizza and post (8)
- 41) Aged Care for first pregnancy (13)
- 44) ...to cause you this trouble, sexist platitude (4,2,1,3)

Down

- 1) Novice, reminds some of word for ape (6)
- 2) Minimalising warning of unpleasant procedure (4,5,2)
- 3) Control (6)
- 7) Unreliable label for misfit (3)
- 8) Goes the weasel (3)
- 10) Lacking ability, hopeless (11)
- 12) Sugary treat (7)
- 14) Pregnancy is never this for a woman, it's full of happening (10)
- 15) Rhymes with flea, coming in the post (3)
- 17) Doh a (4)
- 18) Kangaroo gait (3)
- 23) Wedded assumption (3)
- 25) Used to run the ward (2)
- 27) No one needs this label in life (7,2)
- 28) Trickle (1,6,3)
- 29) 's the word (3)
- 30) For five year-old jokes think b** (6)
- 34) Enemy secretion (7,6)
- 37) Toot Toot... travel stop for Flo's mob (6,7)
- 38) Locked up status (11)
- 40) None of these around in maternity, they're all in the playground (4)
- 42) All together now "1..2..3 XXXX" when breaking down door (4)
- 43) Fainthearted who do embroidery and swoon, go to the races in big hats (6)



This crossword originally featured in Nicky Leap's 'The power of words: revisited' article, which was published in the January 2012 edition of *Essentially MIDIRS*.

midirs

In deep



Using art as reflection in practice:

**a midwifery student's experience
of unconscious reflection, made
conscious and transferable**

KeiShana Coursey

She's growing up in the western world and there's lots of talk about whose boobs are bigger and getting her first bra. Her friend gets one first and the boys in the classroom flick her bra straps. She longs to have her own bra straps flicked because she's definitely not a feminist (not at this point in her life).

The billboards on the way into town show very thin women in bras that push their breasts up to their collarbones. She gets the message that these are potentially powerful tools in sexual warfare. As a teenager her tops have plunging necklines and she refines the art of showing enough, but not too much cleavage depending on the setting, still considering men who look at her chest 'perverts'.

Advertisements and articles in magazines of mothers with babies always show the women looking trim and fit soon after the birth and most show babies being fed with a bottle. She's never taken notice of any real women with young babies. They seem to push them around a mall in a buggy but the babies don't seem to get fed, except from a spoon. She doesn't know what she doesn't know.



Later, she herself is pregnant. There are so many brochures, books and bits of advice given to her by friends, family and neighbours; it's all a haze. At one point her Grandma talks about mammals and feeding breast milk, like the cows on the farm. She's got an iPhone, an iPad and a Twitter account; her life feels as if it's a long way from the farmyard.

She's mostly thinking about the birth... that elusive, terrifying event she's seen women screaming about in agony on TV. That part consumes her.

Soon, she's gazing into her newborn baby's eyes having been through the single most incredible, intense marathon of her life. People have told her that once the baby's born, the pain will go away. But she feels like she's been hit by a truck. Nobody could have explained this to her because birth is clearly beyond words, she knows that now. The midwife says, 'perhaps baby would like a feed'. The scene has already been set.

Every move she makes in her breastfeeding relationship with this precious baby is an uphill battle against sociopolitical, sociocultural and socioeconomic factors; all seemingly stacked against her baby's basic primal need to breastfeed.



During my placements as a midwifery student, I am often overwhelmed with the complexity of the situations encountered. In this instance a woman is choosing to artificially feed her baby by the end of the postnatal period due to a combination of politics; financial woes; sexual identity; media influence; socialisation/normalisation of artificial feeding; political correctness twisted and contorted into a woman's right to choose; primary health care providers that are overworked, underpaid, under-resourced or just plain fed-up; inconsistent advice; lack of information, support, community, confidence, commitment and perhaps an underlying physiological barrier and, and, and...*arrggghhhhhhh*.

These midwifery challenges are what midwifery is all about, aren't they? Primary health care providers walk alongside women, providing women-centred care in a relationship of negotiation. Midwives are only personally ethically accountable for the outcomes of women and their breastfeeding 'status' at the end of the postnatal period. A tick on a referral form at handover of care will apparently suffice and never, ever sums up the sometimes hours or days spent with women addressing their breastfeeding challenges. We are easily able to hide under the flimsy umbrella of informed choice when a woman says she's bought a steriliser and tin of formula.

In this instance I saw the baby open-mouthed and desperate for food and as their breastfeeding relationship evolved, so many scenarios kept getting in the way of this baby's basic primal need. The multiple layers are sometimes most difficult for me to assimilate and I often mentally throw my hands in the air in frustration or resignation. What I read in text books and from experts within the profession doesn't correlate with the lived experience of working with women within the constraints of the technocratic paradigm. This example can be applied to many different scenarios.

So why and how do midwives who are passionate breastfeeding supporters continue battling? How can I work through this? How can I offload? Be a 'reflective practitioner,' they say. I find it near impossible to articulate the complexity of the issue I am reflecting upon in a few hundred words. However, an image tells a thousand words... doesn't it? Certainly art is about individual interpretation.

Whilst reading *The art and soul of midwifery* (Davies 2006), I became utterly inspired by the diversity of birth art and its interrelationship with patriarchal politics and feminist expression. Pam England (as cited in Davies 2006: 36) who uses birth art therapeutically to explore beliefs around pregnancy and childbirth, eluded to the emphasis being on the process of creating the work, as opposed to the end result. That gave me the permission I needed to put brush to paper.

The picking up of the brush, the placing of the paints feels so indulgent. With the intense workload of a second-year student, it feels like a luxury, an irresponsible misuse of time... and yet, the process is incredible. I go into this place of remembering the moments, all adding up. Sometimes it's just one moment, and for others it's a culmination of experiences. I never know what it's going to look like at the end and I've never taken art classes so there

is no formal process involved of drafting or carefully choosing the medium. For this painting, I found an old piece of cardboard and my daughter's watercolour paints. There are no 'learning outcomes' or marking guidelines to be terrified about. This is a deeply free and personal process of reflection that combines my personal experience with evolving midwifery knowledge and allows me to step back into the experience, slowing it down, pausing it when I choose to explore the different aspects of it. I like to imagine myself as a fly on the wall, watching the experience and looking at the different parts of it.

