Midwifery Research Review™

Making Education Easy

Issue 5 – 2014

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Welcome to the latest issue of Midwifery Research Review.

This issue has a mixture of studies. The majority feature exploration of women or midwives experiences, either as qualitative or mixed method studies. The first article is an Australian clinical audit, focusing on outcomes for women with a pre-pregnancy BMI of >40. A topical area, given the current Ministry of Health initiatives related to obesity prevention in New Zealand. This is followed by an interesting Danish study exploring women's experiences of epidural anaesthesia in labour. An exploration of shared decision making in second stage of labour follows, with commentary by guest reviewer Debbie MacGregor. A major study of New Zealand women's decision making about place of birth is next, followed by an exploration of Japanese women's experiences of pharmacological pain relief in New Zealand. 'Responding to a crying infant – you don't learn overnight', might seem self-evident. However this is a sensitive exploration of new mothers' learning curve as they get to know their babies, and recommends supportive practices for midwives. A timely reminder about family violence in and after pregnancy in NZ is next, followed by an interesting exploration of the impact on midwives of the physical and aesthetic design of birthing rooms (thanks again to Debbie). A very interesting look at midwives' experiences of proforma birth plans in the UK is followed by a US review of evidence-based practices in management of second stage of labour.

I hope you enjoy this issue, and look forward to any feedback you might have.

Kind regards,

Jackie Gunn

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Maternal obesity and the first birth: a case for targeted contemporary maternity care

Authors: Slavin V et al.

Summary: This clinical audit study determined the birth outcomes of extremely obese pregnant women (BMI ≥40) having their first birth. Outcomes for 50 extremely obese women who gave birth at 1 site over a 2-year period were reviewed. Data were collected from booking to discharge, and included variables such as model of care, number of appointments, and obstetric and neonatal outcomes. Obese women rarely had contact with a midwife, except at booking. More than half of them (56%) had a caesarean section, which was more than double the rate in normal-weight primiparous women who birthed at the same site during the same period. 64% of them had a normal pregnancy free from complications. For women who planned to labour, birth intervention rates were high. In conclusion, current maternity care provision is not meeting the needs of extremely obese women experiencing their first birth.

Comment (JG): Clinical audit can help identify trends inside individual populations of clients being cared for by an individual service. They are generally specific to the service being audited and are a commonly employed quality control tool. This report is from a mid-size, mixed acuity/complexity Australian maternity hospital where 3500 babies are born annually. While audit findings cannot be directly extrapolated to other settings, the study is included because of the area of the review. The incidence of obesity in the NZ childbearing population is increasing, in particular women with pre-pregnancy BMI >35. This audit asks us the question, is it possible that a similar picture can be found in NZ? While the care that NZ women experience is much more likely to have some continuity of midwifery care, and the women in this study hardly saw a midwife and saw a different doctor every visit, perhaps the continuity influences intervention rates here? The authors' recommendation is for targeted antenatal care to provide more continuity of midwifery care for obese women, perhaps a NZ study would paint a different picture.

Reference: Int J Childbirth 2014;4(2):120-129

Abstract

The experience of giving birth with epidural analgesia

Authors: Jepsen I & Keller K

Summary: This study examined the birthing experiences of women who received epidural analgesia for labour pain. Nine nulliparous women were observed from the time they received epidural analgesia until the birth of their baby. They were then interviewed the next day and again 2 months later. The midwives were interviewed 2–3h after the birth. Two different types of emotional reactions towards epidural analgesia were observed, one of which was marked by a subtle sense of worry and ambivalence. Another important finding referred to the labouring woman's relationship with the midwife: some unnoticed matters of communication and recognition appeared to be of significance.

