Examination of the Newborn: The Key Skills 2. The Cardiovascular System and Congenital Heart Disease

Summary

Many midwives conduct the holistic examination of the newborn prior as part of routine midwifery care. In this second article of a five-part series, consideration is given to the importance of the cardiovascular examination during the screening process. The significance of history taking, risk factors and the process of the cardiac system examination are
discussed. The prerequisite referral pathways within the newborn infant physical examination (NIPE) screening programme are explored.

**Introduction**

Screening for congenital heart disease (CHD) forms part of the systematic newborn infant physical examination, known as NIPE, within England. Assessment of the cardiovascular system is an important element in the examination but is not isolated from other aspects of the holistic examination.⁴ Early detection and diagnosis of CHD ensures appropriate and timely treatment. CHD can be described as a heart condition resulting from an abnormality of the structure or function of the heart present from birth.⁵

**Timing of the examination**

In the United Kingdom (UK), screening for CHD forms part of the NIPE, including examination of the eyes, heart, hips and testes, within male newborns. The NIPE is first performed within 72 hours of life and repeated at six to eight weeks of age.³

Early detection of CHD improves the mortality and long-term morbidity of the infant³; however there is evidence to suggest that fewer than half of all CHDs present at birth are detected during the newborn examination.⁴,⁵ Some critical and major cardiac lesions are detected in the antenatal period as part of the NHS Fetal Anomaly Screening Programme (FASP) during the 20-week ultrasound scan. The FASP target detection rate for cardiac abnormality is 50%.³
The timing of when the cardiovascular examination should take place has long been debated.\textsuperscript{4,5,6} Historically, cardiac examination was delayed for 24 hours to allow for the physiological changes within the baby to take place,\textsuperscript{7} and for duct-dependant, critical congenital heart defects to manifest.\textsuperscript{8}

The literature does not support this, hence the timing of cardiac auscultation appears to be based on custom and practice. The UK National Screening Committee (UK NSC) provides no optimal time to detect abnormalities; however it’s acknowledged that the risk of discharging babies unscreened is greater than conducting early screening.\textsuperscript{9}

Examining the newborn is critical for recognising difficulties in transition to extrauterine life.\textsuperscript{10} The newborn infant’s cardiovascular system undergoes many adaptations following birth and a single examination may not pick up all defects.\textsuperscript{6} Closure of the ductus arteriosus, for example, may not occur until two to seven days of age.\textsuperscript{11,12}

Parents and carers should be advised that their baby’s cardiovascular system is still transitioning following birth, and that it is possible that heart murmurs could be heard on auscultation, especially if these changes are still taking place around the time of the examination.\textsuperscript{13} They should be advised that the absence of a murmur does not rule out the presence of CHD,\textsuperscript{3} and must receive information regarding signs and symptoms of CHD, as well as advice regarding action to be taken if concerns arise.
Fetal to neonatal circulation

The transition from fetal to neonatal life requires closure of temporary circulatory shunts, which are the ductus venosus, ductus arteriosus and foramen ovale. At birth the clamping of the cord results in the termination of the blood flow through the ductus venosus. The result is increased systemic vascular resistance in the newborn.\textsuperscript{14}

When the baby takes its first breath, the pulmonary vessels respond to the increase in the oxygen content of the blood by vasodilation. This reduces pulmonary vascular resistance and encourages blood to flow to the lungs; blood then returns to the left side of the heart.

After birth the pressure in the left side of the heart increases, as the pressure in the right side decreases. These pressure changes force the flap of the foramen ovale to close, which forms the two separate atriums. The ductus arteriosus closes in response to increases in oxygen levels and a reduction in prostaglandins.\textsuperscript{15}

The examination

Purpose

The purpose of the cardiovascular examination is to detect life-threatening congenital cardiac anomalies. Babies may have structural defects or may simply be experiencing a delay in the transition to extrauterine life.

Incidence

The overall incidence of CHD from non-significant to major and critical lesions ranges from six to twelve per 1,000 live births.\textsuperscript{3} Critical congenital heart disease (CCHD) accounts for approximately 15–25% of these, and includes all potentially life-threatening duct-dependent conditions and conditions which require treatment within the first 28 days of life.\textsuperscript{3}
Other defects, including defects not classified as critical but requiring invasive intervention in the first year of life, are categorised as major serious CHD.

Risk factors
Congenital cardiac disease is multifactorial, hence a combination of factors is considered during assessment of the baby (see Box 1).

Box 1 Risk factors for congenital cardiac problems

- Family history of CHD (first-degree relative)
- Fetal trisomies, such as Trisomy 21
- Cardiac abnormality suspected from the antenatal scan
- Maternal exposure to viruses during pregnancy
- Maternal conditions, such as diabetes (type 1), epilepsy, systemic lupus erythematosus (SLE)
- Exposure to teratogenic drugs during pregnancy

Involving parents
Prior to any physical examination, the midwife should enquire about any parental concerns and obtain informed consent.

History
Adopting a holistic approach to the examination, a thorough history should be obtained from the maternal and neonatal health records, and discussion with parents. Factors within Table 1 should be considered.

Table 1 Aetiological factors in congenital heart disease
### Table 7: Aetiological factors in congenital heart disease

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implication</th>
<th>Examples of reluctant heart conditions</th>
</tr>
</thead>
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<tr>
<td>Chromosomal</td>
<td>Trisomy 21</td>
<td>Ventricular septal defects, atrioventricular septal defects</td>
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<td></td>
<td>Turner’s syndrome</td>
<td>Coarctation of the aorta, aortic/mitral valve stenosis</td>
</tr>
<tr>
<td>Associations with other defects</td>
<td>VACTERL association: Pierre Robin syndrome Charge syndrome, cleft lip and palate</td>
<td>Septal defect</td>
</tr>
<tr>
<td>Familial</td>
<td>Sibling: 2–5% risk of CHD Parent: 5–10% risk of CHD</td>
<td>Coarctation of the aorta, ventricular septal defects, patent ductus arteriosus</td>
</tr>
<tr>
<td>Infection</td>
<td>Rubella</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>Amphetamines, lithium, anticonvulsants</td>
<td>Ventricular septal defects</td>
</tr>
<tr>
<td>Teratogens</td>
<td>Alcohol</td>
<td>Septal defects</td>
</tr>
<tr>
<td>Maternal conditions</td>
<td>Diabetes mellitus</td>
<td>Ventricular septal defects, transposition of the great arteries</td>
</tr>
<tr>
<td></td>
<td>Systemic lupus erythematosus (SLE)</td>
<td>Congenital heart block</td>
</tr>
<tr>
<td></td>
<td>Phenylketonuria (PKU), obesity</td>
<td>Atrial septal defects, Tetralogy of Fallot, aortic arch defects</td>
</tr>
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</table>

Factor Implication Examples of reluctant heart conditions
Chromosomal Trisomy 21 Ventricular septal defects, atrioventricular septal defects Turner’s syndrome Coarctation of the aorta, aortic/mitral valve stenosis Associations with other defects VACTERL association Pierre Robin syndrome

Charge syndrome, cleft lip and palate Septal defect Familial Sibling: 2–5% risk of CHD Parent: 5–10% risk of CHD Infection Rubella Coarctation of the aorta, ventricular septal defects, patent ductus arteriosus Drugs Amphetamines, lithium, anticonvulsants Ventricular septal defects Teratogens Alcohol Septal defects Maternal conditions Diabetes mellitus Ventricular septal defects, transposition of the great arteries Systemic lupus erythematosus (SLE) Congenital heart
block Phenylketonuria (PKU), obesity Atrial septal defects, Tetralogy of Fallot, aortic arch defects A detailed history of the baby’s feeding pattern and behaviour should be taken from the parents. The midwife should also observe for the following signs of CHD (see Box 2).

**Box 2 Signs and symptoms of potential critical or major congenital cardiac abnormalities**

- Tachypnoea at rest
- Episodes of apnoea lasting longer than 20 seconds or associated with colour change
- Intercostal, subcostal, sternal or suprasternal recession, nasal flaring
- Central cyanosis
- Visible pulsations over the precordium, heaves, thrills
- Absent or weak femoral pulses
- Presence of cardiac murmurs or extra heart sounds
- Grunting
- Poor feeding
- Poor tone

**Observation**

The midwife should observe whether the baby appears and behaves as expected for its gestation. Good lighting should be used to accurately assess skin colour. Colour is best observed by looking at the lips and mucous membranes, especially in babies with darker skin tones. A healthy baby should be centrally perfused, with no evidence of central cyanosis. Assessment of perfusion is assessed by measuring the capillary refill time, which should be less than three seconds.\(^1\)

Although acrocyanosis is considered normal within the first 24–28 hours,\(^1\) central cyanosis can be difficult to detect, so
the more objective test of pre-ductal and post-ductal oxygen saturations has been adopted by some NHS hospital Trusts.\textsuperscript{10,19} However pulse oximetry is not part of the national NIPE screening programme.\textsuperscript{20} The size and shape of the chest, symmetry of chest movement, and use of diaphragm and abdominal muscles should be noted.\textsuperscript{3}

Palpation Peripheral pulses Femoral and brachial pulses are palpated for rate (110–160 bpm), rhythm and volume as an indicator of cardiac output. Upper and lower extremity pulses should be palpated simultaneously and compared. Weak or absent femoral pulses occur with low cardiac output: for example, coarctation of the aorta; whereas bounding pulses occur with a patent ductus arteriosus.\textsuperscript{1}

\textbf{Precordium}

Observation and palpation of the chest wall for vibratory sensations will detect heaves and thrills. The position of the cardiac apex determines if dextrocardia is present, whereby the apex is situated on the right side of the body.