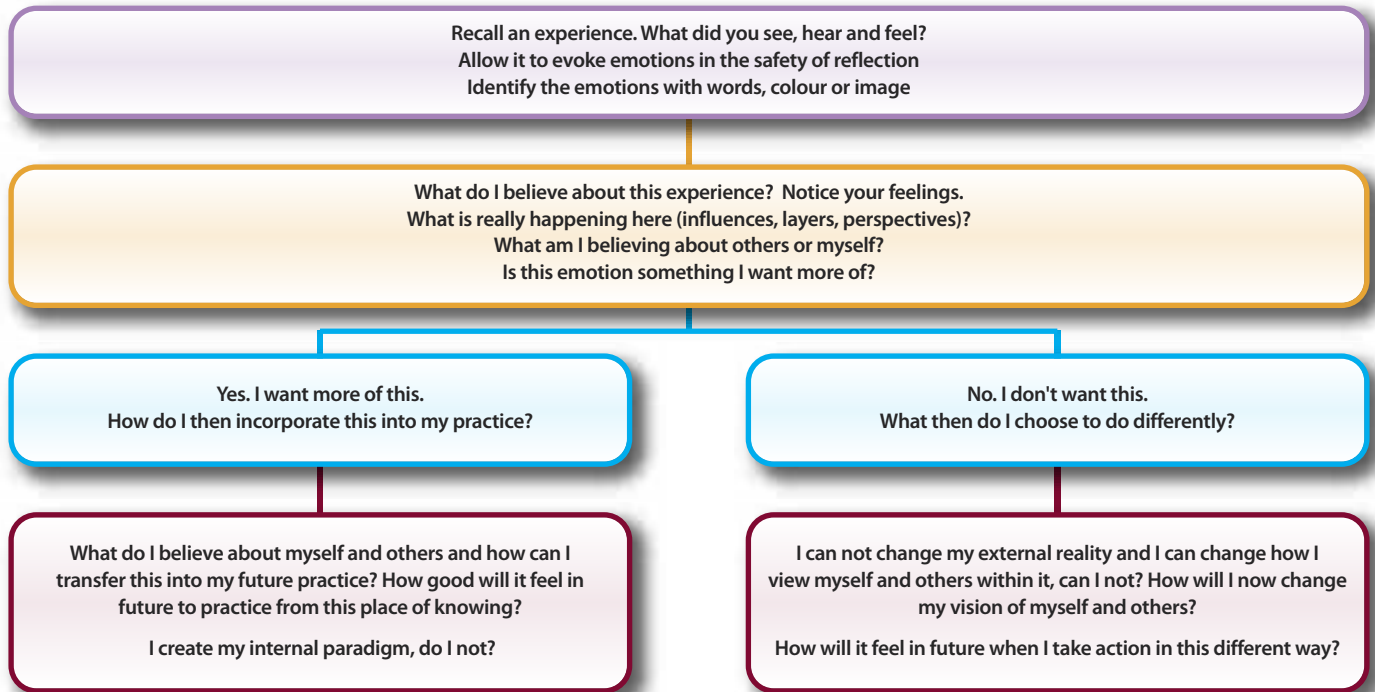
The woman or her family isn't there, nor the midwife or other health professionals, so I can't offend anyone as I examine the layers and find my own meanings. When I look at the many models of 'reflection', there is always the question posed: 'what is happening here?' Holding this in the back of my mind as I paint helps me to incorporate the many layers influencing the scenario. With each layer uncovered, somehow my mind is loosened further into a greater perspective. As the perspective is widened, my judgements and frustrations become softer. The softer they are, the more willing I am to approach them in future with an open mind and more importantly, an action point, a choice. In this instance, my own commitment is particularly to the antenatal period, creating trust, giving consistent advice and encouragement. My intention is to facilitate support that results in confidence, commitment and dedication. The following is a model for reflection using art, emotion and movement of thought into action, for those who choose to have a guided process. In sharing this process I acknowledge my deep gratitude for the insights and strategies of the More to Life programme developed by Dr K. Bradford Brown and Roy Whitten; and for the processes learned during my Neuro-Linguistic Programming training with Patricia and Richard Greenhough.

I will now attempt to explain reflection through art in its simplest form. Essentially, experience evokes emotion. Because thinking is essentially the process of asking and answering questions, the question I pose here would be: 'is this emotion desired or undesired?' followed by 'do I want more of it or do I want to change it?'

If I want more of it, 'how can I create more of that?' If I want less of it, something needs to change, 'how can I change it?'; either the circumstance or the way I feel about it, as depicted in Figure 1. I believe we are under the illusion that we can change our external reality when in fact the internal is the only thing we can change.

Those of us who have been through the earthquakes (in Christchurch, New Zealand) know only too well that the only thing we have control of in life is how we feel about things. Even if we don't like it, the earth is going to keep moving. Do we leave the environment, do we continue feeling the way we feel or can we completely embrace the concept that we have no control over our external reality? If we stay, how do we choose to be with it? Why? How we feel about things determines how we react/behaviour. How we interpret our reality creates the paradigm in which we work.

Figure 1



An example of this is when Robbie Davis-Floyd, referring to her work on the technocratic, humanistic, and holistic paradigms of childbirth (2001) said to our student group, *'the single most important aspect of midwifery care is the paradigm in which the midwife works'*, and I could barely breathe. For me it was like understanding the difference between a meteorologist who likes the technology of rain radars or one who continues to have a deep respect for the sun and the wind itself.

There is a difference between birth-related art and reflective art, one that is usually understood in hindsight. If, at the completion of an art piece, I can say to myself, 'I started in this place, reflecting on an aspect of my experience. I am now in this place, a place that serves me well. I have new realisations about myself and others and this is how I grew through this piece', this is how I define reflective art. When I pick up a brush and paint, it is usually because I'm having a tantrum about something I've seen. I'm therefore experiencing emotions of anger, frustration or judgement and if that same level of emotion exists upon completion of the piece and my intention

was reflection, I know there is more reflection required. Even if that reflection is only acknowledgement of reality being simply as it is and to notice the relief that follows. When the frustration turns into realisation or action, for me it's like the bottleneck before the flow.

Oh, I long for the canvas, the paints, and the time to reflect. It's meditative, hypnotic and an utterly soulful inward journey. I wish it was a compulsory subject and we would simply have to paint, draw and write. Meanwhile, we madly write essays and skip along to placements, anticipating extraordinary experiences that come hand in hand with working with women and birth and when there is more time, there will be more paint.

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KeiShana Coursey

KeiShana Coursey is a midwifery student, Neuro-Linguistic Programming master practitioner, life coach, mother, artist and freelance writer. She is passionate about the holistic paradigm of childbirth and the powerful interconnectedness of body, mind and spirit. Her writing is inspired by a fascination with the potential for health professionals to facilitate transformative experiences whilst working with women. KeiShana most enjoys seeing others realise they are far more than they ever thought possible, and is herself committed to a lifetime of learning. She is currently working to complete her Bachelor of Midwifery at the Christchurch Polytechnic Institute of Technology, New Zealand.

Ask Away



...gives you the opportunity to ask us questions.

Responses from our team of experts will be published regularly.

Q: I am a newly qualified midwife working in a large hospital and I really struggle to organise my workload and keep on top of things, especially when it's busy. Do you have any tips or suggestions?