Comment (JG): This is an interesting Danish study that opens up exploration of midwifery care for women experiencing epidural anaesthesia for analgesia in labour. The research design is complex as it includes observations during the labour, as well as two interviews with the women and one with their midwife, all at different times after the birth. However, the methodology and analysis are thoroughly discussed. The most important findings for midwives are: 1. that women react quite differently to choosing epidural in labour. On one hand some women are confident about their choice and are pleased to leave the chaos of the pain and the 'isolation' created by turning inwards to deal with it. The field observations and the interviews were congruent for these women. On the other hand, some women were more worried about their choice, felt distanced from the labour and their baby, were happy to leave the chaos of the pain behind, but less happy to leave the 'isolation' of the inner process as it felt normal. 2. All of the women needed the midwife's presence and the engagement in the first hour or two after the initiation of the epidural. 3. Continuity of midwife mattered. 4. If the midwife changed, the women wanted the new midwife to understand what she had experienced before the epidural anaesthetic. 5. Crucially, the women may not indicate any of these concerns to the midwife. Careful communication and discussion to elicit the woman's needs is indicated.

Reference: Women Birth 2014;27(2):98-103
Abstract

The role of maternity care providers in promoting shared decision making regarding birthing positions during the second stage of labor

Authors: Nieuwenhuijze M et al.

Summary: This study investigated how maternity care providers communicate with women during the second stage of labour regarding birthing position. 41 audiotapes of women and their maternity care providers during the second stage of labour were analysed. Themes identified in the transcripts included the maternity care provider listening to the women, encouraging them, offering information and choices, using various styles of support, empathy and interaction. The maternity care providers used a dynamic process that moved between open, informative approaches and more closed, directive approaches to enable women to select various birthing positions.

Comment (DM): This article talks of all things that are integral to NZ's unique model of midwifery care i.e. partnership and continuity of care. The adjusted framework for analysing maternity care provider behaviour in enabling women's involvement in shared decision making will already be very familiar to midwives that practice individualised care based on trusting self determination by the woman, as well as trust in the birth process itself. The beauty of continuity of care is the opportunity of time during pregnancy that facilitates shared information and discussion on and perceptions into the woman's preferences and desires. This reduces the challenges that may otherwise occur when navigating the journey taken by some babies to make their entry into the world! The various behaviours and communication patterns discussed should be well practiced by the time the second stage of labour occurs, but for midwives not providing continuity of care, this article will provide refreshing insights into dynamic ways of being with women during the birth process.

Reference: J Midwifery Womens Health 2014;59(3):277-285
Abstract

Independent commentary by Debbie MacGregor

MHPrac (AUT), BHSc (Midwifery), RM

Having been a full time midwifery Lead Maternity Carer (LMC) for 14 years, Debbie became a lecturer in the Department of Midwifery, Faculty of Health and Environmental Science at AUT University in 2010. She teaches across all 3 years as well as presently holding the position of Midwifery Student Liaison. Finding the privilege and satisfaction in providing NZ's unique model of midwifery care hard to let go, Debbie continues to practice as a LMC, looking after a small case load of 10 families a year. Her particular interest is to support women who choose to birth in a primary context. Debbie feels strongly that working as both a midwifery lecturer and LMC each sustain the other.

Independent commentary by Jackie Gunn

MA *Massey* BHSC Ng *C.Sturt* RGON RM

Jackie is a Senior Lecturer in the Dept of Midwifery, Faculty of Health and Environmental Science at AUT University. She has been involved in leadership of midwifery education at AUT University for more than two decades and has practised midwifery in tertiary and primary maternity units and as an LMC midwife. **For full bio CLICK HERE.**

An exploration of influences on women's birthplace decision-making in New Zealand: a mixed methods prospective cohort within the Evaluating Maternity Units study

Authors: Grigg C et al.

Summary: This analysis of the Evaluating Maternity Units prospective cohort study determined influences on women's birthplace decision making in New Zealand. 576 women who had been booked to give birth at a tertiary maternity hospital or 1 of 4 primary maternity units completed the survey. All of the women received midwifery-led continuity of care, regardless of their intended or actual birthplace. Almost all the respondents considered themselves to be the main decision makers for birthplace. The tertiary hospital group rated accessing a specialist facility as the most important factor. Those who chose a primary unit identified several important factors, including closeness to home, ease of access, the atmosphere of the unit and avoidance of unnecessary intervention. The concept of safety was integral to both groups.