\textbf{Liver}

The liver is engorged in the presence of CHD, when central venous pressure increases. A liver edge would be palpable well below the right costal margin in the case of congestive congenital heart defects.\textsuperscript{13}

\textbf{Auscultation}

Auscultation is best accomplished during the quiet, alert or sleep state of the baby.\textsuperscript{21} The heart sounds are described as ‘lub-dub’, the first being documented as S1, the second as S2. The ‘lub’ is produced by the closure of the mitral and tricuspid valves. The ‘dub’ is the second heart sound and results from the closure of the aortic and pulmonary valves.\textsuperscript{11}
It is recommended that practitioners should listen for a full minute at each valve (see Table 2) to ensure that two heart sounds are heard, and to rule out any additional sounds.³

Figure 1 Main auscultatory areas of the heart for examination of the newborn

Note: Botkin-Erba point not normally used by midwives as part of the newborn examination.

Table 2 describes the anatomical regions where the stethoscope is placed.

Table 2 Key auscultatory areas for examination
Murmurs

Murmurs are the sound produced by the turbulent blood flow through the chambers and large blood vessels of the heart, during the cardiac cycle of contraction and relaxation. Murmurs vary, but all murmurs should be considered as an abnormal finding and referred in accordance with professional responsibilities. Significant murmurs are usually loud, heard over a wide area and associated with other findings, whereas benign murmurs are typically short, soft, systolic, and located within the left sternal border, with no other abnormalities.

Cardiac auscultation requires detailed knowledge, practice and experience to ensure competence at distinguishing normal from abnormal; the priority being to master the recognition of normal heart sounds.

Referral

Table 3 illustrates referral pathways for CHD.
Table 3 Referral pathways for CHD3

<table>
<thead>
<tr>
<th>Screening outcome</th>
<th>Action to be taken</th>
</tr>
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<tbody>
<tr>
<td>Screen negative</td>
<td>Repeat examination at 6–8 weeks by a trained healthcare professional. Raise professional and parental awareness of signs of CHD to observe for.</td>
</tr>
<tr>
<td>Screen positive</td>
<td>Babies with screen positive cardiac findings following the NIPE newborn screening examination should be seen by a senior paediatrician with expertise in cardiology before discharge home. There are no NIPE cardiac standards. Babies with screen positive findings on examination should follow locally agreed referral processes. The urgency of referral is dependent on the clinical condition of the baby. Local NHS hospital Trusts may require practitioners to measure or repeat pulse oximetry whilst awaiting medical review following a positive screen. Consider the need for a full set of baseline observations to allow for further insight into the overall clinical condition, and/or potential resuscitation.</td>
</tr>
</tbody>
</table>

Messages for midwives

The role of the midwife is to detect deviations from the normal, rather than to diagnose specific congenital heart defects. The parents and baby should remain at the centre of midwifery care. The examination of the cardiovascular system should not be undertaken in isolation; it is part of the wider holistic examination of the newborn infant. **TPM**

**FIVE PRACTICE PARTNER POINTS**

1. Develop your knowledge by completing the ‘Screening examination of the cardiovascular’ Unit 3 of the NHS Newborn And Infant Physical Examination e-learning programme.
2. Does your local hospital Trust offer pulse oximetry tests routinely for all babies? Examine the conflicting evidence for this.

3. Develop your clinical experience by following a newborn with a positive screening outcome through the referral process – can you observe the subsequent follow-up care?

4. Consider your experience in identifying cyanosis in babies of different heritage. How can you improve this moving forward?

5. Reflect on your experience in identifying murmurs during cardiac auscultation to date. Have you been able to successfully hear a murmur?

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Transmasculine Chestfeeding

1. Infant Feeding and
Transgender Men: Considering Our Own Perceptions

Transmasculine Chestfeeding 1. Infant Feeding and Transgender Men: Considering Our Own Perceptions

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Summary

Infant feeding is a highly emotive topic; add gender as another dimension to infant feeding discussions and thoughts may get more controversial. This article, the first in a two-part series, starts to explore the idea that associating infant feeding solely with women has prevented it from being valued and leads us to consider our own perceptions of gender. It aims to assist the reader in reflecting on whether as professionals living in our current society, we can asexualise breasts and provide the guidance and support that transgender men require, whilst not eroding our personal perceptions of what it means to be a woman.

The context

Human milk is a powerful substance; if nearly all infants were breastfed worldwide, approximately 823,000 child deaths would be prevented annually. In addition to the vast physical health benefits of breastfeeding for infants, breastfed children have increased intelligence.

For those born into poverty, breastfeeding has a positive
impact on their life chances. Furthermore, breastfeeding is known to enhance mother-baby attachment, resulting from increased physical contact, eye contact and frequent response to the cues of the infant. Therefore, breastfeeding not only has positive outcomes for the mother and infant but also for society and the economy.

This knowledge has been reflected in national and global guidance for two decades; the World Health Organization (WHO) and the Department of Health (DH) recommend exclusive breastfeeding for the first six months of an infant’s life. Equipped with the wealth of knowledge surrounding the benefits of human milk, midwives need to be capable of supporting all families to provide human milk to their infants.

Whilst Western society has traditionally associated a family unit as a binary relationship of man and woman, where sex and gender are congruent, family units are changing and it has been increasingly recognised that gender (one’s own social identity), is not always reflective of biological sexual assignment at birth. Whilst acknowledging that gender and lactation can be an emotive topic, this paper aims to explore societal perceptions of transgender men chestfeeding in the United Kingdom (UK).

Chestfeeding is a neutral term that may be used by individuals to describe the act of feeding a baby at the chest with or without a tube to supplement and will be a term used throughout this paper. The term breastfeeding is used within the paper where research discussed is not exclusive to transgender or gender non-conforming individuals.

The statistics

It is not known how many people identify as transgender globally; whilst an estimation of around 25 million has been
suggested, exact numbers are impossible due to people not utilising services or not feeling safe in their society to affirm their gender.\textsuperscript{8} UK gender clinic referrals are rising, with consistently more transgender men in comparison to other genders, thus maternity services may care for an increasing number of transgender men gestating.\textsuperscript{9} 

Whilst statistics of transgender men accessing UK perinatal services are not available, the instigation of Gender Inclusion Midwives within the National Health Service (NHS)\textsuperscript{10} and promotion of inclusive midwifery care\textsuperscript{11} make it apparent that this is a regular occurrence in the UK, and therefore some transgender men will be chestfeeding. 

Physiologically, for some transgender men, chestfeeding is not an option due to the type of top surgery they have had; there may be no mammary tissue, minimal development or a lack of tissue on which to latch.\textsuperscript{7} An in-depth exploration of the physiology and psychological impacts are beyond the scale of this paper. 

\textbf{Breasts and sex} 

The International Lactation Consultant Association report on inequity in breastfeeding\textsuperscript{12} has highlighted that for those identifying as Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual and/or Ally, plus noncisgender and non-straight identities (LGBTQIA+), breastfeeding is not normalised and care is inequitable. 

This is reflected in breastfeeding literature that mirrors the societal assumption of the normal binary cisgender family.\textsuperscript{6} Therefore, consideration needs to be given as to why Western society, such as the UK, at present does not view transgender men chestfeeding as ‘normal’. Despite the anatomy being underdeveloped, males do have the ability to lactate.\textsuperscript{13}
However, in zoological taxonomy, breast anatomy is associated with the female sex of mammals.

It has been suggested that this gave women value as it highlights their uniqueness in reproducing and providing nutrition to an infant.\textsuperscript{14} Alternatively, it could be argued that breastfeeding has been portrayed as a solely feminine task as women are not valued in a patriarchal society; if breastfeeding were more highly valued, then perhaps society would not just view it as the role of women, or a specific sexual difference, but men would find a way to own it too.\textsuperscript{13}

If this viewpoint were correct and breastfeeding were valued, then hypothetically the gender identity of the parent who chooses to feed their infant human milk would be of no concern to society, as there would just be relief that the infant was receiving the benefits of human milk. However, statistics suggest that breastfeeding is not valued in the UK; the Infant Feeding Survey 2010 states that only 34\% of infants in England were being breastfed at six months old.\textsuperscript{15} Whilst Palmer\textsuperscript{16} emphasises that breasts have been sexualised, Brown\textsuperscript{17} proclaims the dual function of breasts, as both sexual stimuli and for nutrition; a viewpoint replicated in modern culture, such as in the poetry of McNish.\textsuperscript{18}

The emphasis on breasts as sexual prevents a different perspective on a historically female task, but when regarded differently breastfeeding actually reveals how unstable the
notion of binary gender is. Thus, where society has ostracised transgender men for chestfeeding, it needs to be considered if the negativity is heightened by the association of breasts and sex, where instead the focus should be nutrition and comfort for the infant.

Can you reflect upon your personal thoughts about whether society would value breastfeeding if it was not solely associated with women?

**Lactation and womanhood**

A study led by a transgender man interviewed both 22 transgender men who had birthed, and a team with experience of caring for transgender people. Whilst the method of convenience sampling was a potential limitation, it was appropriate for the participants sought, and results were enhanced by the individuals deriving from a variety of nations. Five participants reported mammary tissue was a utility with an intended purpose, both nutrition for the infant and a way of promoting attachment, with some stating top surgery could be completed after childbearing.

This is also reflected in the case studies, where in addition to utility, transgender men reported chestfeeding provides the best nutrition and therefore its provision is an expectation of a parent. It could be hypothesised that increased coverage of chestfeeding in the media could compound the realisation to the general public that breasts are more than sexual components; they have a profound intended purpose of feeding and nurturing the future generations.