A: You are not at all unusual in struggling with workload management as a newly qualified midwife, so do not despair! We are practising in extremely busy and demanding times and we all need to hone our organisational skills. The following may help:

- At the start of the shift, make sure that the midwife in charge is fully aware of the extent and limitations in your clinical competencies and skills. Also highlight to her any areas you wish to gain experience in. For example, you may need suturing or cannulation experience. This will assist the coordinator in allocating work appropriately and ensure that your own skills are put to good use with opportunities for further development.
- Always write things down. This applies right at the beginning of your shift and should continue throughout. You may think you will remember something several hours later but with all the distractions of a busy shift you may easily forget something important. It may also help to have one of those multi-coloured biros in your pocket to highlight in different colours things that are most important.
- Plan your work. Before you 'hit the ground running' make sure you are clear about your priorities.
- Introduce yourself to the woman/women you are caring for, and establish their priorities, so that everyone is 'singing from the same hymn sheet'.
- Don't make promises you cannot keep. If you are pushed to give an estimated time for accomplishing a task (for example, discharging a mother and baby) make sure it is realistic. It is always better to give a longer estimate in the first place than go over your estimated time by several hours — this avoids a lot of frustration and grief all round (not to mention complaints!)
- Enlist the help of the woman as an 'aide-mémoire'. For example, if you need to carry out a task at a specific time — such as a set of baby observations — ask the woman to ring the call bell to remind you if you have not returned by an agreed time. The woman is much more likely to remember than you are (it is her precious baby after all!)
- Learn the art of delegation. Maternity support workers and care assistants are often under-utilised for appropriate clinical tasks and would generally much prefer to be asked to do something 'woman focused' rather than just making beds or stocking up (which I appreciate also have to be done at some stage). Establish what their competencies are and exactly how they can help you (and always remember to say 'thank you' for a job well done).
- Make sure you know where everything is kept and how things work. This will cut down on having to ask repeatedly for help.
- Try to be organised and work efficiently. Never make unnecessary trips within the clinical area to collect individual pieces of missing equipment. For example, if you are going to carry out an initial examination of the baby and find that you do not have a tape measure in the room, before dashing

out to get one, consider what else you will need for the examination and whether or not you already have it to hand. If anything else is missing it can be collected at the same time. This saves your legs and your sanity! There is a lot of useful 'Productive Ward' information available on-line from the NHS Institute, see: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html.

- Do not get distracted. If you are interrupted whilst doing something and asked to do something else, consider whether or not it is essential to discontinue your current activity. If not, write down what else it is that you are being asked to do and give a realistic estimate of when you will be able to do it. Completing one task before moving on to the next is always more time efficient.
- Take a few moments to 'take stock' every hour or so. Review your documentation and ensure you are clear about your immediate priorities as the shift progresses.
- Be assertive and don't necessarily agree to do everything you are asked. Effective communication with your colleagues and the women you are caring for in this respect is vital.
- Look after yourself — even a short break is better than no break — and never be a martyr (or think you are superwoman!). If you are offered a break, then take it, even if you would ideally prefer to take it later (for example on nights). Be proactive regarding breaks: good communication with the coordinator to let her know when you can create a 'window of opportunity' often pays dividends — it is one less thing for the coordinator to think about.
- Do not hesitate to ask for help and advice from a senior colleague if you are unsure. It is always better to ask rather than carry out a task that is beyond your competency and it saves time (and is much safer) in the longer term.
- Do not complain to the wrong person. If you are struggling with your workload tell the midwife in charge. It is no use telling the woman you are caring for that you have not had a break for ten hours and there are not enough midwives on duty. This really is not the woman's problem, it is the coordinator's problem and if she cannot deal with it then the on-call manager or the supervisor should. Always escalate any concerns appropriately!
- Ensure you have adequate support and supervision from your colleagues and your SOM. Reflection is a powerful tool in maintaining your sanity and honing your clinical and organisational skills.
- Maintain a positive 'can do' attitude as well as a sense of humour. Remember, you are in a powerful position in terms of setting the tone and atmosphere for the women you are caring for — a smile (even if you're not feeling inwardly smiley) goes a long way to ensuring a pleasant shift for everyone. At the end of the day, you will feel much better about yourself and your work if you have been nice to people (and women will be much more forgiving of any little 'mistakes').
- Finally, do not expect to be the most super-efficient midwife overnight. Give yourself time to develop your organisational skills and do not be too hard on yourself — you will get there in the end!

Answered by Julie Frohlich – Consultant Midwife and Supervisor of Midwives, Guy's and St Thomas' NHS Foundation Trust

Visit Ask Away online: www.midirs.org/em



update on:

Positions for labour and birth

MIDIRS Informed Choice Team

Throughout history, across countries and cultures, art and sculpture have immortalised women in various positions during labour and childbirth. These images show us that where women have the autonomy to adopt a range of positions and are not medically influenced or directed otherwise, they will instinctively seek those positions that afford them the greatest degree of comfort and relief from the pain of childbirth (de Jonge & Lagro-Janssen 2004). In contrast to 'pathological' pain, the pain associated with labour and birth is often described as being a 'positive' pain (Waldenstrom *et al* 1996) which can, to some extent, be affected by how much the woman can be in control of managing it (Mander 2011). Thus, women in labour often instinctively need to remain upright, move around, and adopt a range of positions that ease their labour pain, rather than lie on a bed (MIDIRS 2008).

This update focuses on positions for labour and birth. We recommend that it is read in conjunction with *Informed Choice* leaflet no. 5 'Positions for labour and delivery' which is available at www.infochoice.org.

NB At the inception of *MIDIRS Informed Choice* leaflets, use of the term 'delivery' was commonplace. However, given the impetus for normality in childbirth, MIDIRS feels that this term is no longer appropriate and so this *Informed Choice* update will refer to positions for labour and 'birth'.

Search strategy for positions for labour and birth

The scope of this review focuses on women's positions in labour and birth. It includes women's choice of birth positions as part of pre-birth discussions, access to, and use of, upright positions and birth aids during labour, as well as general changes to the UK birth environment. The literature used comprises mainly original research and systematic reviews published since the last *Informed Choice* update in 2008. However, discussion papers have also been included that explore why women are still not being supported to adopt an upright position in labour. Existing information on key outcomes affected by maternal position has not substantially changed since the last

review (MIDIRS 2008). Overall, the studies that have been identified are of interest because they use the evidence base for upright positioning and mobility during labour, and explore the positive and negative factors of its use in clinical practice.

Historical background

Pain during labour and birth often prompts women to instinctively adopt a range of positions that offer them the greatest relief and comfort, although the freedom to do this can be affected by the birth location. Where the majority of maternity services are located within the facilities of acute hospitals there is a tendency to link labour with illness and the need to use a bed (Newburn & Singh 2005). When the bed is prominently located in the centre of the room and is the most conspicuous feature of that environment, this assumption gains further impetus. However, when women labour at home or in a less medicalised environment, they are frequently observed to follow their bodies and instinctively adopt a range of positions, stay upright and mobilise (MIDIRS 2008). By doing so, women can encourage the normal physiology of labour and birth, optimising their pelvic diameters, using gravity to enhance uterine contractions and fetal descent, and safeguard the perineum (Fahy & Hastie 2008, Romano & Lothian 2008, Buckley 2009, NCT 2009, Schmid & Downe 2010).

Existing knowledge

Research studies into the outcomes of maternal position in labour and birth vary in quality and many are methodologically poor, so their findings need to be interpreted with caution. Despite this, the only negative outcome reported is increased maternal blood loss; positive outcomes include a shorter second stage of labour, fewer instrumental births and reduced analgesic use (Gupta *et al* 2004).

What's new?

Choice in birthing positions

A Cochrane review (Lawrence *et al* 2009), comprising 21 studies and a total of 3706 women, assessed the effects of encouraging women to assume different upright positions (ie walking, standing, sitting, squatting, kneeling and 'all fours' (hands and knees)) versus recumbent positions (ie supine, semi-supine and lateral positions) during the first stage of labour and examined the effect of maternal position on labour duration, mode of delivery and various maternal and neonatal health outcomes.