Comment (JG): The study is robust and testament to the interest of the women (and the researchers) to attend focus groups a year later than planned after the study was interrupted by the devastating earthquakes of 2011. The women in this NZ study all stated that they were the primary decision maker about where they chose to give birth, with the midwife the most influential health professional. In many cases women had decided long before pregnancy where they would give birth. The firmly held, yet contrasting views of the two groups of women about their choice being 'right' and 'safe for them' is revealed as integral to their individual perception of childbirth. The study is a welcome addition to the literature about women's decision making in childbirth.

Reference: BMC Pregnancy Childbirth 2014;14:210
Abstract

Japanese women's experiences of pharmacological pain relief in New Zealand

Authors: Doering K et al.

Summary: This study investigated how Japanese women living in New Zealand feel about using pharmacological pain relief in labour. 13 Japanese women who had given birth in NZ were interviewed. 11 of the women had experienced labour pain and, of these, 9 had received epidural and/or Entonox (a gas mixture of nitrous oxide and oxygen). The contrast between their Japanese cultural expectations and their birth experiences subsequently caused some of the women personal conflict.

Comment (JG): Although this careful qualitative study focuses on Japanese women and their specific cultural approaches to pain in labour, the findings are a timely reminder of how powerful an influence midwives' words can be for labouring women. It also reminds us that 'clumping' people from different cultures under one umbrella runs the danger of assuming that everyone in the group is the same. Individualised care is a strength of New Zealand's LMC system. As in the article on women's experiences of epidural anaesthesia, women do not necessarily tell their midwife what they are thinking. Individualised care can provide the opportunity for space in which women have time to effectively communicate their wishes/decisions. New Zealand's increasing ethnic diversity brings increasing diversity in childbirth traditions and practices. Individualised approaches to midwifery practice can support such rich diversity.

Reference: Women Birth 2014;27(2):121-125
Abstract

Responding to a crying infant – you do not learn it overnight

Authors: Kurth E et al.

Summary: This study examined the views and practices of first-time and experienced mothers in response to infant crying during their first 12 weeks. 15 new mothers of diverse parity and educational background who had given birth to a full-term healthy neonate were included. First-time mothers showed some soothing skills from the outset, but fine-tuned the way they handled the crying infant and their own reactions over time. With growing experience, mothers developed a differentiated understanding of the reason for the crying, and used more successful soothing techniques. They also learned to assess and mitigate their own stress reactions.

Comment (JG): This Swiss study explores women's experiences of their babies' crying and the mothers' responses to the crying. Women increase in confidence over time and from child to child. The findings highlight the difficulty first time mothers in modern industrialised countries may have accessing role models to learn about normal baby behaviour, and therefore the need for information and support both in pregnancy and through the post partum period.

Reference: Midwifery 2014;30(6):742-749
Abstract

Immediate and long-term outcomes of assault in pregnancy

Authors: Gulliver P & Dixon R

Summary: This NZ study examined the immediate and long-term health outcomes of women hospitalised with pregnancy-related assault. The hospital records of pregnant women admitted to a public hospital in New Zealand in 2001–2006 were reviewed. Unique identifiers were used to identify the index pregnancy event, subsequent discharge events and mortality for 5 years after the index event. Discharge records were organised into 3 groups: pregnancy-related hospital admission but no associated or subsequent assault recorded (pregnancy only group); an assault-related hospital admission event after the pregnancy but within 5 years of the index pregnancy (assault after pregnancy group); and an assault recorded within the same hospital admission event as the pregnancy (assault during pregnancy group). Compared with the pregnancy-only group, women in the assault after pregnancy and assault during pregnancy groups were at increased risk for death, preterm labour, antepartum haemorrhage, infectious complication, spontaneous abortion and stillbirth.

