Leadership in Action: Finding Your Community

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Summary

Leadership is not synonymous with isolation; the support of peers, colleagues and clients can help raise voices higher. In this second instalment of the leadership in action series, Zelle Baggaley discusses how individuals can find a community within which to demonstrate their leadership skills.

Harnessing experience

I was six months postpartum before I realised there was no reason to be ashamed of my birth experiences. The leaflets I was given after my crash caesarean were all about where my baby was and what might be wrong with him. There was nothing about how I might feel or how flashbacks and panic attacks would invade my brain. I had only ever heard of postnatal depression or baby blues. I had never heard of post-traumatic stress disorder (PTSD) caused by childbirth experiences.

The support I found in the Birth Trauma Association (BTA) was invaluable; it was a safe space to talk about all the unwieldy emotions I was feeling.

Birth trauma

Birth trauma is defined as emotional, physical or mental distress caused by a birth experience, leading to symptoms such as flashbacks, intrusive thoughts, trigger avoidance, negative cognition and memory loss. It is estimated that 4% of births in the UK per year are affected by birth trauma, but a recent national survey revealed 62% of respondents “did not know anyone suffering from birth trauma”. This indicates that PTSD from childbirth is not disclosed in social situations, or it is viewed as a taboo subject. As a result of this lack of exposure, many people find locating support difficult.

Community

The support I found in the Birth Trauma Association (BTA) was invaluable; it was a safe space to talk about all the unwieldy emotions I was feeling and gave me the opportunity to support and reassure others who felt the same. Soon after, I was invited to become the Community Lead. When the pandemic loomed, membership of the group increased exponentially as fragile parents felt isolated. I investigated ways to ensure present and active support, working within government restrictions.

Demonstrating leadership

I launched a tri-monthly peer support group on Zoom, advertising via social media and parenting groups. I created this space for people to share their burdens and find solace in the stories of others, even whilst
separated by distance, lockdowns and COVID-19. Facilitating group discussions could be challenging at times, sometimes triggering my own trauma. However, I knew that this safe space provided others with the strength and support that was not available in my time of need.

**Moving forward**

Leadership in action often involves the support of others. Find people you share a common ground with and work towards improving practice as a group will ensure you feel supported on the path ahead. **TSM**

Zelle facilitates the Birth Trauma Association's Zoom support group, further details can be located in the Facebook group “TheBTA”.

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**Read The T&Cs: Facilitating True Informed Choice**

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**Summary**

The choices we have and decisions we make throughout life are personal and vary depending on need and context. When making decisions, do we always read the terms and conditions before
clicking “I agree”? Think about some of the big decisions we make – would we choose differently if
we had read the small print? In other words, if we had been able to make an informed choice? The
concept of informed choice for childbearing women, people and their families’ is complex and far-
reaching. Kat Skeates and Laura Henry examine informed decision-making and the impact COVID-19
has had on birth choices.

**Facilitating informed choice**

Personalised, safe and compassionate care is at the heart of maternity care policies and guidance. Facilitating informed choice and decision-making, as a basic and vital human right under the European Convention on Human Rights, is fundamental to midwifery practice. Legally-valid informed choice requires the provision of evidence-based information including risks, benefits and potential outcomes with consideration of the personal perspectives, preferences and needs of the people in our care.

Decisions made by the pregnant person, made voluntarily with capacity, must be respected even when the decision could result in perceived or actual harm to the person or their fetus, which has no human rights prior to livebirth in many countries around the world. Despite the legal clarity, informed choice in practice presents complex moral and ethical dilemmas for families and professionals. Whilst midwives and other birth workers aim to support informed choice to those in their care, researchers argue that informed choice is “at best illusory”.

**A delicate balance**

The concept of “informed choice” is dynamic, influenced by a multitude of factors, including:

- individual beliefs, values and actions, shaped by their lived experiences
- ideals of their family and friends
- relationship with healthcare providers
- wider society and culture
- organisational factors such as healthcare policies and services.
Frequently, for midwives and those providing care to childbearing people, decision-making is closely linked to risk assessment.7

Every contact with a midwife involves assessing the health and wellbeing of those in their care, including assessing personal needs, safety and preferences. Multiple contextual factors can influence the information health professionals share, including:

- knowledge of latest research, guidelines and policies
- local culture and practices
- fear of litigation
- complex health needs of those in our care
- service provision and environments
- resources (time, staffing, information and service resource)
- relationships and models of care
- personal bias
- structural and institutional racism.
Levy’s grounded theory in research describes how midwives tend to ‘protectively steer’ families to make decisions that they feel are the safest, aligned to their own perspectives, local guidelines and practices.\textsuperscript{8}

However, strengthening rights-based, personalised care requires midwives and maternity-care staff to take a different approach, one that centres individuals, considering their values, needs and preferences as the priority. This is essential throughout all phases of childbearing, birth and early parenthood.

It can be particularly challenging to facilitate informed decision-making during active labour and birth, as it may be more difficult for birthing people to process new information.

As such, preparing for labour and birth in pregnancy is important. Exploring and documenting birth preferences, considering all eventualities, during unhurried antenatal birth conversations can act as ‘advanced directives’, enabling birthing people to share their values and needs for labour and birth to retain control over their experiences.\textsuperscript{9}

Despite this, it remains the duty of midwives and birth-workers to gain informed consent for all care provision offered, regardless of prior direction, as personal preferences are transient and continually shift.