The review found that women randomised to an upright position, as opposed to being recumbent during the first stage of labour, experienced labours that were approximately one hour shorter in

duration (MD -0.99; 95% CI 1.60 to 0.39). There were no differences between the groups as regards the uptake of opioid analgesics; however, women randomised to upright groups were significantly less likely to use epidural anaesthesia (RR 0.83; 95% CI 0.72 to 0.96; $P = 0.01$). There were no statistical differences between the 'upright' and 'recumbent' groups in terms of labour duration for the second stage, mode of delivery, and other maternal and neonatal health outcomes. It should be noted however that none of the studies made comparisons between different upright and recumbent positions, and neither did they offer much evidence in terms of women's satisfaction with positions used and overall birth experience. Lawrence *et al* (2009) concluded that mobilisation and upright positions during the first stage of labour reduce labour duration without increasing clinical intervention or negative health outcomes for mothers and babies.

Existing evidence identified a reduction in the reporting of severe pain during the second stage of labour for women using any upright or lateral position as compared with women lying on their back during labour (Gupta *et al* 2004, Lawrence *et al* 2009). Further research is planned by the Cochrane Pregnancy and Childbirth Group to explore the extent to which the positions adopted by women, as well as their mobility during labour, affect their perception of pain (Jones *et al* 2011).

The role of the midwife is key if women are to be supported to adopt positions that are instinctive rather than conventional when they are in labour. De Jonge *et al* (2008) conducted six focus groups with a purposive sample of 31 Dutch primary care midwives to explore a range of factors that might influence their practice with regard to advising and supporting women to use different positions in labour, including antenatal education. It was found that although the midwives might favour upright positions and use both non-supine and supine positions in their practice, and the majority also used birthing stools, they also reported often assisting women to birth in the supine position. There was a range of practices with regard to when the midwives discussed positions in labour and only one midwife routinely discussed birthing positions in the antenatal clinic. Practitioners' preference



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for birthing positions was influenced by their pre- and post-registration experience, their knowledge and skills, and practice routines. All participants indicated that they were frequently prepared to sacrifice their own comfort to support women's positioning choices (de Jonge *et al* 2008).

The same researcher also explored women's choice of birthing positions in a large retrospective cohort study involving 665 low-risk women who received midwife led care (de Jonge *et al* 2009). Women were surveyed about their birth position for the second stage of labour through a postal questionnaire sent out three to four years after they gave birth. While the key findings from this survey were that the majority of woman pushed and gave birth in the supine position, these data needs to be treated with some caution as the delay in data collection affects both the recall of the women and its application to current clinical practice.

Access to, and use of, birth aids

Recent studies on the use of birth aids are limited with only a couple of studies exploring access to, and use of, birth stools. Thies-Lagergren & Kvist (2009) undertook a small feasibility study (n=68), ahead of their full-scale randomised controlled trial (RCT), to test the primary hypothesis that birthing on a birth chair (the BirthRite® seat) would reduce the number of women experiencing a vaginal instrumental birth. Outcomes of interest were oxytocic augmentation, length of second stage, perineal trauma and oedema, maternal blood loss, haemoglobin level, neonatal Apgar scores, umbilical cord pH and admission to NICU. The initial feasibility study included only 68 women, 34 randomised to the intervention and 33 to the control group (NB one woman regretted participation after randomisation to the control group). The initial analysis found no statistically significant difference in the number of instrumental births between the experimental group (n=4) and the control group (n=7) (OR=0.50; 95% CI=0.14-1.80) with the other key variables showing no differences apart from a slightly reduced incidence of perineal trauma (Thies-Lagergren & Kvist 2009).

Following on from their feasibility study, Thies-Lagergren *et al* (2011) conducted a larger RCT to test the hypothesis that in nulliparous women the use of the birthing seat during the second stage of labour decreases the number of instrumental births, which may then counterbalance the increase in perineal trauma and maternal blood loss. One thousand and two Swedish women were randomised to either deliver on the birth chair (experimental group) or in any other position (control group). Of these 1002 women, 973 achieved spontaneous onset of labour; 800 had normal vaginal births; 150 had instrumental births and 52 had emergency caesarean sections. Data analysis found there were no statistically significant differences regarding instrumental births or perineal tears; however, women using the



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birth seat had an increased blood loss of between 500-1000ml (Thies-Lagergren *et al* 2011).

The final paper in this section is a retrospective case note audit (n=31) from Australia (Bayes 2011), which arose from an increasing number of low-risk women giving birth in the lithotomy position at a maternity unit in Western Australia. The primary outcome audited was the incidence of perineal trauma involving the anal sphincter; however, additional data included analgesia used, length of second stage and recorded rationale for lithotomy position.

In 18 of the 31 cases reviewed, the woman's obstetric risk profile changed during labour; 10 of these 18 women experienced delay in the second stage and this was why lithotomy was used. There were concerns about a non-reassuring fetal heart rate pattern in the remaining eight women. For all 18 women, transfer into lithotomy proceeded preparation for an instrumental birth; however, all 18 women achieved normal births. In 12 cases (39%), there was no documented indication for transfer into lithotomy position. The incidence of perineal lacerations were significantly increased amongst women birthing in lithotomy ($P=0.002$) (Bayes 2011).

The changing birth environment

On several occasions in this update, we have had cause to link together women's choice of positions in labour and the environment or location for the birth. Where the preceding studies have looked at positions in labour with regard to measurable outcomes in terms of morbidity, there have been other publications that have explored psychological aspects of how the environment might affect the woman's experience of pain in labour. Lepori and colleagues (2008) discuss these aspects as part of midwives' guardianship of the birthplace

(Lepori *et al* 2008). The authors emphasise the significance of the *mindbodyspirit* experience of childbirth and how individuals experience any environment through at least three bodies:

- The '*moving*' body needs space and freedom to move, walk, stretch, kneel, lean, squat, be still, stand and follow the body
- The '*feeling*' body requires soft yielding or firm, supportive surfaces and different textures; the correct temperature; to be touched/not touched; immersion in water and, needs to feel safe, protected, loved and respected
- The '*dreaming*' body responds to colours, images, nature, soft curves (as opposed to angular structures), and may prefer darkness or a dimly lit environment. Because the dreaming body needs to remain focused the avoidance of harsh lighting, noise and stimulus is important in minimising distraction (Lepori *et al* 2008).

These are interesting concepts which possibly resonate with many midwives from their own observations of women's preferences for the environment around them, even when these are fairly conventional hospital rooms. Historically, hospital birthing rooms have been planned according to a pathological concept of childbirth, which views the bed as the focus of the room and the sole item of furniture that women can use for their labour and baby's birth (Lepori *et al* 2008). The authors point out that women who are empowered to give birth naturally (without clinical intervention) are less interested in the minutiae of what the environment looks like, than in what it offers them in terms of useful space and to move freely (see Box 1).

Summary

The World Health Organization (WHO) advises against women being recumbent or supine for long periods during labour or when giving birth, advocating that health care professionals should encourage women to be more mobile while adopting those positions that afford them the greatest comfort and relief

(Lavender & Mlay 2006). Although maternity units claim to offer women an informed choice to adopt those positions in which they feel most comfortable, in reality, the majority of women still appear to end up labouring on a bed, often in a recumbent or semi-supine position (Healthcare Commission 2007, Dodwell 2009). Where births predominantly take place in hospital labour rooms with a bed occupying the focal position, it is only logical that most women assume this is where they should be, and automatically adopt a 'patient' role. Women tend to believe this is expected of them both culturally and socially. If this trend is to change, it is essential that more attention is paid to the environment where labour and birth takes place. This also requires that women receive advice and support from practitioners who are knowledgeable about the research evidence on upright and alternative positioning options for labour and birth.