This could have positive ramifications for breastfeeding rates. However, case study findings would suggest it is not just the public that has difficulty asexualising breasts, but healthcare professionals too. One individual stated they did not disclose their gender identity during childbearing,
believing that professionals would not be able to separate lactation from womanhood. The inability to disentangle pregnancy and lactation from the woman is reflected in guidelines.

The World Professional Association for Transgender Health (WPATH) Standards of Care\(^2\) state the importance of reproductive health discussions prior to gender reassignment surgery, but transgender men lactating is not incorporated as part of this discussion.

Participants in MacDonald et al.\(^7\) did not instigate discussions with surgeons around lactation as they were fearful the surgeons would not carry out masculinisation surgery. There was the belief that surgeons’ views of gender remained binary, and breasts were associated with the biological assignment of females. Some participants delayed top surgery because of the want to feed human milk, for the nutritional and bonding benefits.

However, four of the nine participants who had top surgery prior to becoming pregnant had not considered lactation at the time. Therefore, they and their future infants were let down by the standards, which do not require such discussion, but also by the professionals in not commencing it.

It may be argued by some that the absence of lactation
consideration in the WPATH Standards of Care\textsuperscript{22} is not an issue as men do not breastfeed, and therefore individuals transitioning to the male gender spectrum do not need a conversation about lactation. However, this viewpoint compounds the reality of Western society being based on a binary gender.

Conversely, it could be theorised that lactation is not included in the standards as the importance of human milk for the infant and society continues to be undermined and underestimated within high-income countries, reflected in reported breastfeeding rates.\textsuperscript{1}

It could be hypothesised that increased coverage of chestfeeding in the media could compound the realisation to the general public that breasts are more than sexual components; they have a profound intended purpose of feeding and nurturing the future generations.

Reflect on your ideas and experiences of gender – can you separate breastfeeding or chestfeeding from womanhood?

**What the guidelines say**

The lack of consideration of transgender men in midwifery guidance reflects that of lactation not being considered in the WPATH Standards of Care.\textsuperscript{22} Despite Brighton and Sussex University Hospitals publishing awareness of the need for gender inclusivity in lactation,\textsuperscript{10} Botelle et al.\textsuperscript{23} highlight that the National Institute of Clinical Excellence, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Midwives have not yet provided guidance on transmasculine pregnancy.

In relation to infant feeding, Baby Friendly Initiative standards\textsuperscript{24} and the Nursing and Midwifery Council midwifery standards\textsuperscript{25} are yet to be updated with inclusive language,
potentially showing that the changing family unit is not yet promoted by the midwifery professional body. However, this does not mean that midwives should not reflect on the societal and cultural viewpoints of transgender men chestfeeding and learn how to support them when the individual makes this feeding choice.

How do you feel about supporting transgender men to chestfeed?

Consider how professional guidance could incorporate language that is inclusive and does not lessen the importance of women in infant feeding.

**Conclusion**

In conclusion, whilst breasts have a dual function (both sexual and infant nutrition), Western society has focused on the sexual, which both devalues human milk and renders acceptance of chestfeeding in society extremely difficult. Some of these issues have been explored in this paper, but to understand it further an in-depth review of the history of breastfeeding in the UK would be beneficial. In addition, a comprehensive examination of literature exploring birth and lactation in societies where gender has historically been more fluid may enhance the discussion.

For those who do choose to chestfeed and are supported to do so, perhaps society and professionals have something to learn from the choices they make, as it emphasises the utility and purpose of mammary tissue and the importance of human milk.

Whilst the concept of gender and lactation can be emotive, to not educate ourselves as a society, as midwives and via education, about how to support transgender men chestfeeding would be a disservice to the families we care for, their infants, and ultimately the whole of society when we know the benefits of human milk on the economy. TPM
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The Aspire Study 5. Reflections On Midwifery-Led Research

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Summary

This reflection on the ASPIRE (Achieving Safe and Personalised maternity care In Response to Epidemics) COVID-19 study, the final article in this series, focuses on our experiences of undertaking research as a smaller maternity unit without a dedicated maternity research team. This experience highlighted the importance of having research resources, including informatics support. This process also highlighted the importance of listening to the voice of all stakeholders in maternity, including staff, pregnant and postnatal people, and their families.

Introduction

When we were first contacted to take part in the ASPIRE study, we were particularly excited to take part, especially as we do not have a significant research portfolio, and have not undertaken any midwifery-led research within the hospital Trust. There are many reasons for this, chief among them is that we don’t have a midwifery research team at the hospital.
I work as the Clinical Governance Lead Midwife for the division in our hospital Trust, and therefore maintain oversight of research within the division. With this in mind, it was the perfect opportunity for me to become a Principal Investigator (PI) for the first time.

Creating a research team

Firstly we needed to create and upskill a team of midwives who would be able to undertake interviews as a part of this qualitative research study. All of the midwifery team were asked if they wanted to undertake the research as bank (which is additional work on top of their regular hours), and we quickly recruited three midwives. We then worked on upskilling ourselves so that we had the appropriate skills required. This included undertaking Good Clinical Practice training, learning how to undertake interviews and how to use MS Teams for this purpose.

Rising to challenges

We encountered several challenges as we started to undertake the research. The first was that all of the staff were working on the study in their free time, working on bank. This meant that there were many instances when ‘real life’ prevented the team from working on the study, and one of the team members had to pull out early on because they could not commit much time to the study. It also meant that when the maternity department was busier, or
when members of the team were on annual leave, the productivity of the project was severely affected. I worked full-time and therefore had to schedule interviews into my existing working day, which meant that I had to play a juggling act to make sure that my day-to-day work was completed as well as the additional work being PI on the ASPIRE study.

Most of the team undertook interviews from home, which meant that they had the space for undertaking the interviews in privacy (notwithstanding the interruptions from people at the door, children and various animals!). When I undertook interviews, these were undertaken from work, which meant that I had to find a private space to ensure a high-quality interview. Space is very much at a premium in any maternity department, and I was regularly to be found in an empty side room or borrowing someone’s office for an hour or so.

Some staff members preferred to be interviewed in person, and this worked really well, still using MS Teams to record the interviews, although the interruptions soon revolved around answering bleeps and telephone calls rather than children and cats. We also learned how important it was to remain flexible, ensuring that we worked around staff members’ on-call schedules and commitments.

During the autumn of 2021 we moved to the data phase of the ASPIRE study. We moved to a fully electronic patient record in 2019, having previously used a maternity information system. Whilst this means that a considerable amount of data is available to be shared with the ASPIRE team for their analysis, it has required a considerable amount of informatics resources.

**Hearing the voice of staff**

Between our small research team, we had a very broad range of contacts, which meant that we were very successful in securing
interviews with a wide range of both senior and junior staff members. I quickly recognised how talking about their experiences during the COVID-19 pandemic became an opportunity for reflection and, at times, the interview was a moving experience for both the interviewer and interviewee.

Hearing the same difficulties from different staff members not only reinforced the importance of ensuring clear communication with staff, but also highlighted the difficulties of communicating with a diverse staff group, most of whom work shifts and many of whom are part-time.

**Hearing the voice of all pregnant people and their families**

We had learned from the experiences of other hospital Trusts who had started their recruitment and tried to proactively target patient groups that are normally a little more difficult to access.

We worked with our bereavement midwife to interview pregnant and postnatal people who had lost their baby during pregnancy, and utilised networks to access pregnant and postnatal people for whom English was not their first language.

Through our social media adverts, we attempted to directly target people who were from Black, Asian and Minority Ethnic backgrounds.
The rich information we obtained from our interviews helped the research midwives to better understand the service we provide and pregnant people’s experiences of it. Our maternity department is an early adopter for continuity of carer and was fortunate during COVID-19 to have benefited from accelerated access to community hubs from which a significant proportion of antenatal and postnatal care was provided.

Through the interviews, we listened to people’s varied experiences, both positive and negative. Whilst there was rarely a complete consensus of opinion, this highlighted the importance of ensuring we listen to and understand the voices and experiences of diverse members of our population to ensure that the service we continue to grow evolves into one which best meets the needs of all people.

**Conclusion**

This first step into research has shown us how research can bring great benefits to our maternity department, staff and the people we care for. However, it has also demonstrated the importance of ensuring there are adequate resources to undertake the research before we begin to take on more projects. This would include not just securing time for research midwives, but also for ensuring there are adequate resources within the informatics department to provide the data requested by the research team. Research is crucial for the provision of maternity care; it helps us to understand better the needs of our population and how we can develop our services to provide effective care. Building a strong foundation for research through the development of a
midwifery research team will enable us to continue to explore and expand on our knowledgebase of midwifery and maternity care provision. TPM

Acknowledgement

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Optimising Medical Births: Supporting Women Who Choose To Use Opioid Pain Relief In Labour

Optimising Medical Births: Supporting Women Who Choose To Use Opioid Pain Relief In Labour

Angela Willis – Fetal Surveillance Specialist Midwife, Great Western Hospitals NHS Foundation Trust
Supporting women in understanding their pain relief choices and administering pain relief is a key component of being a midwife in the intrapartum setting, whether facilitating a home birth, birth centre or labour ward location. There are around 615,500 births in the UK every year, with an estimated 250,000 women choosing pethidine in labour.¹ Opioid medication options for women vary by hospital, but what is the evidence for midwives to be able to holistically support women and birthing people choosing opioid pain relief?