Birth choices became constrained during the COVID-19 pandemic as a result of imposed restrictions and guidelines to reduce unnecessary close contact between individuals, especially in healthcare settings.

\textbf{Choice constrained: the impact of COVID-19}

Specific restrictions in maternity settings included pregnant people attending antenatal appointments and scans alone, as well as installing limits on birth partners and visitors. Although these new policies were
somewhat accepted at the beginning of the pandemic to maintain safety in response to the rapid development of COVID-19, restrictions continue to linger in many areas despite most other restrictions across the UK being lifted.\textsuperscript{10,11}

Perhaps the most contentious restriction was the limited access of birth partners to labouring people, despite WHO stating the attendance of a companion of choice should be supported regardless of suspected or confirmed COVID-19 infection.\textsuperscript{12,13} Birth companions are described as a “lifesaving intervention” (see figure 1), the exclusion of which is “unethical”, undermining basic human rights.\textsuperscript{14}

During the pandemic, many hospitals required the birthing person be in “active labour” before a companion could attend. In obstetric settings, vaginal examination is often used to determine active labour over other physiological signs, but active labour diagnosis can be inconsistently defined.\textsuperscript{15}

Pregnant people may feel pressured to consent to a vaginal examination in order to have their chosen companion by their side, whereas they may have otherwise declined it. Birthing people may also feel pressured to make decisions without the advice or reassurance of their birth partner, fearing partners may miss the birth entirely. This can lead to those receiving care having to adjust to the needs of the system rather than the system adjusting to their individual needs. Rapidly changing guidelines and practices without underpinning evidence of effectiveness and safety could unnecessarily limit choices without improving outcomes.\textsuperscript{13}

\textbf{Figure 1: The benefits of Birth Companionship}
Power imbalances and finding solutions

Midwives can feel powerless, trapped between their desire to advocate for birthing people and the guidelines and policies they feel duty-bound to follow. Equally, birthing people can feel powerless in a system where healthcare providers encourage decisions reflecting policies written for populations rather than exploring individualised needs. Obstacles must be addressed to instigate change for better outcomes.
One way to address these challenges is through effective education surrounding the language we use. When a person declines an aspect of a care pathway, they are often labelled as “refusing”, indicating compliance was expected and leading to possible coercion.\textsuperscript{18}

Midwives must be mindful of the language used in both written and verbal communication, ensuring the use of appropriate translation services and tools as required. Document what discussions were had and their outcomes; care is “accepted” or “declined” rather than “agreed” or “refused” and “consent was given” rather than “consent gained”.

There are a range of tools available to support person-centred decision-making and support planning (Box 1, Box 2). The concept of shared decision-making (SDM) initially offers a useful framework.

It moves away from paternalistic hierarchy and puts midwives and birthing people on equal footing when it comes to decision-making.\textsuperscript{21} However, birthing women and people should be at the centre of decision-making, with midwives and birth workers offering options and information, and supporting birthing people to make their choices considering individual wants, needs, beliefs and other personal factors.\textsuperscript{4}

Midwives can help birthing people interpret and understand various care options, relevant evidence and information, using the tools to inform person-centred conversations. Benefits of person-centred decision-making include increased understanding between birthing people and healthcare providers, promoting mutual trust and respect, and allows care to be individualised.\textsuperscript{21}

\textbf{Box 1: Three-step model for Person-Centred Decision-Making}
b. Relational Midwifery Care

By building a relationship of trust, midwives can better facilitate individualised and informed decision-making and respect a person’s right to accept or decline care.16 As guided by Montgomery case law,19 understanding what is important to each person and family is a key aspect of supporting them with appropriate and relevant information to make decisions centred on their individual circumstances and values. Positive relationships with person-centred decision-making leads to more positive feelings towards their birth experience.3,20

c. Personalised Care in Practice

Personalised care and supporting planning (PCSP) enables safe care and as such is a priority across local maternity systems in the UK. PCSP is determined by five technical criteria, as outlined in the universal personalised care model:

1. People are central in developing and agreeing their PCSP, including deciding who is involved in the process.
2. People have proactive, personalised conversations that focus on what matters to them, paying attention to their needs and wider health and wellbeing.
3. People agree the health and wellbeing outcomes they want to achieve in partnership with relevant professionals.
4. Each person has a shareable PCSP that records what matters to them, their outcomes and how they will be achieved.
5. People are able to formally and informally review their PCSP.

Box 2: The BRAIN Tool:

- **What are the Benefits?**
- **What are the Risks?**
- **Are there any Alternatives?**
- **What’s my Intuition/any further Intervention?**
- **What if we do Nothing?**

References

Addressing Personal Bias In Relation To Weight Bias: Part 2

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Summary

In part two of this series, Nicola Salmon explores how to recognise bias and the practical steps
healthcare practitioners can take to eradicate it through recognition, challenging, noticing and leadership.

Unconscious bias

Recognising bias exists is the first step towards addressing it. We all hold this bias to some degree, regardless of the size of our own bodies, demonstrated in how we talk about our own bodies and how we treat other people’s bodies. Harvard University’s Implicit Association Test[^1] can highlight where you may hold unconscious bias. Answering these questions will assist in supporting a conscious awareness:

- How do you feel about losing/gaining weight in your own body?
- How do you feel when people in your life lose/gain weight?
- What assumptions do you make about fat folks based on looking at them?