We noted earlier in this review that 'new' research in this area is limited; this is logical when the existing evidence provides guidance on positions for labour and birth that demonstrate benefits for women. Most of what has been found reflects poorly on the implementation of this evidence within UK maternity services (Newburn *et al* 2011), which is interesting in relation to aspects of informed choice. Unless midwives inform women about the known outcomes associated with the various positions used for labour and birth, it is unlikely that practices will change. Not informing women about the adverse effects of labouring while lying down for long periods or being semi-recumbent/supine for birth, suggests poor professional knowledge of the research evidence and current national clinical guidance for intrapartum care (NICE 2007). While some maternity services have transposed this evidence to make ground-breaking changes to their birth facilities and their approach to labouring women, this does not appear to have been adopted nationally. It would seem that more rigorous efforts are needed to raise the profile of informed choice in this aspect of midwifery care.

Box 1: Birth environment

Women '...do not need particular colours, or beautiful furniture that reminds them of their homes. They do not need a homey atmosphere so much as a space in which they can move around and change position whenever they wish to. They need a space in which to express themselves, in which to wait; they need the space-time to let it happen. The only thing they really need is not to be forced into a particular position. Even pain dissolves with movement; pain-killers are a consequence of stillness' (Lepori et al 2008:100).

For childbearing women, this philosophy needs to be transposed into a birth location that offers them freedom of movement and the ability to choose and control their level of comfort and ease. Lepori *et al* (2008) recommend that this includes access to a range of fittings and supportive aids that help to meet women's needs during labour and birth. These include: bars that women can hold onto; benches at various heights that they can rest their elbows against while in a kneeling position; soft fabric ceiling ropes that they can grip to help relieve pelvic tension; moveable birthing stools, floor mats and birth balls. Given the analgesic benefits of immersion in water, its buoyancy and supportive nature in facilitating women's ease of movement, it is also recommended that a pool is available in every birth room. In the UK, NCT has been proactive in trying to raise awareness of the importance of the environment for birth (Singh & Newburn 2006) and in producing an audit tool by which maternity care providers can assess their facilities for women using their services (NCT 2003).



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This article concludes the current Informed Choice update series within *Essentially MIDIRS*. From April 2012 we will be bringing you a brand new series of articles and introducing our new heroine, Sandra...



Kate Pearson © MIDIRS

midirs diary

Winter/Spring 2012

Keep up to date with a selection of useful events and study days

Friday 10th February

Teaching Active Birth

Liverpool, UK | £85 | 07773 42474 |
www.nct.org.uk

Monday 13th February

Teaching Active Birth

Newcastle, UK | £85 | 07773 42474 |
www.nct.org.uk

Saturday 18th February

Annual Women's Health Update

Sydney, AUS | £see website | +61130 079779 |
www.healthed.com.au

Wednesday 22nd – Friday 24th February

Breastfeeding & Lactation Management for Neonatal Staff

London, UK | £390 | 0844 801 241 |
live.unicef.org.uk

Friday 24th February

Babywearing Peer Supporter

Cardiff, UK | £135/£150 | 03008 001471 |
www.schoolofbabywearing.com

Saturday 25th February

Prenatal and Birth Work

Stroud, UK | £80 | 01453 751816 |
www.birthwithspirit.co.uk

Tuesday 28th February

Enabling Mothers to Breastfeed for Six Months

Manchester, UK | £85 | 07773 42474 |
www.nct.org.uk

Tuesday 28th February – Friday 2nd March

Management of the Labour Ward

London, UK | £491.40-£705.60 | 02077 726200 |
www.rcog.org.uk

Wednesday 29th February

– Thursday 1st March

Project Management

London, UK | £405 | 0844 801 241 |
live.unicef.org.uk

Friday 2nd March

Teaching Active Birth

Manchester, UK | £85 | 07773 42474 |
www.nct.org.uk

Saturday 3rd March

Babywearing Peer Supporter

Exeter, UK | £135/£150 | 03008 001471 |
www.schoolofbabywearing.com

Sunday 4th March

Using Slings for Labour & Birth

Frome, UK | £45 | 03008 001471 |
www.schoolofbabywearing.com

Tuesday 6th March

Breastfeeding: Working it Out Online (Programme 1)

Online | £see website | +61398 850855 |
www.breastfeeding.asn.au

Tuesday 6th March

What do you Tell a Pregnant Woman about Alcohol?

Manchester, UK | £free | 02084 585951 |
www.nofas-uk.org

Wednesday 7th March

Enabling Mothers to Breastfeed for Six Months

Edinburgh, UK | £85 | 07773 42474 |
www.nct.org.uk

Wednesday 7th – Friday 9th March

Train the Trainer

London, UK | £690 | 0844 801 241 |
live.unicef.org.uk

Friday 9th March – Sunday 11th March

Babywearing Consultancy

Peterborough, UK | £360/£400 | 03008 001471 |
www.schoolofbabywearing.com

Friday 9th March

Pregnancy and Complex Social Factors

London, UK | £see website | 02077 726459 |
www.rcog.org.uk

Friday 9th March

PROMPT: Training the Trainer

London, UK | £see website | 02077 726468 |
www.rcog.org.uk

Tuesday 13th March

Breastfeeding: Working it Out Online (Programme 2)

Online | £see website | +61398 850855 |
www.breastfeeding.asn.au

Thursday 15th March

Auditing Practices to Support Breastfeeding

London, UK | £250 | 0844 801 241 |
www.unicef.org.uk

Tuesday 20th March

Supervisors of Midwives Roadshow

Belfast, UK | £free | www.nmc-uk.org

Friday 23rd March

Supporting Parents through Pregnancy Loss and the Death of a Baby

Buckinghamshire, UK | £99 | 01494 568910 |
www.eventbrite.co.uk

Wednesday 11th April – Sunday 15th April

Midwifery Today Conference: Skill, Wisdom, Culture, Love

Harrisburg, USA | £see website | +11541 3447438 |
www.midwiferytoday.com

If you would like us to consider listing your event in Essentially MIDIRS,
please submit details via the MIDIRS Midwifery Events Diary at www.midirs.org.



midirs book reviews



Connecting you to the world of maternity books

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The Natal Hypnotherapy™ Better Birth Companion

- **Effective birth preparation: your practical guide to a better birth.** Howell M. Headley Down: Intuition UN Ltd, 2009. 294 pages. £8.99. ISBN: 9781905220595
- **Effective birth preparation [CD].** 3rd ed. Natal Hypnotherapy. Headley Down: Intuition UN Ltd, 2010. £11.99. ISBN 9781905220502

The *Better birth companion* toolkit is comprised of a book and a Natal Hypnotherapy CD for birth preparation. The book is laid out into three key parts: the process of instinctive birth and the impact of fear on labour; understanding hypnotherapy; and how to use hypnosis as preparation for birth.