Types of opiate pain relief available in the UK

There are three opioid-based medications open to women and birthing people during labour, depending on where they decide to have their baby in the UK. Traditionally the opioid of choice has always been pethidine, however more recently, diamorphine has been used. Diamorphine and pethidine are both intramuscular injections with pethidine administered every four hours in labour or a maximum of 10 mg of diamorphine in four hours which can be given as one dose or multiple smaller doses.²

The benefits and side effects of pethidine and diamorphine are similar. Benefits include women and birthing people feeling more comfortable with contractions, and the ability to sleep, rest and ‘switch off’ the conscious thinking mind, which can support the physiological labour process by supporting the parasympathetic system. One study found the use of pethidine in nulliparous women reduced the active labour stage compared to placebo medication.³
The effectiveness of pethidine during labour has mixed evidence overall, with the Cochrane Database of Systematic Reviews stating opioid-based medications in labour provide some comfort to women in labour, but maternal satisfaction with opioid-based analgesia remains low.\textsuperscript{4} Epidurals and water immersion, in contrast, have the highest maternal satisfaction with birth from the available research.\textsuperscript{5,6} In addition, longitudinal studies have been undertaken in relation to substance misuse in adolescence. The use of pethidine appears to have no long-term impact on smoking or substance misuse status at 20 years old.\textsuperscript{7}

A randomised controlled trial exploring the outcomes of pethidine and diamorphine found diamorphine provided improved pain relief at 60 minutes; however the average length of labour was 82 minutes longer with diamorphine.

The women who had diamorphine reported more pain overall, possibly due to the increased length of labour. There were no statistical differences between pethidine and diamorphine in neonatal side effects.\textsuperscript{8}

Opioid medications in labour have also explored pethidine and paracetamol. One small study of 80 primiparous women comparing 50 mg of pethidine to 1,000 mg IV paracetamol concluded that
the IV paracetamol was more effective at relieving labour pain. However caution should be used as this was a small study and the most common strength of pethidine is 100 mg in labour administered in the UK.\textsuperscript{9}

The most common side effects of pethidine and diamorphine are nausea and sickness. An antiemetic should be offered at the same time as the administration of the pethidine or diamorphine. In addition hydration is important during labour and isotonic drinks or light snacks can be encouraged. Caution must be utilised to ensure women do not drink too much to prevent fluid overload and hyponatraemia.\textsuperscript{10}

Measuring urine output and using urinalysis can help with decision-making regarding adequate hydration in labour. Other side effects of pethidine and diamorphine include a feeling of loss of control, hallucinations, neonatal respiratory depression and challenges with breastfeeding or chestfeeding.

The third opioid option available for women in labour is remifentanil via patient-controlled analgesia (PCA) IV infusion. The RESPITE study explored remifentanil as an alternative option to pethidine for women requesting opiate pain relief in labour.

Remifentanil is a newer class of opioid that has a much faster metabolism when compared to other opioid pain relief. This means it is shorter acting than pethidine or diamorphine, but also has a lower chance of accumulation within the body. As a result, it is administered intravenously and where women can have a dose every two minutes, provided there are no respiratory depression effects.
Due to the ethics of blinding pain relief in labour and the inability to blind the administration of pethidine or remifentanil, this RESPITE randomised controlled trial explored 401 women out of 2,950 eligible women. It needs to be acknowledged that 1,797 women did not consent to being part of the trial.

This study found only 19% of women in the remifentanil group converted to an epidural compared to 41% of the pethidine group. The caesarean birth rate between both groups remained the same at 21%, however the instrumental births were far lower at 15% in the remifentanil group compared to 26% in the pethidine group.

The spontaneous vaginal births were 64% with the remifentanil group (53% in the pethidine group), highlighting the benefits of remifentanil infusion in labour compared to pethidine or diamorphine. Instrumental birth has higher risks and if the use of remifentanil can improve spontaneous vaginal birth rates, then maternal satisfaction with birth, maternal confidence and empowerment may be improved as well as reducing maternal and neonatal morbidity and long-term health complications.  

One of the other benefits is the perception of control. If women find the remifentanil is effective, they are likely to continue using their PCA. If women dislike the side effects, then they will stop using their PCA at any stage which is a huge benefit over pethidine or diamorphine where, if the side
effects are undesirable, the half-life is two to four hours.

Remifentanil is quicker to act and is metabolised by the body much more quickly, reducing the transfer across the placenta to the baby. Side effects of remifentanil include itching, nausea and vomiting, reduced heart rate and reduced blood pressure along with respiratory depression or hypoventilation, which are medical emergencies to be aware of. Remifentanil also requires IV access for administration which may be off-putting to women who are needle-phobic. Remifentanil is only likely to be administered in an obstetric-led unit, therefore restricting the choice of place of birth when compared to pethidine or diamorphine.

The role of the midwife and safety of opioid pain relief in labour

The most common side effect of any opiate administered in labour is sedation and drowsiness, which can pose a mobility risk. This is vital when discussing pain relief options with women in the antenatal period and during labour. Women who have opioid medications will be unable to use water immersion for around two hours after administration, and with a continuous PCA, remifentanil will be unlikely to use water immersion at all.

Conversations regarding pain relief choices should begin to take place in pregnancy during antenatal classes and during the birth planning talk at around 34–36 weeks. Women should be informed during pregnancy what analgesia choices are available in their local hospital or home birth settings due to the variation between hospitals. When documenting pain relief discussions, BRAN should be utilised:

- Benefits of intended pain relief offered
- Risks of pain relief offered
- Alternatives
- Nothing (tell them what will happen if they choose
nothing right now) – women should be encouraged to ask for pain relief when they want it, rather than to be continually asked about their pain or offered pain relief as this can impact their confidence in labour.

Regular observations including heart rate, blood pressure and respiration rate are important for the midwife to monitor with any opioid pain relief, particularly with remifentanil infusion and removing the PCA button, applying facial oxygen and referring to obstetricians if maternal observations become abnormal. Naloxone is usually the reversal medication of choice if respiratory depression happens at any stage, and midwives should be aware of where it is, how to administer and what the dosage is.

TENS, Entonox, aromatherapy, massage, acupuncture and other comfort measures such as rebozo or hypnobirthing can all be used alongside opioid pain relief and a woman should also be supported with her decision if she decides she wants to transfer to an epidural at a later stage.

A recent systematic review of qualitative data on women’s experiences with pharmacological and non-pharmacological pain relief methods found mixed evidence in relation to pain relief.

Whilst pharmacological pain relief reduces discomfort felt in labour, the negative side effects can have long-lasting impacts for women. In addition the non-pharmacological pain relief options can help bonding with birthing partners and
healthcare professionals. Opiates during labour provide an opportunity to combine pharmacological and non-pharmacological pain relief options which may help improve women’s satisfaction, and help midwives in providing holistic woman-centred care.

**Supporting positioning with opioid pain relief**

Any opioid administered can aid a woman or birthing person in feeling more comfortable, and even relaxing or sleeping. Side-lying positions can aid optimal fetal positioning along with using a peanut ball to keep the pelvis open.

Whilst peanut balls have only been researched in women with epidural analgesia, these have been shown to reduce the length of labour and potentially reduce the caesarean birth rate and women who want to rest, or feel the sedative effects, can be supported in using a peanut ball in a range of positions.

Peanut balls can also be used in a supported rocking position to promote active birth and involve birthing partners. If a woman feels able to be mobile, then the midwife should encourage and support upright birth using birthing stools, supported techniques with partners, rebozo, hands and knees, beanbags, birthing beds, slings or other birthing equipment to aid optimal fetal positioning and labour progress.

Spinning babies or biomechanics for birth to support fetal positioning should also be supported, particularly if there is a delay in progress or malposition suspected from assessing the full holistic clinical picture.

**Post-partum care with opioid pain relief**

Opioid medication crosses the placenta, and therefore it is important for the midwife to observe and assess the baby immediately post-birth. Respiratory depression can be a reason for commencing neonatal resuscitation. The administration of opiate medication in labour can also suppress and inhibit the
sucking and swallowing reflex which can impact the commencement of breastfeeding, but also impact breastfeeding duration for families.

Adequate breastfeeding support for those who choose to breastfeed or chestfeed, optimum skin-to-skin contact and trying to commence breastfeeding in the first hour after birth should be supported. Hand-expressing colostrum (either in the antenatal period or postnatally) or continued skin-to-skin can aid the initiation of breastfeeding.

Opiate pain relief comes with both benefits and risks. It is vital as a midwife to provide women with evidence-based information, choices and options, and support women with ways to promote an active birth with analgesia. **TPM**

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The Asset Model: What Midwives Need To Support Alternative Physiological Births (Outwith Guidelines)

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Summary

This article presents the ASSET model, a pneumonic that highlights what midwives need to support alternative physiological birth choices, with applications to all birth choices and midwifery practice. The model was developed following the data collection and analysis of a large qualitative study that focused on how NHS midwives supported these birth choices in practice. The analysis answered three
core research questions: the processes of midwifery care, the midwives’ experiences, and the sociocultural-political influences on midwifery practice. This model can be used to inform the skills and support midwives need to drive forward the personalised care agenda.