Challenge

Change often starts close to home. Consider what you can do to recognise and challenge the bias you might hold for people in bigger bodies. Aim to:

- Demonstrate support regardless of the size of their body.
- Diversify your social media feed to see Black, fat, trans, Brown and disabled bodies.
- Notice the language you use to talk about your own body and others’ bodies. Is the language neutral, or does it imply negativity?

Notice
Much of what we do in healthcare is because “it’s how it has always been done”. When studying or on clinical placements, reflect on how your own, or other people’s, biases impact your support of fat folks. Be aware of:

- Statements linking poor-quality research or where the researcher has drawn conclusions from anti-fat biases.
- Protocols with a different action based on weight or BMI, without adequate, quality evidence.
- Conversations and comments about people’s bodies in or out of earshot.

**Lead**

Often student or newly-qualified midwives feel unable to influence the status quo. Be kind to yourself and focus your efforts on what you can personally change. Consider how small actions can ensure that fat people feel safer in your care, contributing to wider change. These actions could include:

- Providing choice around weighing.
- Not making assumptions about a person’s diet and movement habits; ask the same questions you would ask someone in a smaller body.
- Asking if they have ever experienced disordered eating/eating disorders. Consider how conversations about food and weight could impact on mental health.
- Being prepared with appropriate equipment, including a larger blood pressure cuff, appropriate seating, disposable bedpans to assist with urine samples and larger sizes in gowns and disposable knickers.

**Conclusion**

Fat folks deserve the same level of humanised care and respect as anyone else. Speak to them and touch their bodies with kindness, and do not make assumptions about their health or ability to maintain a pregnancy and give birth based on their body size. **TSM**

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Summary

In the first part of this Anatomy and Physiology in Focus series (see: *The Student Midwife*, July 2021), we followed the development of the embryo from the point of fertilisation until the formation of the trilaminar disc. At this point, the three germ layers of the human body have formed during the process called **gastrulation**: the ectoderm, mesoderm, and endoderm. In this second part, we shall follow the development of the embryo from the beginning of the third week until the end of the embryonic period.

Organogenesis and neurulation

The third week heralds the start of **organogenesis**, whereby all organ systems are formed. At this point the embryo is still shaped like a disc, wider at the **cranial** (head) end than the **caudal** (tail) end. The first embryonic system to develop is the neurological. Specialised cells within the mesoderm layer of the embryonic disc send chemical signals (a process called **induction**) to
the ectoderm above. The **neural plate** forms along the long axis of the embryo. The edges of the plate then curve upwards, towards each other and join together to form the **neural tube**, which will develop into the spinal cord (see figure 1). Formation of the neural tube (**neurulation**) begins in the upper middle section and progresses in a cranial and caudal direction. Neural tube defects occur when closure of the neural tube does not complete. This can give rise to the condition known as **spina bifida**, which occurs most commonly in the lumbosacral region of the spine. Spina bifida is where the vertebrae of the spine do not develop properly, often involving the underlying neural tissue. Research has shown that a daily supplement of 400 micrograms of folic acid can significantly reduce the incidence of spina bifida. This should ideally be taken from three months prior to conception, in order to be most effective. Embryological brain development begins from the third week of life, as the cranial end of the neural tube dilates and bends to form the **forebrain, midbrain** and **hindbrain**.

Embryonic folding

**Figure 2**

At the start of the fourth week a process called **embryonic folding** occurs. The growth of the neural tube within the ectoderm layer outstrips development in the other two layers of the embryonic disc. This causes the cranial and caudal end of the embryo to curl up and over at each end, enclosing the developing structures of the mesoderm and endoderm within. The amniotic cavity follows this folding process and will expand to surround the embryo. In addition to the folding of the cranial and caudal ends, lateral folding also occurs. The left and right edges of the embryo fold up and over. As the two edges approach the midline, they entrap part of the yolk sac within the embryo and leave part outside (see figure 2). The two parts of the yolk sac remain connected via the **vitelline duct**. If the process of lateral folding fails to complete, a birth defect called **gastroschisis** develops. This is where the baby is born with part of the intestines on the external abdominal wall.

Cardiac looping
The primordial (primitive) heart originates from both a left and right zone of specialised mesoderm at the cranial end of the embryo. As lateral embryonic folding occurs, these left and right components fuse together into a single heart tube. Simultaneously, the process of longitudinal folding causes the heart to move ventrally and caudally into the thoracic area of the embryo. There is now a long, segmented tube with the primitive atrium situated at its base, underneath the structures that will become the left and right ventricles and the outflow tracts. A fascinating process ensues, called cardiac looping. The primitive atrium at the base of the heart tube loops backwards and upwards. The primitive right ventricle and outflow tracts (bulbus cordis) move down and over to the right. The primitive left ventricle moves over to the left. Cardiac looping finishes with the four chambers in their correct locations (see figure 3). When an error in this process occurs, cardiac looping occurs in the opposite direction leading to dextrocardia.
This is where the heart is located on the right side of the body. Following cardiac looping, the septation of the four heart chambers occurs, as well as the development of the heart valves and the great vessels. This complex developmental process, which completes so early in embryonic life, can commonly result in the development of congenital heart defects (CHD). The incidence of CHD is 8 per 1000 births, ranging from the clinically insignificant to critical conditions that require early surgery. Only about 50% of CHD are detected by antenatal ultrasound. For this reason, the midwife needs to be aware of the signs and symptoms of CHD when examining the newborn.