The author's tone is down to earth, conversational and positive about childbirth, putting the reader at ease, and is broken up with useful subheadings, bullet points and bold text. Each page also has a succinct quote on childbirth and mothering at the bottom. Throughout the book are women's personal experiences of childbirth, which are fascinating to read and help put the main content of the book into perspective. Overall, the book places a lot of emphasis on learning to trust the instinctive nature of birth and aims to equip women with confidence for their own labour. I particularly enjoyed the focus on the emotional aspect of labour, rather than the physical process.

Another excellent aspect of the book is a focus on the role of the birth partner, including acting as a gatekeeper between the birthing woman and medical staff, and the physical and emotional support a woman requires during labour.

The toolkit includes a birth preparation CD which can be used from 32 weeks onwards. I found the CD useful as a way of relaxing during pregnancy and reducing fear in the run-up to birth. I used it daily after my due date and probably twice daily when I came up to 42 weeks' gestation, before going into labour naturally. I would wholeheartedly recommend it as a relaxation technique for other pregnant women.

Used alongside the CD, the book acts as a practical workbook with space to jot down thoughts, feelings and emotions surrounding pregnancy and birth. I also found the comprehensive Appendix section of the book useful, as it contained frequently asked questions about hypnosis, an explanatory list of other complementary therapies which could be used during pregnancy and birth, and a glossary of terms.

I think the toolkit would be extremely useful for pregnant women preparing for birth, or for midwives interested in the use of hypnotherapy during labour.

Reviewed by Tasha Cooper, Assistant Editor, Essentially MIDIRS.

Why didn't anyone tell me? Collective wisdom on creating a family from conception to birth and beyond

Griffin R. Camberwell, VIC: Acer Press, 2010, 290 pages, £34.95, ISBN 9780864318787.

Author Rebecca Griffin has provided a wonderful and unique introductory text to the world of the new parent. Suitable for both parents and professionals it offers the reader a basic outline of the topic being discussed, a brief look at the issues that this raises, and then perhaps most useful of all, a collection of relevant experiences as described by a parent.

Taking Naomi Stadlen's (2004) key text *What mothers do* to the next level, this book covers all aspects of parenthood from conception and pregnancy through to birth and postnatal life. It helpfully provides this in the same format for each chapter making the book easy to follow and navigate. The focus is on the experience rather than the detail of the subject being discussed, however, should the reader wish to develop their knowledge further, over a third of the book is later dedicated to resources, references and further reading. This is also displayed in a uniform format providing contact information for Australia, New Zealand, Canada, United States, Ireland and the UK.

One of the most refreshing aspects of reading Griffin's text is that it is modern and unbiased. Unlike many books which may only have a token chapter dedicated to the experience of the father and of same sex parents, this book not only refers to the range of experiences of all parents throughout each topic, but also has regular direct accounts provided by fathers and same sex parents.

Rebecca Griffin has clearly worked hard to provide a simple, comprehensive book, which approaches the subject of parenthood from the emotional and experiential perspective. Perhaps it is because of this that occasionally it can feel that there are slightly more negative stories than positive ones, particularly when looking at pregnancy and birth. Overall though, the author's presence is not felt too often in the writing as it is made clear from the outset that the book is not aimed at providing solutions to parenting problems or opinions on birth choices. Because of this and the brief but helpful chapter about interpreting research it could also be a beneficial addition to the bookshelf of new families as they navigate their way through the early days.

With a background in mental health provision Griffin clearly wishes there to be more support for the psychological well-being of parents and even offers a

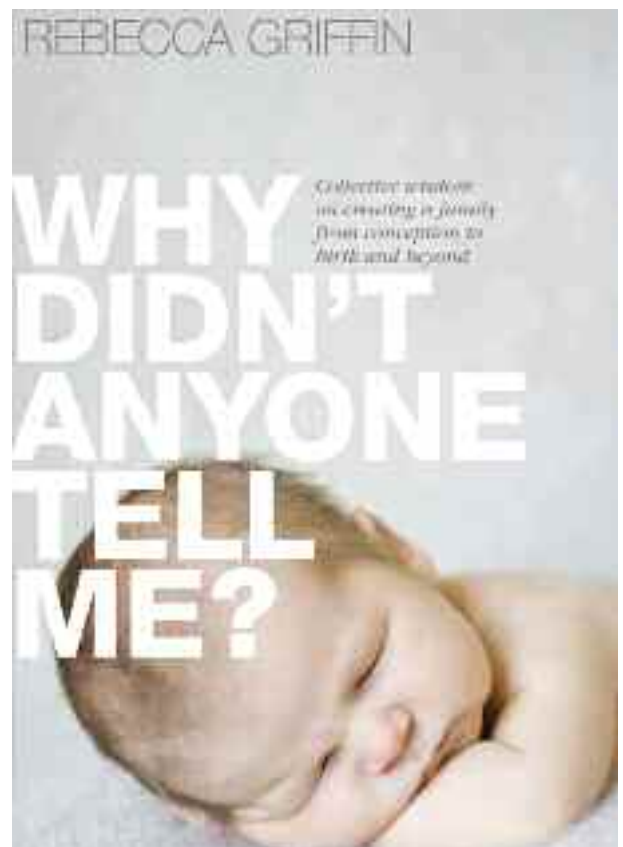
simple guide on how to start your own support group as the book comes to a close. Her aim is fulfilled by reading the stories of mothers, fathers and their families as it brings a true sense of person to each subject. By reading this text it should help those working with parents to really walk in their shoes and gain an insight into the different ways each individual can interpret and feel in a situation.

Overall this book is excellent value for money and a perfect starting point for anyone beginning a career working with families, mothers and women in general.

Reference

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Reviewed by Shona Kitchener, doula, student NCT postnatal facilitator.



Joined-up Knowing



I am here: reflective learning and a poem about a midwife, mother and a baby

Jen Leamon

Reflection has, over the past 20 years, become an integral part of professional development. My personal journey of learning about and engaging in reflection comes from engagement in practice, research, and my education and facilitating of others' learning. I remember being introduced to the concepts and theory of reflection whilst on my preparation to become a midwife teacher in the 1990s at Surrey University. During this time I found I could write reflectively. In contrast to the more traditional forms of writing where the author is invisible, I found that by being present in the first person, I was enabled to locate myself with my experiences which aided my learning from the past and planning for the future. This, as Webb (1992), Rolfe (1997) and I have identified, can enable personal and professional development (Leamon 2004, Leamon et al 2009).

I have sought to use reflection as a way to enable my continued development and to offer it as a process to help others in their professional development (Leamon 2002, 2009). I recognise that whilst I may find a personal affiliation with reflection, others may not, or those new to the process may be unsure of how to engage with it effectively. To aid this process there are many reflective tools, models or frameworks available to provide a structure or process to help people get started. For instance Gibbs (1988), Ghaye & Lillyman (1997), Jasper (2003), Bolton (2005), Moon & Fowler (2008), Scaife (2010) and Taylor (2010).

Johns (2004) adds to these resources in his suggestion that reflection can broadly be considered to fall into two forms, the cognitive and the mindful. Cognitive reflection is presented as something someone does; in contrast, mindful reflection is linked to being in '*a way that honours the intuitive and holistic nature of experience*' (Johns & Freshwater 2005:7). In considering reflection in this dynamic way, the outcome formats of the reflective process are multiple. Bolton (2005) and Taylor (2010) offer guidance and inspiration regarding many different formats of reflective activity.