Introduction

Full-scope midwifery was defined by the Lancet Midwifery Series\textsuperscript{1} which includes the optimisation of normal biological, psychological, social and cultural processes whilst respecting women’s individual circumstances and views. In the UK, women and birthing people have the legal right to bodily autonomy during pregnancy and childbirth, along with the right to decline care or recommendations.\textsuperscript{2} Together, midwives have the professional, ethical and legal obligation to ensure women’s birthing choices are supported and respected, including those that sit ‘outside of guidelines’.\textsuperscript{3}

However, realities in practice, where midwives are employed by institutions, can make supporting these choices difficult – issues of hyper-adherence to guidelines, fears of adverse outcomes and potential reprimands or litigation can pose barriers.\textsuperscript{4} That said, some employed midwives have successfully supported these birthing decisions, and my research study was designed to capture how the midwives delivered their care, their experiences of doing so and the sociocultural-political influencers on their practice.\textsuperscript{5}

In my study, I used the term ‘alternative physiological births’ to convey birthing decisions that went outside of local or national guidelines where women were in pursuit of a normal physiological birth.\textsuperscript{5} I recruited 45 NHS midwives who self-defined as supportive/facilitative of these decisions and collected 65 pieces of data through self-written
narratives and interviews. Here, the midwives shared professional stories of practice, using ‘real-life’ examples of delivering their care. Examples are found in Table 1. The data were analysed in several different ways, answering different research questions of the same dataset. Those findings have or will be reported elsewhere.

The purpose of this article is to share a model that was developed from across the dataset showing what midwives need to support alternative physiological birth choices, from the personal to system level. Given the Better Births’ aims of greater personalised care, this model could help inform the skills and support midwives need to practise within an authentically personalised way.

Table 1 Examples of birth decisions
<table>
<thead>
<tr>
<th>Birth decisions otherwise ‘healthy’ pregnancy</th>
<th>Birth decisions ‘complicated’ pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declining vaginal examinations during labour</td>
<td>Vaginal birth after caesarean (VBAC) home birth, birth centre or at hospital without usual monitoring</td>
</tr>
<tr>
<td>Declining postdates induction of labour (IOL)</td>
<td>VBAC (after 2 or 3 caesareans) home birth/birth centre</td>
</tr>
<tr>
<td>Declining all monitoring during labour and/or freebirth</td>
<td>Waterbirth – VBAC or gestational diabetes or twin pregnancy or breech presentation at home/birth centre or at hospital without usual monitoring</td>
</tr>
<tr>
<td>Declining recommended medical interventions (not emergency)</td>
<td>Raised BMI (&gt;35–50) home birth or birth centre</td>
</tr>
<tr>
<td>Declining antenatal screening/scans</td>
<td>Breech home birth or birth centre or at hospital without usual monitoring</td>
</tr>
<tr>
<td>Declining antibiotics and/or augmentation for GBS+ or PRSOM</td>
<td>Medical conditions such as epilepsy, diabetes, blood clotting disorder, hypothyroidism, blood-borne virus – home birth or birth centre</td>
</tr>
</tbody>
</table>

Birth decisions otherwise ‘healthy’ pregnancy Birth decisions ‘complicated’ pregnancy Declining vaginal examinations during labour Vaginal birth after caesarean (VBAC) home birth, birth centre or at hospital without usual monitoring Declining postdates induction of labour (IOL) VBAC (after 2 or 3 caesareans) home birth/birth centre Declining all monitoring during labour and/or freebirth Waterbirth – VBAC or gestational diabetes or twin pregnancy or breech presentation at home/birth centre or at hospital without usual monitoring Declining recommended medical interventions (not emergency) Raised BMI (>35–50) home birth or birth centre Declining antenatal screening/scans Breech home birth or birth centre or
at hospital without usual monitoring Declining antibiotics and/or augmentation for GBS+ or PRSOM Medical conditions such as epilepsy, diabetes, blood clotting disorder, hypothyroidism, blood-borne virus — home birth or birth centre

Asset

The mnemonic ‘ASSET’ was developed to highlight a) that midwives are the ‘asset’ for women getting their needs met and b) situates what midwives need from an individual level across to the organisational level. The model is illustrated in Figure 1 and an explanation for each section will be provided below.

Figure 1 The ASSET model

![Figure 1 The ASSET model](image)

A: Autonomy; access, assess and apply evidence-based medicine (EBM)

Autonomy The King’s Fund’ cites Van den Broeck et al’s.8 robust definition of autonomy; it refers to the need for volition, choice and freedom to organise our experiences for ourselves, and for self-integrity — being able to integrate our behaviour
and experiences with our sense of self – for example, as a provider of high-quality and compassionate care.

From my study, the midwives had variable workplace experiences. For those who had control and power over their working lives while supported to work in line with their midwifery philosophy and values, flourished. Conversely, those who were not supported or trusted to work autonomously reported negative experiences with huge impacts on their wellbeing.

Workplace cultures and politics were key influential factors. Lack of autonomy is a reason for midwives leaving the profession which needs urgently addressing for those who work in suboptimal environments.

**Access, assess and apply EBM**

Midwives in this study (who worked across Bands 5–8 and across settings community/hospital) were skilled and confident in their research and evidence-based skills. Rather than relying on the local guidelines to be the sole source of information for their practice, the midwives reported extensive wider knowledge bases and sources of information.

This included accessing, assessing (critiquing) and applying original research findings to the person in their care. It also entailed accessing wider sources of guidelines including the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and connecting to midwives working at other hospitals.

For example, where a midwife participant had restrictive guidelines, say for group B strep (GBS) and water births, they used their wider knowledge and networks to source guidelines from another hospital where those restrictions were not in place.
This had a two-fold effect, that they understood that local guidelines vary greatly, are not always based on the latest evidence, so by being aware they sought to understand the underpinning research, anatomy or physiological arguments to support effective care planning. Second, drawing on other guidelines was a tool to advocate for women’s decisions. Collectively, the midwives emphasised the research skills required to be an effective practitioner.

**S: Skills; skill development Skills in physiological birth and across all settings**

Essential for all the midwives in this study, and indeed central to the role of the midwife was extensive experience in supporting physiological labour and birth. Having expertise in physiological birth created the competence to apply those skills to the more complex alternative birthing decisions or situations.

When facing a complex alternative birthing decision such as twins in water, they referred back to their knowledge of anatomy and physiology, applying it to the current situation.

Working through a range of possible scenarios, and sometimes practical simulations, the midwives demonstrated careful planning and contingency planning based on enhancing the physiology. Such expertise was gained from actively seeking opportunities either as a student or once qualified – this may have been asking for specific mentoring, requesting to work at a birth centre or joining a home birth or caseloading team.

For others, they happened to be placed in certain areas with enabling environments for physiological birth (hospital or areas with high home birth rates or proactively used birth centres) which informed their skill development. For some, it was by chance they worked with a particular mentor who had these skills and supported the midwife participants to gain knowledge, skills, confidence and passion for supporting physiological labour and birth.
Skill development/CPD

This point relates to the role of the organisation to help midwives access opportunities for ongoing skill development in physiological birth. Hospitals must ensure these training needs and development are met for all midwives, working in all areas of clinical practice. Of particular importance now, as the continuity models are increasingly rolled out, all midwives must have physiological birth skill development.

S: Systems approach; support

A systems approach that supports full-scope midwifery

Where some of the participants worked in hostile environments, unsupportive of midwifery and women’s autonomy, this created poor working relationships with negative impacts on the midwives’ mental, emotional, physical and financial wellbeing. Working as a ‘lone ranger’ when delivering authentic woman-centred care is unsustainable, leads to distress and burnout, and for some is a leading factor in leaving the profession (which mirrors the numerous studies about why midwives leave).9,10

Conversely, some participants worked in supportive environments whereby the organisational values and culture created the optimal environment for midwives to deliver woman-centred care where women’s (alternative) choices were ‘normalised’.

These positive cultures went beyond individual midwives, teams, or areas of midwifery practice. As such, the burden of delivering woman-centred care was not placed upon one individual or team, rather, it was a shared vision and a collective responsibility across the organisation. Central to this was the valuing of women’s autonomy over organisational needs, and trust in the midwives to deliver such care.

Support Midwives need support that is accessible, timely and
restorative. From my study, sometimes this was as simple as calling a senior or consultant midwife for reassurance that the care plan was appropriate, or to brainstorm the situation which may have become unexpectedly complex.

For others, debriefing through challenging episodes of care were required. In other circumstances, support for women and birthing people’s decisions were cultivated through formalised care pathways, care planning proformas or guidelines – viewed as supportive mechanisms.

Overall, midwives need to know they have the support of the organisation, from managers to heads of midwifery, to reduce the potential for burnout outlined above and to enhance the psychological safety for midwives.

E: Empathy and compassion; emotional intelligence

The midwife participants demonstrated high levels of empathy and compassion for the women in their care. Empathic concern was expressed by midwives who were moved by the women’s accounts, usually distressing, which ‘compelled them to act’ to support the decisions.

Such compulsion seemed to create a mother-midwife allegiance that mitigated against potential obstacles such as workplace cultures or constraints. Such emotional attunement results in empathic responses to serve the women’s needs that can be viewed as ‘compassionate midwifery care’.¹¹

As such, emotional intelligence skills need to be embedded within the university and hospital organisations to ensure safe, respectful and dignified care is provided. Moreover, that these midwives had variable workplace contexts, midwives delivering this care must be afforded the same respect and dignity within their workplaces.

This includes empathy and compassion from their colleagues and managers to foster greater relational inter and intra working.
Within an empathetic and compassionate model of working, resistance to ‘blame cultures’\textsuperscript{12,13} is more easily attained. In turn, this enhances a ‘transparency culture’ that is well evidenced as a safer culture for all.\textsuperscript{14}

\textbf{T: Trusting relationships}

While much attention is given to the trust benefits within the mother-midwife relationship from the women’s perspective, this study extends this vital component of care. Trust was seen as the ‘glue’ within the mother-midwife relationships; the midwives recognised they needed to be deemed trustworthy by the women and made great efforts to convey and be trustworthy — echoing other research. Unique to this research is that trust was seen as reciprocal, and where midwives trusted the women, they were more confident and willing to support the birthing decisions.