Gastrointestinal system

The gastrointestinal system develops from a convoluted tube, with foregut, midgut, and hindgut sections. The entrapped yolk sac becomes part of the embryonic midgut. For a period of time, the growth of the gastrointestinal system outstrips the space within the embryo and at around six weeks a loop of intestine will herniate out into the umbilical cord. This remains in the cord (see figure 4) until the embryo is 12 weeks, when the abdominal cavity is large enough for it to return. However, in rare cases this fails to occur and the loop of intestine remains in the cord at birth – a condition called exomphalos. This is one of the reasons why the midwife should never clamp the cord too close to the umbilicus. At first both ends of the gut tube are closed. During the fourth week, the oropharyngeal
membrane punctures at the cranial end of the tube, forming the early mouth. The cloacal membrane punctures at the tail end to form the anus and urogenital openings.¹

**Reproductive system**

The sex of the baby is determined at the point of fertilisation, dependent on whether an x (female) or y (male) sperm penetrates the egg.¹⁰ However early development of the reproductive system is identical until about seven weeks gestation, with primitive reproductive tracts and gonads (sex organs) that can become either male or female. At seven weeks, in male embryos, a gene from the y chromosome generates a chemical trigger that initiates development of the testes from the gonads. Specialised cells within the testes then produce testosterone and inhibit the development of the female reproductive system.¹ Absence of this stimulus from the y chromosome leads to the development of a female.

**Respiratory system**

Development of the respiratory system occurs from week four as lung buds start to grow out from the area of the foregut that will become the oesophagus.¹¹ Normally the connection with the oesophagus closes and the systems separate, but in rare instances the connection remains and the newborn can have a condition known as tracheoesophageal fistula.¹² The bronchial tree is initially rudimentary and the respiratory system undergoes phases of development that do not complete until after birth.¹² The age of fetal viability, meaning when survival is possible outside of the uterus, is closely linked to the development of the respiratory system.¹³ This is currently set at 24 weeks of pregnancy in the UK, because the alveoli of the lungs are not usually sufficient in number to permit newborn survival before this time.¹³

For a detailed animation of the embryonic folding process see: [https://youtu.be/yXUv4MPuNTA](https://youtu.be/yXUv4MPuNTA)

**Concluding embryology**

From the end of the eighth week all bodily systems are laid down and the embryo becomes the fetus. Knowledge of embryology is important as it enables the midwife to understand how and when congenital conditions can occur. This translates into appropriate health education in pregnancy. It also provides a foundation for the skills and knowledge pertaining to the systematic examination of the newborn. TSM

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A major component of building your resilience and self-development when moving forward is reflecting. Reflection is one of your greatest tools as a clinical practitioner, continuing throughout your career. It requires practice and evaluation as an ongoing skill.

Reflection recognises your strengths and weaknesses; it can refine your clinical skills and combine textbook knowledge with experiential memory, converting it into skilled practice. But has the formal process of reflection ever overwhelmed you? It needn’t be a burden if you break it down.
My recommendations are to:

1. Make short reflective notes every single day of your placement. Even if it’s just a couple of sentences, use it as a memory trigger for when you have time to write up a formal reflection.

2. Keep a reflective journal over your student journey so that you can look back through these reflections and see how much you have grown and developed.

3. Revisit past reflections to help you to determine whether past actions that were evaluated have had the opportunity to be refined. You can also ask yourself if there is still room for improvement.

4. Explore different reflective models to find a model that suits your style of writing or resonates with the way you prefer to reflect. Models such as Gibbs, Schön, Kolb, Johns and Driscoll are all good to try, using simple frameworks to help you consider all aspects of your reflection.

There is always something to reflect upon after each shift. Getting into the habit of regularly writing reflective notes can help when it comes to formative assignments, revalidation and, ultimately, becoming the skilled midwife you have the potential to be.

I have more tools to help you reflect, including reflective journals, and free downloadable planning tools on my website www.thehappystudentcompany.com TSM

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“I Wondered How I Would Manage the Commitments”: Exploring Challenges to Accessing Midwifery Training

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**Summary**

Students enter midwifery training at every stage of life; it is never too late. There are numerous pathways, with individual circumstances varying widely. Personal responsibilities, particularly common for mature students, can make the commitment of a midwifery degree daunting. In this article, Stacey Molineux and Jennifer Foster discuss managing their caring and financial responsibilities alongside training and reveal strategies to overcome these challenges.
Mature aspiring student midwives are often concerned about managing the financial costs of childcare. I was no different in this respect. I researched my financial options prior to commencing my college access course, and the discontinuation of the NHS healthcare student bursary concerned me. I explored benefits claims, student loans and childcare grants. Childcare would be my family’s largest financial outgoing, being in excess of £10,000 per year once I started university, and my household income meant we would not qualify for a childcare grant from Student Finance.