One format that represents mindful reflection is the creation of poems. Jasper (2003:165) suggests that poetry can be seen as '*shorthand reflective writing*'. Within poems, authors use metaphors, imagery, rhythm and repetition of key words as devices to communicate the essence of the experience (Bolton 2005). Taylor (2010) explains how some poems she has written are not necessarily for sharing with a public audience and others are. I can empathise with this as I wrote a poem following sipping tea and eating cake with Tricia Anderson. At the time she was juggling life and the pursuit of her doctorate alongside the presence of a brain tumour. As I drove home, words about her, her passion for life, for midwifery, echoed in my head. I put them to paper and decided to share them with Tricia as a gift. I was glad she read my poem: *Tricia: You are like the moon*, before her untimely death. Along with others' tributes my poem was later shared with a wider audience (Leamon 2007).



The creation of the poem *I am here: The midwife the mother and the baby* was not something I planned or anticipated when I attended the study day: *Tell it right, Start it right* facilitated by the Down's Syndrome Association (DSA) (<http://www.downs-syndrome.org.uk/training/maternity.html>). I am not sure what I expected. What I experienced was a day that was emotive, thought provoking, engaging, and more. We were taken on a journey through details about the 'tell it right' survey, attitudes to Down's syndrome, three stories from women who had a child with Down's syndrome, hearing from a young woman with Down's syndrome, reflecting on best practice, and tips on delivering the news.

Collectively, these individual elements made an impact and when I got home I felt the need to note down my thoughts; to remember them. My fingers moved rapidly across the keyboard, I ignored the typos, the spelling mistakes and kept going. I wrote in no real order or structure about how and what the midwife can do when 'telling it right' or sharing the woman's journey having given birth to a baby with Down's syndrome and about

the presence of the child who lives with and is labelled with having Down's syndrome. Initially, a story of three parts, to represent the three voices I heard during the day, emerged. I returned to my writing, and over time that evening I settled on the following poem to reflect my memories of the day. I have given the midwife, the mother, the father and the baby names, and I have presented them in different text and colour to highlight their individual perspective and voice as I want to present them as real even if they are not.

In offering this poem to a wider audience I am seeking to do several things. Firstly by sharing my personal reflections of an amazing study day I want to communicate the messages I took away from that experience and offer it as a resource for others' reflection and possible action to attend such an event. The second reason is to offer a mindful output of reflective writing for others to read. The third reason is to promote the readers thinking and proactive action in terms of preparation regarding: what you would do if you suspected a baby you had helped a woman birth had Down's syndrome?

I am here: The midwife the mother and the baby

I wonder what today will bring
I wonder who I will be allocated to care for
I wonder how this woman will progress on her journey
I wonder what details I will find in her notes

I look, I read and all seems OK, no surprises here.
I look at Emma and she at me we share a smile, all seems OK here
I look and listen to Emma as she journeys through contraction after effective contraction
I look at the pattern of Emma's labour and feel all seems OK here

I wonder what today will bring
I wonder if the midwife will be good and kind
I wonder when this journey through labour will end
I wonder how many more contractions I need to have before I hold my baby

I know things are going well
I know Emma baby and hubby are doing well
I know I need to get things ready, for this baby is soon to be born
I know I have enjoyed sharing this journey

I am doing this
I am having our baby
I am a mixture of excited and happy and scared
I am grateful for Sue's care

I am here
I am breathing, moving and looking around
I am being looked at, touched with kindness and laid on my mum
I am here

I wonder as I look at the baby if all is OK here
I wonder about her eyes, her tone and her tongue
I wonder what on earth I do next, to say something, nothing, OK let's just take a brief break
I wonder if the paed's will agree with me, I wonder how this journey will end

I wonder how much our lives will change now she is here
I wonder about how much I feel love for her already
I wonder who she will take after
I wonder why Sue is looking at me in this strange way as she leaves the room

I have talked to others and we planned what words to say
I have information from the DSA website
I have to balance the known and unknown, positive aspects with the concerns
I have to be brave and keep calm as I change these parents' lives

I start slow, with words of affirmation that the baby looks well
I start to share what is now our concern as the paed' agrees, selecting my words with care
I start to notice the change in them as the news hits home
I start to see their lost dreams; I indicate they will not take this journey alone

I don't know now what to think or feel
I don't know what to do or say
I don't know what will happen next
I don't know how I will, we will share our news, I have shattered dreams

I am here
I am breathing, my heart is strong
I am your daughter, my journey has begun
I am here

I am your Mummy you are my daughter
I am scared of what I have heard and yet already forgotten
I am feeling guilty about my sense of loss, yet you are here
I am confused the test said I had a low risk



I am amazed by Emma and Joe and how over the last few days they have absorbed so much
I am more aware now of the needs of babies with Down's syndrome and their parents
I am grateful for the support I have had in order to support Emma, Joe and baby Lilly
I am hoping we have prepared as well as we can this family for their unknown journey

I remember a friend saying pregnancy is the easy bit being a parent is harder
I remember a friend saying being a parent is a journey into the unknown
I remember the midwife saying it can still be a journey of discovery and joy as well as challenge
I remember how I felt before I knew and I hope I will soon feel that way again

I am here
I am able to learn, it may be at a slower pace but I can learn
I am able to love, laugh, cry like you
I am here

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Jen Leamon

Throughout my 30 years as a midwife, a theme that links my experience in practice, research and education is my interest in listening to and learning from people's experience. Within my Doctorate I heard stories from mothers, midwives and students and explored how we can learn from them using different story genres. Since this time I have with my colleagues and students at Bournemouth University developed story sharing as a process to enhance learning and development via mindful and cognitive reflection. My hope and aspiration is that via sharing reflective writing with each other we can learn and enhance personal and collective midwifery knowledge.

midirs Writes



Editorial comment on issues addressed
in this month's Essentially MIDIRS...

February 2012 • Volume 3 • Number 2



Kate Pearson © MIDIRS

Comment by

Sara Wickham Editor

Love, kisses, and other ways of knowing

A few weeks ago, I carried out a literature search on shoulder dystocia for a workshop that I was facilitating. Amidst the abundance of medically-focused papers I spotted a recent article that had been published in the US journal *Midwifery Today*. In it, Sister MorningStar (2011) had taken a rather different approach to the one considered authoritative in mainstream practice. She noted that,

'The mother wants the baby out. The midwife wants the baby out and there's a billion years of nature that want it all to work. Sometimes, beyond the intellect, beyond the textbook, beyond the steps one, two and three, there is a way. The way out of somewhere stuck and the way in to peaceful freedom is what working with shoulder dystocia is all about' (MorningStar 2011:33).

Her article included a page of bullet points which (amongst other things) looked at predisposing factors, step-by-step assessment, resolution and evaluation of shoulder dystocia. Some of the points made weren't that different in essence from those taught on modern obstetric emergency courses, though some were worded rather differently. Three sentences in particular stood out for me. Once the baby is born, MorningStar suggests that the midwife should, *'...stimulate the baby, cover with kisses, cover with a dry, warm blanket and assess for primary and/or secondary apnea'* (2011:34). She later suggests that it is important to, *'...thank the mother for her strength, courage and cooperation'* (2011:34) and her article concludes with the following words:

'Do not elicit fear in a mother, no matter what is going on. Elicit her conscious

awareness and active participation. Her love for her baby has the most power and motivation to help' (2011:34).