Moreover, the other findings highlighted how important trust was within the midwives’ working relationships. The absence of trust was a precursor to challenging experiences, vulnerability and negative experiences. Moreover, trust from the employers links to an enabling (or not) workplace environment, influencing the extent to which midwives were able to practise autonomously.

Therefore, trust as the glue for all relationships means organisations must work to create trusting environments for and between all professional groups so as to maximise women’s experiences of respectful maternity care.

\textbf{Urgent recommendations at an organisational level}

Frontline midwives need to be supported within non-punitive, open and learning cultures where their autonomy is respected. A supportive work environment is an enabling factor for providing true woman-centred care and creating the space for full-scope midwifery.
The benefits to women are well documented, therefore, could be used to enhance women’s psychological and physiological birth outcomes. Ideas for implementation are provided below aimed at senior midwives, managers, and Trust boards:

- Organisation-wide education regarding women’s childbirth legal rights (to include senior medics, midwives, Trust board directors, legal department etc.).
- Consider formalised documentation that reflects women’s human rights in childbirth, with the responsibilities of all maternity staff to ensure dignity and respect for women’s autonomy clearly identified. Such documentation could include guidance with common scenarios, to ensure that staff are reminded that, whatever their views about the decisions made, if the woman is properly informed (and not pressured with biased or repeated information) her decision should always override that of her attendants unless she has, in a legal sense, lost competence, which is very rare indeed.

To stimulate positive change that enhances women’s access to meaningful choices could include the development of a co-created toolkit (informed by all maternity staff, representation from all practice settings, and birthing
people) that has the support of senior management.

- And/or an ‘alternative birth choice bundle’ could be developed, a toolkit designed to help support women, midwives and hospitals to provide safe, woman-centred care where choices are outside of guidelines.
- Identify a lead midwife (in the absence of a consultant midwife) who could be the liaison between maternity staff, the multidisciplinary team, legal and managerial teams.
- Set up supportive learning sessions for multidisciplinary teams to discuss what has worked well when supporting/ facilitating women’s alternative birthing choices.
- Establish ‘open door’ sessions for junior/inexperienced staff to discuss ongoing cases with senior/experienced midwives. These can be used to provide support, and/or identify gaps in knowledge or skill sets. This could generate a co-created action plan for staff skill development, where both the individual midwife and the hospital are obligated to fulfil training needs.
- Offer debriefing sessions to all/any staff automatically after challenging experiences – not just related to adverse outcomes, but issues of relationships with women or their families breaking down, issues of poor communication between staff, inappropriate care etc.
- Provide ongoing feedback from women who have requested alternative birth choices. Inviting women after their birth to share their stories with staff could provide beneficial learning opportunities and validation of the service provision.

**Conclusion**

This model was developed during the latter stage of my PhD in 2018 but has since been echoed by two key reports. First, the General Medical Council November 2019 Caring for doctors, caring for patients\(^\text{15}\) report highlighted the need for GPs to
have autonomy and control over their working lives and practice; a sense of belonging through positive team working and cultures, and competence that includes access to ongoing professional development.

Second, King’s Fund in September 2020 The courage of compassion: supporting nurses and midwives to deliver high-quality care7 highlighted the need for autonomy, belonging and contribution. The latter relates to the need to feel effective as though we are contributing something of value. Collectively, the reports and this model acknowledge and detail what is needed for health professionals to flourish within their work. Enabling environments that support health professionals will only have a positive impact on service user experiences and outcomes.

Furthermore, it is in line with the personalised care agenda, as this model provides an overview of what midwives need to deliver such care. While extra challenging due to the pandemic, we must not lose sight of these necessities to recruit and importantly, retain our staff. I urge organisations to review their workplace cultures and move toward an enabling environment where midwives are supported and trusted to do the job they are trained to do. TPM

References


Overcoming Obstacles: Empowering Birth Partners to Find Their Place

Nicole Rajan-Brown – Hypnobirthing practitioner and second year student midwife, University of Salford
Introduction

Hypnobirthing has gained momentum over recent years as a method for building confidence and decreasing fear across the childbirth continuum. Midwives play an important role in empowering birthing people and their partners in their birth experiences, which includes utilising hypnobirthing concepts, whether couples are actively hypnobirthing or not. Hypnobirthing practitioner Nicole Rajan-Brown examines the hypnobirthing methods midwives can incorporate into their practice to empower birth partners in their role across the childbirth continuum.

Birth partners

Over the last fifty years, birth partners have played an increasingly important role in the birth room, as the value of birth experiences has been amplified.¹ Birth partners have not always been supported to play an active role in pregnancy and childbirth, often reporting feeling alienated.¹ Yet, lacking a birth partner has been found to increase the chance of a negative birth experience; in integrating birth partners into perinatal care, positive experiences can be encouraged.² Hypnobirthing, a form of antenatal education, combines...
relaxation through self-hypnosis and empowerment through knowledge, supporting birthing people and their partners to approach birth confidently. This education promotes optimal, person-centred birth through informed choices, understanding of physiology and birth partner participation. The midwife’s role reflects these values; midwifery care and support should be offered by extension to a birthing person’s wider support system. This article explores how midwives can acknowledge, validate and facilitate the birth partner role using hypnobirthing principles.

**Validity**

The benefits of Continuity of Carer (CoC) are well evidenced, improving outcomes for birthing people and babies. Relational CoC within formal healthcare provision is becoming increasingly commonplace. Yet, the CoC relationship is not solely provided by the healthcare professionals, but extends to the birthing parent’s support system, including their birthing partner. The birthing partner often provides support across the childbirth continuum, building a meaningful and intimate relationship, advocating, and providing practical and emotional support. This partnership offers a holistic understanding of the birthing person and unique expertise. The presence of a birth partner increases positive birth experiences; in supporting and encouraging birth partners to be validated in their role and integrating them into the care provided, confident, positive experiences can be encouraged.

Birth partners often feel forgotten within maternity care. Current societal norms do not promote active partner involvement and the limit of statutory leave for attending appointments is low. Alongside maintaining the safety and normality of a pregnancy and birth, the midwife’s role is to facilitate ‘what matters’, supporting not only the birth of a
child, but also the birth of a family. Hypnobirthing education highlights this essential role of building confidence, thus encouraging active engagement in care. By acknowledging the partner’s role and building a relationship with them, the midwife not only harnesses

**Choice**

Education is a significant element of formal antenatal care, and midwives are duty bound to provide evidence-based care, promoting informed choice, empowerment and self-advocacy. Hypnobirthing values evidence-based education, supporting families to develop their understanding of birth and the choices available to them. Birth partners can act as advocates alongside midwives, supporting birthing people’s needs and rights. Partners can be actively involved in these discussions, exploring their expectations and fears, and defining how they can participate. However, appointments are often purely focused on the mother or birthing parent, without considering the input of partners.

Birth partners should be encouraged to ask questions about the pregnancy and birth, validating their involvement in, and understanding of, childbirth. Use of the BRAIN acronym (Box 1) can be helpful to support partner involvement in informed decision making. Birth plans can also be used as a tool to prompt families to explore their choices. The knowledge gained from creating a birth plan provides partners with a practical role – the facilitator of the birth plan – whilst offering a clear document for healthcare providers communicating individual choices, and their rationale. The physicality of this document cements the role of the birth partner and directs the wider care team when holding space during birth.

**Box 1: BRAIN tool for informed choice**

Benefits
Midwives can introduce birth partner to practical roles, including promoting fluid intake, basic massage, breathing and relaxation techniques for use during the intrapartum period. Postnatally, partners can be encouraged to consider topics such as cutting the cord, skin-to-skin, supporting chest/breastfeeding, identifying feeding cues and taking on wider caring roles with the newborn, such as changing, bathing and massage. These roles encourage bonding and increase a feeling of involvement, which can reduce postnatal depression. However, the birth partner role should not become rigidly defined, remaining individualised. Through discussions, birth partners can be empowered to find their own place, where they are comfortable, without being relegated to the sidelines.

**Protection and Physiology**

Birth physiology is central to the logic and evidence base of hypnobirthing. In understanding the intricacies of birth processes, families can enter birth with confidence. By protecting the birthing space and ensuring the environment remains safe, private, warm and comfortable, the birth partner facilitates the creation and protection of an oxytocin-filled bubble, essential to the physiology and experience of labour. The protection and promotion of physiology extends beyond the intrapartum period. Antenatally, the birth partner can help protect the birthing person from continual communication and questioning about the arrival of the baby from well-meaning friends and family, which may be anxiety-inducing, promoting oxytocin-antagonising adrenaline. Postnatally, the birth partner acts as a gatekeeper, ensuring the family is not overwhelmed by visitors during those first days with a newborn, which are important for bonding and establishing
infant feeding.

Recent data has highlighted the importance of gatekeeping for establishing breastfeeding,\textsuperscript{10} with family distance from visitors and external pressures during the pandemic being attributed to an increase in feeding rates.\textsuperscript{11} Furthermore, UNICEF identifies the benefits to neonates of maintaining a small number of people offering bottle feeds, reiterating the importance of this time regardless of the chosen feeding method.\textsuperscript{13} This element of the birth partner role is detailed in a recent study exploring paternal physiology over the childbirth continuum; testosterone levels reduce, promoting supportive and caring behaviours.\textsuperscript{8} Midwives, however, must be cognisant of promoting the involvement of not just male, but all birth partners; significant others, friends, family members, doulas and beyond can all be encouraged to identify potential triggers, positive or negative, that may impact hormonal physiology. In encouraging this active involvement, midwives can promote this element of birth partner support, regardless of their antenatal education and knowledge.