These financial concerns seemed insurmountable barriers to starting my midwifery journey. The maintenance loan would be used for childcare, leaving nothing for household bills and living expenses. I adapted our budget, reducing TV packages and mobile contracts. I found cheaper service providers for utilities and insurance. I reduced our weekly shopping bill by looking for cheaper alternatives and keeping to the essentials. Albeit a start, I still worried about the constraints on my family for the sake of my dreams.
Finding solutions

As my options were limited, I began thinking about part-time work. Although I was advised against working alongside my studies, this was my only solution. I continued working 16 to 25 hours a week throughout college. I also volunteered for a few hours a week at a local trust, which not only helped confirm I was choosing the right profession, but gave me the opportunity to join the trust’s bank staff as a healthcare assistant. This provided me with flexibility in working hours and a head start in my education as a healthcare professional. I learned about communicating with the wider multidisciplinary team and service users, performing clinical skills, and how to use medical equipment. Most importantly, I learned how hard NHS staff work whilst under pressure from workloads, staffing levels and many other constraints.

Upon starting my degree, I continued to work an average of 16 hours per week. This was particularly difficult alongside placement. For my first placement with community midwifery, shifts were Monday to Friday, 8:30am to 4:30pm. This shift pattern meant I could only organise paid work Saturdays and Sundays, which usually comprised of a long day (7am to 9pm) and an early shift (7am to 3pm). I worked seven days a week for a whole month. This sacrifice meant I was unable to spend much time with my children, but we managed as a family and knew this was a short-term situation. My next placement block was on delivery suite, which meant three twelve-hour shifts, usually a mix of days and nights. This shift pattern allowed me to organise paid work shifts around placement much more easily. However, the announcement of the increased NHS Learning Support Fund was a relief. The additional financial support allowed me to work bank shifts to enhance my finances, rather than as a necessity.
You can overcome barriers. Research and organisation are often paramount to achievement. Identify what the barrier is, research others’ solutions to overcoming them, and create a plan to fit your circumstances. We are in charge of achieving our own dreams, so grab every resource at your disposal, hold on tight and fight for your future.

Jennifer Foster

A leap of faith

Embarking on a midwifery journey is daunting at the best of times, particularly if you have children at home. Prior to starting midwifery, I wondered how I would manage the commitments that would inevitably follow leaving a full-time job to become a student midwife. Working full-time hours, often at short notice, combined with academic work leaves little time for extracurricular activities or family time. But I am grateful every day I made this crazy leap of faith.

Ordinarily, universities are for young people, straight out of school or college, not for mature students with children or other caring responsibilities. I can confidently say a quarter of my cohort are parents. Midwifery is a career that comes to many later in life, following their own experiences of perinatal care. Midwifery has a notable representation of mature students. Knowing I have other parents around helps lessen the dreaded, all-consuming ‘mum guilt’ that hits when you least expect it. Similarly, when deadlines are looming you need to know you are not alone.

Balancing emotions
Despite the challenges of a midwifery degree including the long shifts and night shifts, the ever-increasing workload and juggling childcare, it is possible to be a parent and a student midwife. Organising childcare, for me, was possibly the most challenging and frustrating aspect of this degree; finding a childcare provider available and willing to work ad-hoc shifts, or making childcare arrangements with family, is a military operation. I have faced comments about my selfishness at abandoning my son to pursue my midwifery dream, a sentiment that has been echoed by family and friends alike. However, I feel I am thriving as a parent, setting an example for my son to grow up by. The guilt over missing Nativity plays, birthdays and parents evenings can sometimes leave a black cloud hanging over my head, but ultimately there is nothing I would rather be doing. When these feelings strike, I reach for my treasured service-user testimonials to remind me why I am doing this. To maximise work-life balance, I endeavour to complete the majority of my academic work whilst my son attends school or is in bed, allowing my free time to be spent with family. Protecting family time lessens the guilt experienced when unable to attend events.

The implementation of the *Standards for student supervision and assessment* within practice has created more flexibility with rostered shifts further supporting a work-life balance. Midwifery is not without challenges, however, finding good friends to support you helps to prevent burnout. I am lucky that my friendship group primarily falls within the Midwifery Society committee. Surrounding myself with those who understand the extreme emotions felt during a midwifery degree helps to lessen stress and anxiety, and promotes a much-needed feeling of camaraderie.
A different perception of success

I expected my student experience to be dampened by being a parent and, while I do not go on the raucous nights out like some of my peers, I became president of the Midwifery Society and a Students’ Union (SU) department representative. I was lucky to attend a university where the SU allowed me to bring my son to society meetings. They also hold family days for the children of students. Attending a university that welcomes families made the transition to university smoother. I felt confident I would be supported to not only succeed, but to get the very best out of my time as a student.

Being a parent and a midwifery student is hard but not impossible. Every challenge I face and hurdle I overcome makes me more determined to succeed, to show other aspiring student midwives they can achieve far more than they can imagine. The only ceiling of success imposed upon mature students is one of fear and anxiety about taking the next step; age and background does not define you. If there is one thing I have taken away from my midwifery journey, it is that I am far more capable than I ever imagined.

Conclusion

“...I have faced comments about my selfishness at abandoning my son to pursue my midwifery dream.”

Maternity educators must work to break down the barriers in place to accessing midwifery training, and current students must work to break down negative perceptions of midwifery studentship. All types of people access perinatal care, and it is important that the
midwifery workforce reflects this heterogeneity. These barriers, though daunting, are not insurmountable. With careful research, planning and support, the challenges created by commitments and responsibilities become attainable. Self-management is a crucial skill for midwives to develop within their practice, especially as the model of care within England moves towards continuity. With dedication, adaptability and commitment, it is possible to not only fulfil the goal of completing midwifery training, but to excel.