Comment (JG): While the findings in this report will not be new to midwives, the 5-year follow-up findings are an indication of the long term effects of the assaults. It would be interesting to know if the picture in 2014 is any different to the data described and analysed here. The report uses data collected between 2001 and 2006, a minimum of 8 years and as many as 13 years ago. In the interim there has been significant investment in family violence screening training across the health professions, which is one of the interventions recognised in the report. Nonetheless, almost 2500 women required a hospital admission for assault by an intimate partner in these years. Some died, many had injuries five years later. The report is a shocking reminder of the ongoing level of violence experienced by many women in our communities.

Reference: Aust N Z J Obstet Gynaecol 2014;54(3):256-262
Abstract

The hardware and software implications of hospital birth room design: a midwifery perspective

Authors: Hammond A et al.

Summary: This Australian study examined the impact of physical and aesthetic design of hospital birth rooms on midwives. The labours of 6 women cared for by midwives in one birth centre and two labour wards within 2 Australian hospitals were filmed. Subsequently, 8 midwives were interviewed while they watched the filmed labour of the woman they cared for. Thematic analysis of the midwife interviews showed that they were strongly affected by the design of the birth room. Aesthetic features, room layout and the design of equipment and fixtures all impacted on the midwives and their practice in both the birth centre and the labour ward.

Comment (DM): This is an important piece of work for any hospital board or community trust that is planning to upgrade existing or create new birthing facilities, as is rumoured to be the case in Auckland shortly! The study clearly identifies that midwives need to be key collaborators in any work-place design, with serious consideration given by planners to creating a birthing environment that supports the midwife to support the woman to birth in the most physiological way possible. The midwives in this study demonstrate impressive flexibility and creativity in upholding birthing women's needs, even when the environment was less than conducive to the comfort of both. Not all midwives would be so accommodating. An appropriate birthing environment design should be implicit in shaping, influencing and supporting autonomous midwifery practice, thereby hopefully contributing towards enhanced outcomes. This article throws down the gauntlet to all prospective planners and designers of hospital birthing rooms!

Reference: Midwifery 2014;30(7):825-830
Abstract

Unique and proforma birth plans: a qualitative exploration of midwives' experiences

Authors: Welsh J & Symon A

Summary: This study examined UK midwives' experiences with unique or proforma birth plans. Focus groups of midwives in 5 midwife-led units and 4 obstetric-led units in the East of England participated. Three main themes arose. Firstly, the term 'birth plan' was criticised for encouraging the belief that birth can be 'planned'. Secondly, birth plans were a source of irritation for midwives in both groups, although the cause of the irritation differed between groups. Finally, midwives in both groups felt that birth plans put pressure on them, although the source of the pressure and the way in which midwives reacted to this pressure differed between groups.

Comment (JG): What an interesting study this UK research is. It seems strange that women don't develop their care plan with their midwife, a negotiated care plan has been a requirement of the NZ primary maternity service specifications for so long that it is a natural part of antenatal care. The NZ maternity system provides continuity of midwifery care for nearly all women during pregnancy and childbirth so that a care plan can be initiated and developed over time. By the time labour and birth arrives, the midwife and the woman have a shared understanding of the woman's wishes. The study reminds us of the precious gift that is continuity of care for both women and midwives, but also that negotiated care is the norm for both LMC and core midwifery services.

Reference: Midwifery 2014;30(7):885-891
Abstract

A review of evidence-based practices for management of the second stage of labor

Authors: Kopas M

Summary: This review discussed evidence-based practices for second-stage labour care, including risk factors for perineal trauma and prolonged second stage, and examined a variety of care practices including positions, styles of pushing, use of epidural analgesia, and perineal support techniques. Each woman should be individually assessed and informed of the potential risks to her and her foetus of a prolonged second stage of labour.

Comment (JG): This US review of the evidence for care practices in second stage labour is a useful addition to the literature. It is written in a readable style which makes it very accessible. It contains tables with useful summaries of the research that provides the evidence for practice. It covers maternal positions, delayed pushing, directed versus spontaneous pushing, OP position in second stage, duration of second stage, hand techniques and perineal trauma, compresses and perineal trauma. It may be a useful resource for educators.

Reference: J Midwifery Women Health 2014;59(3):264-276
Abstract