**Overcoming Obstacles**

The restrictions implemented during the COVID-19 pandemic have highlighted the importance of the presence of birth partners.\textsuperscript{13} Throughout, birth partner presence during antenatal appointments and scans, induction or on postnatal wards has been restricted; many were only permitted to be present during established labour or, in some cases, not at all.\textsuperscript{13} These times of restriction are often times when birthing people feel vulnerable and are offered the least professional support, as one-to-one care is not always available. These obstacles have highlighted that birth partner involvement is not an optional extra. Furthermore, most births in the UK take place in a hospital setting or birth centre, where the environment is perceived as being ‘controlled’ by professionals.
Hypnobirthing concepts highlight the effect these unspoken, social barriers can have on behaviours, and works to break these down by acknowledging their existence. Partners may feel uncomfortable putting forward their opinions thanks to the common trope of birthing partners being ‘hopeless’ in the birth room. However, by engaging the birth partner at all stages of the childbearing continuum, midwives can actively help overcome these obstacles.

**Summary**

Hypnobirthing aims to empower families to take control of their birth, promoting a positive experience. Midwives play an important role in integrating birth partners into the care of the birthing person across the continuum by validating their place, whilst facilitating them to find their own, unique role. By using hypnobirthing principles to consider the importance of the birth partner’s involvement, midwives can ensure their unique knowledge and relationship is harnessed to benefit the birthing individual, enhancing the holistic care provided. TSM

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Positive Planning with The Happy Student Company – Boundaries

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January brings about a new sense of starting afresh, and the opportunity to make new choices in how we look after ourselves in the year going forward. You can choose habits and boundaries that will benefit you or disadvantage you.

Creating healthy boundaries around your work, study and social life are a form of critical self-care that effect your personal resilience and will ultimately contribute towards your professional wellbeing. For these reasons, considering what your boundaries look like is an exercise worth exploring.

Are you aware of your personal boundaries already? Have a think about the following questions and create some of your own along the same theme.

- How many hours of sleep does your body need?
- How many hours of socialising a week is enough for you? Too much can drain you, not enough might isolate you.
• How long can you study before you need a break?
• Do you know what your triggers are for needing some space away from others?
• Who or what absorbs too much of your time?
• How many hours in a week can you realistically allow for bank shifts/overtime/group study?
• How often will you put your phone away this week, for some intentional screen-free time?

Boundaries are a choice that only you can make and enforce but they will influence your capacity and stamina for your life mission. Take a little look at your timetable for the week ahead and decide how you want to allocate your free hours. Protect these decisions you’ve made and the boundaries you’ve drawn up, and suddenly the week might not look overwhelming!

For more information on creating boundaries, and other resilience building tools, check out my book ‘The Resilience Plan for Healthcare Students’. TSM
“There Are Many Ways To Be A Midwife”: Career Pathways In Midwifery

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Summary

Upon starting midwifery training, students largely visualise a clinical career, working on the frontline of perinatal care. However, careers in midwifery span many disciplines, providing many career options for qualified midwives. In this special
report, midwives from research, academic and consultancy positions discuss the importance of their roles, the challenges, benefits and relevance to clinical midwifery.

**Research midwifery – Zainab Sarwar**

Evidence-based practice. A term embedded within midwifery, and the driving force in evolving practice. The journey to finding the “evidence” is definitely something, as a research midwife, I have much gratitude for. The transition to life as a research midwife was certainly different from the familiar, comforting sounds of the labour ward. As research midwives, we are in a unique position to understand the needs of women, birthing people and their families, playing a pivotal role within the multidisciplinary team (MDT) by ensuring research activity is considerate of the needs of service users. The role allows you to continue practising autonomously, prioritising and maintaining your own workload.

Research midwives work in a variety of roles: designing studies, setting up trials, gaining consent, collecting and inputting data, analysing data and publicising results. The varied and flexible nature of the role, alongside the encouragement to pursue personal interests is fantastic. Work spans across obstetrics, gynaecology, paediatrics, neonatal and COVID-19 research. I try to fit in some clinical work where possible, in between home educating my children, and advocating for individuals from ethnic minority backgrounds. Recently I’ve been working on a project with the Royal College of Midwives (RCM).
Effective communication and interpersonal skills are essential when discussing research with families, as informed consent is reinforced continuously within research. Communication skills are vital, required to initiate engaging discussions around the research topic and to facilitate conversations around care and the evidence surrounding the study topic to ensure all questions are addressed prior to decision-making. Time management, flexibility and adaptation are crucial skills to ensure studies are managed to a high standard.

There are opportunities within trials to develop a caseload, allowing excellent continuity of care. The benefits of continuity of care are well documented\(^1\) with evidence showing that hospitals engaged in research have better patient outcomes.\(^2\) There are different pressures and challenges working within research – and definitely more paperwork! Creating an engaging research environment is particularly challenging due to clinical pressures on staff and, at times, the reluctance to accept temporary changes in practice. However, having worked clinically, I appreciate these challenges and practicalities.

Presenting and teaching staff is imperative to raise awareness of research; research teams heavily rely on working alongside the clinical team in a busy, time-restricted environment to identify and discuss trials with birthing people and their families. Each trial stipulates how and when people can be approached to discuss research. Service users have the right to decline meeting the research team, and this can be
difficult to accept when there may be treatments you feel, as a research midwife, could benefit them. However, supporting the choices made by families is an important skill and it is crucial to respect the decisions made.

"There are different pressures and challenges working within research - and definitely more paperwork"

Awareness of research is essential to any midwife’s role to evaluate current practice and to support choices that may be considered “out of normal practice”. There are many opportunities to develop current skills, as well as prospects of acquiring new knowledge and skills with exposure to different fields.

There is also the potential to expand career choices in different directions, clinically or academically. Being part of the research process can be incredibly rewarding: you may help direct the future of care provided to women, pregnant people and their families – and enables you to maintain a healthier work-life balance.

**Academic midwifery – John Pendleton**

As a student midwife, I remember a lecturer asking, “Why do you want to be a midwife?”. After careful questioning it became clear she queried my motives. She suspected I was using my midwifery degree as a stepping-stone to management and therefore fulfilling the stereotype of men in nursing and midwifery by hopping on the infamous “glass-escalator” as quickly as possible, away from hands-on caring roles towards a more gender-congruent position in a strategic role.

It would seem from this vantage point of Senior Lecturer that
the – self-fulfilling? – prophecy has come true but I do remember being baffled by her questions at the time. My burning ambition then, as now, was to be a midwife and ensure women and birthing people were able to access the care and support they need to have a positive pregnancy and birth experience.

I had no thought of becoming an academic. What I had not anticipated was how much I loved supporting students when in practice. I enjoyed watching their confidence and competence develop and derived as much job satisfaction from this as I did from supporting the families in my caseload. It also allowed me to keep up-to-date in my knowledge and challenged me to constantly ensure I was providing the most current evidence-based care.

But I was also conscious of the need to ensure I was “evidence-based” in the way that I facilitated learning to students and, as a result, I was inspired to embark on a master’s degree in Practice Education. This also had the benefit of bringing me back into the university environment where I was invited to support students with guest lecturing and helping with clinical skills sessions. When a position was advertised for a midwifery lecturer at my local university, I realised I now had concrete examples of teaching and relevant advanced study to put in an application which, I am sure, helped me to stand out from other applicants.

I had intended to combine my job as a lecturer with bank shifts but sadly this was not practicable. I soon learned working full-time in academia is every bit as demanding and all-consuming as working clinically. Teaching and assessing is
at the core of what I do but only represents one element. As I have progressed to Senior Lecturer, I have taken on the leadership role of Admissions Tutor. Midwifery is among the most popular courses. Designing, quality assuring and delivering an interview process that selects the most suitable applicants from many hundreds of hopefuls has been rewarding but time consuming.

I have also started to develop a research profile. Currently, I am conducting research into the experiences of BAME student midwives alongside writing my PhD thesis on the experiences of men who work as midwives.

This year we have also had our new curriculum validated by the Nursing and Midwifery Council (NMC), which took many months of planning, whilst simultaneously delivering a programme which has, inevitably, required continuous complex adaptations due to the pandemic. These roles require multiple meetings and collaborative working with our NHS Trust partners, service user organisations and our student body.

The main function of a consultant midwife is to provide clinical leadership, strategic insight and educational expertise alongside research and expert practice. It may seem like I have travelled a long way from my ambition to ensure birthing people can access the care they need but, in fact, the greatest satisfaction I have in my role is very much aligned to that original ambition. As a Module Leader for Research Methods, I strive to ensure that students develop an
understanding of not just how research is carried out, but how it can affect change and the importance of creating a midwifery-focused evidence base. In this way, I am contributing to supporting women, birthing people and families as an educator for many cohorts of future midwives.

If I have any words of advice for any students or midwives contemplating the possibility of a career in Higher Education I would say this:

- Do not assume that it is something only other people can do. Many of us have felt that imposter syndrome.
- Start testing whether it is for you by offering to support clinical skills sessions at your local university.
- Many universities offer modular master’s degrees for health and social care students and your trust may be willing to fund some of these modules if there is a business need. There are postgraduate loans available to support further study.

Ultimately, you may decide that a career in higher education
is not for you but upskilling and developing relationships with colleagues outside of the NHS will expose you to new opportunities and career possibilities. Perhaps more importantly, it will allow you to appreciate there are many ways to be a midwife which are just as valuable to meeting the needs of women and birthing people as “hands-on” midwifery.