Juxtaposed knowledges

This approach – or at least the focus on love, kisses, and thanking women for birthing their babies – is very unlike those embedded in UK emergency skills courses, Cochrane reviews or NICE guidance. Although just to doublecheck I wasn't wrong in making that claim, I did another literature search on the terms 'love' and 'Cochrane' in the *MIDIRS Reference Database*. I was quite excited when I got five results, but less so when I realised that three of them were citing an article by Ina May Gaskin (2001) which was entitled 'The dark side of US obstetrics' love affair with misoprostol' and one had picked up *MIDIRS Midwifery Digest* Editor Sally Marchant's



remark in her commentary on Heazell *et al* (2008) that she loves reading feedback from questionnaires. In fact, the only one which used the concept of love in a similar way to Sister MorningStar was the 2007 Cochrane review on early skin-to-skin contact for mothers and their healthy newborn infants (Moore *et al* 2007), which looked at maternal affectionate love and touch during observed breastfeeding. Love, it would seem, isn't quite as all around us as Hollywood would have us believe.

I was therefore quite delighted, just a few days later, to read Lesley Page's (2011) editorial in *Women and Birth*; 'The state of the world and modern midwifery'. Lesley wrote about the way in which our treatment of women and babies during birth can have a profound effect upon the world:

'Wherever we are in the world, putting this awareness and knowledge into action whilst at the same time respecting women, trusting them, treating them with kindness, recognising their strength and responding to them as individuals, is crucial. This approach will help us build a better world by helping that first entry into life, when experiencing care that is safe, sensitive and supportive will enable women and their partners to take the journey into family with love and not fear in their hearts. If all families started from love and grew in love with the birth of each child the world I imagine in 20 years time is safer and happier than the one we are living in now' (Page 2011:140).

The importance of love and of trusting women's knowledge is referred to in both these articles, yet this is frequently lacking in modern maternity care. How often does the word love feature in the guidelines of your local maternity unit? How many mothers in the UK are thanked for their courage in birthing their baby's shoulders? More often than not, there is a sense that it is the courageous, knowledgeable professional with their mnemonics and manoeuvres who has done all the work and, while I don't want to suggest that these things have no value, I think it is easy to forget the value of the work that is done by women, babies and families, not to mention the kinds of knowledge and ways of knowing that don't easily fit into our modern scientific approach.

"Love, it would seem, isn't quite as all around us as Hollywood would have us believe"



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In this issue of *Essentially MIDIRS*, we bring you material from lots of different ways and means of knowing. We have science, research, art and poetry. We have articles outlining and celebrating things that midwives have learned from experience, and reflection on studies exploring midwives' skills. We have in-depth critiques of reviews and research and quick glances at work published elsewhere that may interest, educate or otherwise enlighten you. There is value in inclusivity, in using a range of sources of knowledge, just as there is value in being a critical consumer of all kinds of knowledge and ways of knowing. And, old-fashioned as it might sound, there is value in not forgetting that love gets (most) babies in, love can get babies out, and – with the greatest respect to the scientific model and all its advantages – love might just be what keeps the world going round.

References

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- MorningStar S (2011). Shoulder dystocia - the perils and possibilities. *Midwifery Today* (99):33-5.
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For your portfolio...

Personal Reflective Learning Log

How to use this section: This section of *Essentially MIDIRS* has been specially designed for you to tear out and put in your portfolio, and can be used in a number of ways. Simply tearing off this page and putting it into your portfolio will evidence your subscription to a professional midwifery journal. The first box on this page lists the original articles that featured in this edition of *Essentially MIDIRS*, and you may like to use the check boxes beside each of these as a simple means of evidencing which of these you have read. The blank space alongside the original articles list can be used for notes, reflection, or for referencing other pages in your portfolio where you have included reflection upon anything you have read in *Essentially MIDIRS*. We also offer space for reflecting upon the abstracts and commentaries provided in the MIDIRS Update section and (overleaf) an exercise or puzzle which will help you think more deeply about a particular study or area of practice.

Original Articles

This edition of *Essentially MIDIRS* contained the following original articles:

- ☐ Understanding physiological breech birth
- ☐ ReView: Management of sickle cell disease in pregnancy
- ☐ Using art as reflection in practice: a midwifery student's experience of unconscious reflection, made conscious and transferable
- ☐ Informed Choice Update on Positions for labour and birth
- ☐ I am here: reflective learning and a poem about a midwife, mother and a baby
- ☐ Love, kisses, and other ways of knowing

The space on the right is provided for you to reflect on how any of these articles might relate to, affect, influence or impact upon your practice.

MIDIRS Update

Of the abstracts featured in this section, are there any articles that you plan to read in their entirety? Do any raise issues for you in relation to practice? Are there any which you feel could be usefully shared with colleagues and/or with the women and families you attend? Are there any research findings or conclusions that are in conflict with your experience and/or prior knowledge and, if so, do you plan to look at this further?



Question of the month:

This month's MIDIRS Update section featured a study (p12) which found that learning infant massage techniques helped to reduce stress levels in new fathers, and we have featured a number of other studies over the past few months that have looked at different aspects of new fathers' experiences and highlighted the need for more inclusivity. How can fathers be more included during pregnancy and birth?



Thinking about ... Normal birth

Featured Study: Edwards A, Conduit J (2011). Do women's ideas of 'normal' birth match those held by professionals? *British Journal of Midwifery* 19(11):720-722, 724, 726-728.

On p5 of this issue, we featured the abstract of a study that explored women's definitions of normal birth and how these differed from health professionals' definitions. It is not essential that you read this study in full in order to complete this exercise, but if you would like to do so and do not have access to a library, you can purchase a single copy at www.midirs.org/em.

1. Over the years, a number of terms have been used to describe 'normal' birth, some of which are listed below. Each of these terms has its place but may also have certain downsides. We invite you to think about the pros and cons of using each of the words below when describing normal birth and reflect on the words you currently use.

Normal
Uncomplicated
Natural
Spontaneous
Straightforward
2. Have you encountered other terms that you think are useful? If you were tasked with choosing the term that would be used in information leaflets and with women and their families, what term(s) would you choose/use and why?
3. One of the key themes that arose in Edwards & Conduit's (2011) study was that women's greatest source of knowledge was friends and family, yet, *'unfortunately, most of the stories the participants had heard were negative, further raising their anxieties about experiencing childbirth themselves'* (Edwards & Conduit 2011:726). Are there ways that we can address this without undermining women's relationships with their loved ones?
4. The women in this study were pregnant with their first babies. From your own experiences of working with women, do you think the findings might have been different if the researchers had asked women who had already given birth and, if so, how?

Learning, thinking and reflection

This space is offered for you to make notes of any other learning, thinking or reflection which you have recently been engaged in, whether this has been triggered by reading *Essentially MIDIRS*, attending a study day or conference, or by issues arising in practice or conversation with colleagues.

Positions available all around the UK.

We understand that you help your mums through the difficult choices they have to make by giving them well considered options and the benefit of your knowledge and experience. We aim to do this in turn with all our Midwives and because we are in the enviable position of having one of the most extensive networks of contacts with healthcare providers in the private and public sector, the opportunities we provide reach far and wide.

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