TSM

References


Investigating IBCLCs - Expanding horizons through advanced breastfeeding education

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Summary

International Board Certified Lactation Consultants (IBCLCs) are an important part of the multidisciplinary team. Midwives have a role in supporting all infant-feeding journeys and protecting breastfeeding as a form of health promotion. In the first part of this series, Laura Henry looks at the basics – what is an IBCLC, why are they important and why should midwives consider certification?
**What is an IBCLC?**

An IBCLC is a professional clinical expert in breast/chestfeeding and human lactation, who works as part of the parent-child health team to promote and protect the feeding journey. The IBCLC supports parents to meet their infant-feeding goals by providing lactation education to healthcare professionals (HPs) and families, and resolving feeding-related issues if they arise. Like midwives and other HPs, IBCLCs work within a scope of practice and code of conduct to provide safe, high-quality, evidence-based care.

**The key skills that make an IBCLC**

- Advocate
- Clinical Expert
- Collaborator
- Educator
- Facilitator
- Investigator
- Policy Consultant
- Professional
- Promoter

**Why are IBCLCs important?**

A systematic review concluded that IBCLC involvement within the childbearing continuum increased breastfeeding rates at initiation, and in exclusive breastfeeding between one and six months. IBCLC input can therefore improve outcomes for individual health and the wider societal benefits of breastfeeding. Furthermore, an IBCLC can support hospitals seeking Baby Friendly Initiative Status, providing expert training for staff and dedicated infant feeding support services.

**Why should HPs consider obtaining certification?**

Becoming a clinical expert in lactation is an asset, not only to staffing skill mix and service users, but also to individuals as autonomous practitioners, enhancing professional knowledge. The role of the IBCLC overlaps with the role of the midwife. While the hours of clinical lactation practice and learning may sound daunting, these hours can be accumulated while working as a midwife and do not require direct supervision.

**Becoming an IBCLC**

- 95 hours lactation education
- 1,000 hours clinical lactation practice
Conclusion

IBCLCs have widespread benefits for both HPs, families and organisations, including the NHS or independent practice. Although becoming an IBCLC is not a prerequisite of midwifery practice, the role can evolve to suit the needs of the individual and their clients, opening doors to specialisation and management alongside clinical practice. TSM

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Why do they matter?: Commercial partnerships with the infant feeding world


Twitter: @makesmilk

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Summary

Partnerships with charities and public organisations are a tactic commercial companies use to seek new customers. The UK restricts advertising of first infant milk formula. However, if a formula company gains access to families and professionals through a partnership or sponsorship deals, they benefit from a cost-effective marketing tool. With increased pressure on public funds, it is tempting for companies to enter relationships with respected organisations. However, families pay the price – often literally – for products that cost more, even though they are nutritionally equivalent to much cheaper options. Emma Pickett explores why these partnerships matter.
Big business

Conversations about infant feeding on social media are a constant hot topic. One of the UK’s largest charities, with over five million members, recently announced a new working relationship with a formula company, to ‘enable the planting of trees’.

Partnerships, whether sponsoring awards, paying for events, or offering deals through other organisations, are a well-established technique to reach customers. The WHO International Code of Marketing of Breastmilk Substitutes prevents formula companies from advertising.¹ Even though the code is now in its 40th year, its importance in the face of a multi-billion-dollar industry has never been more significant. Only part of the WHO code was inscribed into UK law: formula companies are not allowed to advertise formula for babies under six months of age (i.e. first formula milks). But in the face of this restriction, companies got creative.

Baby Clubs, greenwashing and halos

Formula companies spend millions on marketing, a budget that is constantly increasing.² Where does that money go if a core product cannot be advertised? The answer is wider branding and the promotion of follow-on milks, which are not nutritionally necessary. Companies also create helplines and ‘Baby Clubs’, providing direct access to families, often even before babies are born. They have taken advantage of partnerships to gain personal data, which is handed to marketing teams, taking advantage of a ‘Baby Club loophole’. When questioned on the ethics of this, formula milk companies have claimed these controversial partnerships are formed with the wider brands non-specific to formula branches, hoping to stem the public outcry. However, many remain unconvinced.
The formula industry is a major contributor to greenhouse gases and the use of water and packaging. Companies have been sanctioned for their environmental records and not meeting the Producer Responsibility Regulations, including some of the largest fines ever handed out by the UK's Environment Agency. Aligning with an established, pro-environment charity, promotes 'greenwashing'. Through partnerships, companies can bask in the glow of an established reputation – known as the ‘halo effect’ – and gain access to new communities, where they can observe patterns of behaviour. They use partners' social media platforms and advertising budgets to reach out to customers when they are restricted from direct contact. Partnerships are also often cheaper than mass advertising campaigns. If formula companies can find a way to contact professionals who work with families and who may not be fully trained in conflict of interest, UNICEF Baby Friendly or the differences between formula types, even better.
Ethics and inequalities

Those who care about the ethics of formula promotion are often labelled as narrow-minded who do not ‘get’ what formula means for families. Health professionals and volunteers regularly support families to use formula and know its value. We see families who struggle to afford formula and families who mistakenly believe more expensive brands are better. The All-Party Parliamentary Group on Infant Feeding and Inequalities found promoted brands to be 50% more expensive than using the least costly brand. All formula milks are legally required to be compositionally equivalent. Higher costs equate to advertising, packaging, and branding, not better or safer formula.