Pre hospital, urgent and emergency care midwifery – Stephanie Heys, Amanda Mansfield and Dawn Kerslake

Working within Ambulance NHS Trusts as a midwife provides an invaluable insight into the pre-hospital setting and the varied roles of those working within it. From calling 111 for advice during pregnancy, dialling 999 in an emergency, attending a home birth, to supporting a breech delivery on the motorway; call handlers, paramedics and ambulance clinicians are key providers of urgent and emergency care to women and birthing people of childbearing age.

Being a consultant midwife within the ambulance service is a challenging, dynamic and unique role. Consultant midwives are recognised as clinical leaders contributing to improvement in quality of care across maternity services.¹

The main function of a consultant midwife is to provide clinical leadership, strategic insight and educational expertise
alongside research and expert practice. In 2008, the London Ambulance Service welcomed their first consultant midwife. Now, 80% of England’s Ambulance Services have a nominated Lead Midwife/Paramedic (including Consultant Midwife, Practice Lead, Practice Education and Maternity Management posts). The use of maternity leadership in pre-hospital settings, such as NHS Ambulance Services, the generic provider of 111 and 999 services, reveals acknowledgement of the vital role midwives play across urgent and emergency care.

There are many areas of practice in which midwifery enhances the care provision outside of hospital trusts. A retrospective service evaluation within the north east of England during 2017-2018 recognised paramedics attended 28-89% of out of hospital (OOH) births, were present for 28-65% of these births, including 88.3% uncomplicated precipitous-term births.

Despite a high percentage of births being uncomplicated, over ten percent of births attended to by ambulance clinicians are classed as an emergency, as unplanned OOH births are associated with increased adverse outcomes, emphasising the need for skilled and competent clinicians in attendance during these incidences. Ambulance clinicians not only attend to and transfer birthing people and babies; they use critical clinical decision-making skills when attending obstetric and neonatal emergencies, evidencing the complex nature of OOH care.
Challenges in the pre-hospital setting include considerations of the environment in which care is delivered, skill set of clinicians, scope of practice and decision-making approaches in highly-intense situations. Human factors and the importance of team working is a vital component of midwifery leadership, with the consultant midwife providing additional expertise ensuring staff are prepared for attending maternity-related calls. The consultant midwife works alongside other members of the consultant body including consultant paramedics and pre-hospital emergency doctors with the ability to influence widely not only amongst staff, but across a geographical reach. This unique perspective enables the consultant midwife to look critically at pathways of care for pregnant people, optimising safety and using innovation to redesign services.

The role of the consultant midwife is ever-evolving and forward-looking; more investment is needed for maternity leadership in ambulance trusts. Student midwives should be encouraged to explore such pathways upon qualifying. TSM

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Investigating IBCLCs – Supporting Informed Choice

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Summary

In part two of this series exploring the role of International Board Certified Lactation Consultants (IBCLCs), Laura Henry and Lucy Ruddle examine the vital skill of providing unbiased information to support informed infant feeding choices.

Choices matter

Choices are influenced on a multitude of levels. We all have personal beliefs, norms and values that direct our actions. These beliefs are shaped by our family and friends, as well as wider societal, cultural and organisational factors. Irrespective of the choice, parents may feel guilt, judgement and fear about their decisions. Family and social influences have a particular impact; many people emulate the feeding choices they are exposed to most.\textsuperscript{1,2} Lifestyle factors are another influence on decision making.\textsuperscript{3,4}
Facilitating decisions

The IBCLCs role is to empower families to meet their individual feeding goals through the facilitation of informed decision. As specialist practitioners, IBCLCs can provide more focused information on infant feeding than midwives, who provide a far broader service. This can allow dedicated consultation time for more in-depth exploration of individual factors and the holistic picture behind the decision to feed human milk.

Consistency and continuity

Structured and paced support from professionals and peers focused on developing the skills and knowledge of parents increases the duration of chest/breastfeeding. Research demonstrates continuity of carer and consistency of information provided leads to more confident decision making; specifically providing homogenous support to parents throughout the multidisciplinary team to prevent confusion and misdirection. The success of IBCLC support can give insight into how other healthcare professionals (HCPs) can support informed infant feeding choices.

Conclusion

A flexible, paced approach is required when sharing infant feeding information. It is important HCPs and IBCLCs hold a space individual needs of families, ensuring that unbiased facts are communicated clearly. The multidisciplinary team when educating families about infant feeding choices. TSM

References

Navigating Social Media: Professionalism In The 21st Century
Navigating Social Media: Professionalism In The 21st Century

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Summary

Many student midwives find themselves confused in aligning their social media presence with their newfound role as healthcare professionals. Inclusivity and freedom of identity are current hot topics: is it acceptable that some students are expected to hide their true selves to comply with an outdated perception of professionalism? For example, does someone’s choice of clothing affect their ability to be seen as “professional”? Should universities be criticising or even disciplining students over outfits worn on social media? This article explores the difficulties student midwives face as they try to balance professionalism with being true to their own identities and how they represent themselves on social media.

Defining professionalism

The Nursing and Midwifery Council (NMC) advises student midwives to uphold professionalism at all times,¹ yet opinions differ on the definition of “professionalism”.² This difference can cause conflict for student midwives as they establish themselves as healthcare professionals, leaving them confused and unable to express themselves freely. As a predominately female workforce, many midwifery students find themselves affected by gender bias within a healthcare system that is built on patriarchal hierarchies.³ The use of social media adds to this issue; anecdotes abound of students and healthcare professionals being reprimanded for the content they post,
criticism over their choice of clothing and suggestions that they are acting in a provocative manner.

The scale of the issue

Midwives have worked, and continue to work, tirelessly to prioritise the rights of the women and birthing people in their care. How can perinatal services be truly inclusive and free from discrimination when student midwives, the majority of whom are female, still find themselves on the receiving end of gender bias? A bias that tells them how they are permitted to dress outside a professional setting.

In her book Why Women are Blamed for Everything, Dr Jessica Taylor discusses how inert sexism has led to female victims of sexual assault being blamed for their perpetrator’s crimes because of their sexual history or the way they have chosen to dress. Earlier this year, there was a public outcry against victim blaming after the tragic murders of Sarah Everard and Sabina Nessa.

Public opinion is moving away from the notion that women need to take steps to keep themselves safe, to one where men are made responsible for their actions. The time has come for these outdated ideas and opinions to be eradicated. Everybody has the right to express themselves freely, including which outfits they wear when posting photographs of themselves on social media accounts.

A person is capable of professionalism at work regardless of
how they dress outside of the workplace. If we offer individualised care without bias or discrimination, then we need to accept everybody’s right to choose – including our own.

An antiquated approach

Many students struggle with establishing their identity when transitioning to higher education. Gender bias and discrimination were found to be factors in the emotional burnout experienced by some female medical students. This is compounded in student midwives who are susceptible to stress and often lack self-empathy. Self-esteem is important for healthcare students, leading to better overall care for service-users.

When people are self-confident, other people’s confidence in their ability to provide quality care increases. Shaming healthcare students over their clothing can only serve to lower confidence. With the growth of the #MeToo movement, and a greater social awareness of the dangers surrounding formulating opinions and assumptions based upon clothing, healthcare professions and universities must re-evaluate the link between a person’s choice of clothing and their perceived professionalism.

An alternative approach
Rather than disciplining or criticising a person’s outfit, it is time to look more constructively at how a person demonstrates professional behaviour on social media. Such constructive steps could include only sharing factual information from reliable sources, and promoting principles of anti-racism, inclusivity and kindness.

Useful advice could extend to addressing concerns about the dangers of social media such as being traced. Students could be advised to avoid using their full names on-line and to switch on high-level privacy settings. This education could be taught alongside the NMC’s guidance on social media usage.

Rather than disciplining or criticising a person’s outfit, it is time to look more constructively at how a person demonstrates professional behaviour on social media.

Confusion and fear

A massive 95% of UK adults use a social media platform. The NMC offers some guidance concerning the inappropriate use of social media, including protecting patient confidentiality and cyber bullying. However, little information is offered concerning how social
media can be used responsibly, or even be of benefit. The unprofessional use of social media is a common reason for universities to take disciplinary action against healthcare students.\(^\text{10}\)

However, many students have little awareness of their universities’ rules regarding social media. Mabey et al interviewed physiotherapy students and found over half did not realise their university had a policy on the use of social media.\(^\text{10}\) Such confusion can lead to students fearing using social media. Such fear could be detrimental to the midwifery profession as social media is becoming a platform for many modern-day midwifery services.

**Not all negative**

Social media offer a previously unheard population the chance to influence and instigate change. It is important that those voices are heard and that influential institutions take the opportunity to listen and act.

Recently, a university issued an apology over Twitter after a medical student was criticised for her choice of dress during a practical exam. No doubt this apology was influenced by the fact that the original tweet was shared over 3,000 times.\(^\text{11}\)

Furthermore, online forums offers improved access to perinatal care. The Facemums platform, for example, is an incredibly successful Facebook forum allowing midwives to communicate with maternity service-users to provide support and advice. This online support has been particularly valuable during the
COVID-19 pandemic.\textsuperscript{12}

With researchers recommending further expansion of these platforms,\textsuperscript{13} the development of robust social media guidelines are required for healthcare professionals to feel confident and supported in using them.

Moving forwards

A recent study found medical students wanted to use social media professionally but were unclear on how to achieve this,\textsuperscript{14} supporting the recommendation that professional guidelines should be refined and updated to meet the needs of a more social media-driven society. Midwives and students need to understand the expectations of their professional body.

Educational and healthcare institutions have a duty to guide their students and employees in the effective and confident use of social media, ensuring these policies are updated to include robust information about how students should conduct
themselves in person and online. However, these expectations need to reflect modern society.

More research needs to be carried out into how service-users perceive professionalism, as well as the views and opinions of healthcare students. TSM

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