As prices increase, Healthy Start vouchers have not kept pace. Nor have wages. Figures in 2018 showed fewer than 500,000 individuals received Healthy Start benefits – a 30% reduction from 2011. Uptake by those eligible for the scheme has also reduced from around 80% in 2011 to 65% in 2018. The inquiry showed that Healthy Start vouchers do not cover the cost of feeding a baby aged two to three months if families purchase most of the popular brands. The cheaper, nutritionally equivalent supermarket brands are not available universally. Families sometimes resorted to stretching out product use by not following safe guidelines on re-using and storage, using more water than recommended or by giving infants cereal and other inappropriate foods.

It is not just charities or professional organisations that are vulnerable to taking on questionable commercial partnerships and succumbing to the influence of skilled PR and marketing teams. For many years, Public Health England has partnered with a commercial company with a formula milk arm for its ‘Change4Life’ campaign. As one of the world’s largest manufacturers of infant formula, and a company that recently admitted more than 60% of its portfolio cannot be considered healthy food, this choice may seem surprising. With the public sector short on funds, and charities and other organisations seeing a significant loss of income during the pandemic, deals are especially tempting.

Decision making
While some argue that parents should be capable of seeing through sponsorships and partnerships in order to make their own decisions independently, many believe the marketing tactics of the formula feed companies should face tighter control. The companies themselves would not continue with these partnerships without translation into profits. Borrowing the reputation of an established, respected organisation is an efficient method of gaining consumer trust with an audience desperate to find products that are perceived as the best for their child.

The NHS Long Term Plan committed all health professionals to a future of working within UNICEF Baby Friendly guidance. Most areas in the UK are already operating with an understanding that families have a right to make choices free from commercial influence. However, new families are vulnerable and when faced with a shelf full of products, making a decision can feel overwhelming. Is it right they should be influenced by organisations with the largest advertising spend? Is it right a company can align itself with a respected organisation to appear more credible or ethical? Is it right that parents are the ones paying for those partnerships?
Professional implications

When it comes to sponsored health-related events, some health professionals are offended by the claim that attendance impacts on their professional bias. They feel it is insulting to imply they will be unduly influenced, or it may affect their work with parents. It is precisely this belief that we are not affected by partnerships that makes them so dangerous. As researchers Cain and Detsky\(^8\) state, ‘conflicts of interest are problematic, not only because they are widespread but also because most people incorrectly think that succumbing to them is due to intentional corruption, a problem for only a few bad apples.’ We often believe other people are affected by conflict of interest, but not ourselves. In one study of health professionals, 61% said commercial promotions and contacts did not influence their own work, but believe this was only true for 16% of others.\(^9\) Advertising and promotion employ subconscious messaging, influencing professionals’ decision-making and care subconsciously.

Conclusion

A formula company representative walking through the postnatal ward, handing out samples and advising parents not to bother with breastfeeding is not acceptable. That is a no-brainer. However, where do you draw the line in appropriate infant formula promotion? The UK government has decided advertising infant formula is not in our national interest. The NHS has decided health professionals must not be seen to endorse any one product. Companies have to get creative in order to reach families. It is our job to protect families from undue influence at their most vulnerable time, to signpost them to evidence-based information and to educate others to understand why this matters. TSM

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5. All-Party Parliamentary Group on Infant Feeding. Cross-party group on Infant Feeding and


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**Leadership in Action - Finding your voice**

Krystyna Nowobilinska-Dean [she/her] - Newly-qualified Midwife, UK

Instagram: @kryssiki

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**Summary**

Leadership in midwifery must be demonstrated by all registrants. However, developing leadership skills can be daunting. This series explores how student midwives can work to embed these core skills into their practice. In this first instalment, Nicole Rajan-Brown and Krystyna Nowobilinska-Dean discuss how students can find the courage to speak out to promote change within perinatal care.

A major element of leadership is finding the courage to use your voice. However, making your voice heard is often the hardest part. The archaic view of hierarchy places students at the bottom of the chain, causing a lack of confidence in challenging practice or suggesting improvements. As advocates for birthing people, peers and colleagues, students are ideally placed to demonstrate leadership qualities.

**The bare necessities**
Leadership improves outcomes, standards of care, and staff satisfaction. Although the term ‘leadership’ can feel intimidating, ‘leadership’ and ‘leader’ are not synonymous; while ‘leader’ refers to hierarchy, ‘leadership’ is the skillset and act of leading. This distinction supports midwifery students to demonstrate leadership without named responsibility. As defined by The Code, students must intertwine these skills into clinical practice. This is not an optional extra – it’s an essential element of midwifery development and training.

**Local leadership**

Every word, action, and choice has a cascading effect. Refusing to follow blindly accepted cultural norms, and acts of compassion and respect do not go unnoticed. Leadership does not equate to national indignation; making local changes in your Trust, staff room, and birth room, creates ripples. Stepping outside of your comfort zone is often necessary. But be mindful of when, where, and who to speak out to, and consider the impact it will have. Professional Midwifery Advocates and Freedom to Speak Up Guardians can offer support and provide protection.

**Leadership in practice**

- Managing independent learning
- Supporting peer development
- Participating in audits and working groups
- Suggesting service improvements
- Attending training

**What next?**

Finding your voice starts with reflection. Use practice scenarios to consider how situations could be handled differently in the future. Practice key phrases in the mirror so they can be relayed confidently and firmly and ask for support where it is needed. **TSM**
Practice in the mirror

- Perhaps we could consider XYZ?
- L’s preferred pronouns are...
- That could be construed as racist, what did you mean?
- Could you please explain your rationale for this care decision to help me understand?
- Could we discuss this in private?

References


Are you calling me fat? Part 1: The Research

Nicola Salmon [she/her] - Fat-positive fertility coach

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Summary

The bias fat people face in healthcare is systemic, but judgmental and shaming behaviour can be particularly devastating in fertility and perinatal care. Midwives can have a positive impact on the care of fat people throughout their pregnancies when they begin to understand and explore how bias shows up in their work and how even the smallest of actions can have a big impact on the
Lived experience

My palms were sweating as I perched on the edge of the small plastic chair in the hallway that was too small for my body. I felt like I was waiting outside the headmaster’s office to be told off but, in reality, I was waiting to advocate for my birth choices. My midwife told me I was not allowed to have a home birth and if I did want to “put my health and my baby at risk”, I would need to arrange a meeting with the Head of Midwifery to discuss my choices.

I spent the last couple of weeks anxiously collating all the research available about home births in bigger bodies, overwhelmingly showing home birth was a safe birth choice for those with a higher BMI (Body Mass Index). Research and difficult conversations about what I was “allowed” to do during birth was not how I wanted to spend my time at 35 weeks’ pregnant.

So why did I have to have a meeting with the Head of Midwifery for my choice to be signed off? Why did I have to jump through additional hoops to access care that people in smaller bodies received without question? This was one of the ways that anti-fat bias showed up in my pregnancy and birth.

Anti-fat bias
Anti-fat bias is the discrimination fat people face based on the size of their body. We all hold a form of this bias to varying degrees, largely due to the persistent idea in Western culture that thinness is the ideal and healthiest body shape. We are all familiar with the idea that when we look a certain way, only then will we be happy, healthy and live our best life. Our value is often based on how attractive we are to cismen. These ideas fuel the way that fat bodies are seen by our society and portrayed by the media.

I have come a long way in the seven years from that appointment and I have embraced the word fat as a neutral descriptor of my body.

**Stigma and cycling**

Weight stigma is the discrimination faced by fat people due to their BMI or weight. This has been shown to impact healthcare, including shorter appointment times, treatment with less dignity, receipt of fewer test and treatment options, and experience of longer periods before diagnosis. Health conditions in fat patients frequently go undiagnosed or misdiagnosed because their doctors tell them to return when they have lost weight.

Weight Cycling is repeated weight loss and weight gain, common for many fat people who have dieted in the past. When weight increases and decreases rapidly over a short time there is a negative impact on health, increasing the risk of both coronary heart disease and high blood pressure.

The majority of research on the dangers of obesity fails to consider that many participants have been yo-yo dieting for large portions of their life and may still be dieting, which affects how their bodies function. Both factors increase chronic inflammation, impact mental health and increase the risk of comorbidities. The bias reflected in research is then translated into what practitioners consider best, and evidence-based practice.
Evidence-based practice is held as the gold standard for healthcare and the basis for clinical decision making but this research is only as good as the humans carrying it out. We all hold bias based on our narrow perception of the world; these biases include our perceptions about fat people and extend into professional and academic practice. For any area of study, we must consider the original sources of the research with a critical eye. Most of the research in relation to body weight is not black and white, and often not all the studies confirm that when BMI increases, so does risk.

Gilman and Poston’s collected works on perinatal obesity highlights how the research explores fat bodies, exemplified with BMI and early pregnancy loss. The editors forefront a study showing the highest association between BMI and loss, however, this study was not reflective of the wider research picture presented. The two largest studies representing 7,696 IVF/ICSI cycles, demonstrated no relationship between BMI and early pregnancy loss. In highlighting a study demonstrating the greatest significance, more robust research, with greater bearing, is left in the background.

Furthermore, a large meta-analysis showed women with a BMI over 25 had a 67% greater chance of experiencing a miscarriage compared with a woman with a normal BMI. This does equate to a 67% chance of having a miscarriage. It means that if 10% of women with a normal BMI have a miscarriage, their research suggests that 16.7% of women with a higher BMI will have a miscarriage. The presentation of statistics can be misleading. In a further eight studies explored by the authors, undertaken since the meta-analysis, three studies found no evidence of a link, and two studies found a link without statistical significance, leaving only three studies demonstrating
a statistically significant link. Correlation does not equal causation. Healthcare professionals must be aware of the bias present in research, considering both individual papers, as well as the wider research picture to make appropriate critiques when using evidence to guide practice.

**Critiquing Research**

Where does the research sit within the hierarchy of evidence?
Does the research design align with the research purpose?
Has the research been carried out appropriately?
Are the presented findings and conclusions supported by the evidence?

Nicola offers a program for healthcare professionals discussing fertility care, the research into pregnancy risk and inclusive practice. Learn more here and use code SMJ15 for a 15% discount.
Conclusion

When practicing midwifery, it is essential to remember researchers are not infallible; we should use critical analysis to question conclusions made in research and how they are applied in practice. Evidence-based practice is a central element of midwifery, but research is deeply nuanced and inconclusive, and should not be used to deny compassionate, respectful and evidence-based care to those who have bigger bodies.  
TSM

References