

## HOME BIRTH Supplement



**Outcomes by planned place of birth:  
Implications of the Birthplace Study**

Cathy Warwick

**The Birthplace Study:  
Turning the tide of childbirth**

Cathy Rogers, Carole Yearley and Carol Littlehales

**Perceptions of birth in a stand-alone  
centre compared to other options**

Cathy Rogers, Joan Harman and Dan Selo-Ojeme

**Supervision issues: Lessons to  
learn from a home birth**

Jamie Richardson

**Ideals, expectations and reality:  
Challenges for student midwives**

Angela Barkley

# Outcomes by planned place of birth: Implications of the Birthplace Study

As readers will be aware, 'Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England National Prospective Cohort Study' (Birthplace in England Collaborative Group, 2011) was published on 24 November. Not surprisingly, there has been much media coverage of the findings, and, typically, the discussion polarized into homebirth versus hospital birth, with comments frequently based on personal agendas and preferences rather than the actual outcomes of the study. Headlines in the popular press ranged from 'Home as safe as hospital for second births' (Laurance, 2011) to 'Home births three times more risky than hospital' (Smith, 2011). Now that the initial excitement has died down it is important that maternity services professionals take a look at the key messages emerging from this major study undertaken between April 2008 and April 2010 and consider what we should do next.

## A free choice in place of birth

The study found that for low-risk women giving birth is generally very safe. The researchers conclude:

***'Our findings generally would support women with healthy, straightforward pregnancies having a free choice of where they feel most comfortable to give birth.'***

This is good news. We can all breathe a sigh of relief that the major policy documents driving the direction of maternity services provision across the UK do not all need to be rewritten. However, the fact that must be faced is that the Birthplace Study is endorsing a policy of choice that has



been in place since 1983 when *Changing Childbirth* was first published, but has not been fully implemented. This is surely shocking. When on earth will we start putting policy into practice?

Having asked that question, however, it has to be acknowledged that turning a tanker (or maybe the status quo) around isn't easy. Indeed, 92% of women give birth in hospital and the provision of not only homebirth services but also free-standing and alongside maternity units is woefully lacking. It is very hard for midwives to offer women an informed choice of place of birth if the service has no capacity to accommodate that choice. It is also very hard for midwives to support choice if they themselves have had virtually no experience of supporting women in different settings.

Equally, how can women make a choice of something that does not exist? Only the very well-informed choose a homebirth in those areas where rates are virtually non-existent. Other women will be surprised that such a choice is even possible. Why are we so bad at putting policy into practice? Is it because, although policy documents support choice, some professionals still hold the belief that most women, regardless of risk status, are better off in hospital? Is it because it is felt that centralizing care must be the most efficient way of delivering services? Is it because women, even when

choices are available, continue to choose the option of obstetric-based care?

Perhaps all of these are true in different measure in different places and have combined together since 1983 to create a range of catch-22s and to stymie a real alteration in the way capacity is distributed throughout the system. Following the findings of the Birthplace Study none of these reasons can now be said to be valid. Surely change is no longer an option. This is no longer just about choice—it is about whether or not we want to ensure the best outcomes for women and their babies.

The Birthplace Study is unequivocal in its conclusion that 'maternity units appear to be safe for the baby. Mothers planning births in midwifery units see no differences in adverse outcomes for babies compared with obstetric units' and not only are these units safe but they 'also offer benefits for the mother. There are many more 'normal births' with mothers having significantly fewer interventions'.

In addition, the Birthplace Study found that 'for women at low risk of complications having a second or subsequent baby, homebirths appear to be safe for the baby and offer benefits for the mother. 90% of planned homebirths are 'normal births' compared to under 60% of planned obstetric unit births'.

The economic evidence from the Birthplace Study is equally compelling—the main drivers for costs were found to be overheads and staffing and both of these contribute to the fact that hospitals, which have to have all services on standby 24/7, are the most expensive way to provide services. The cost of births in midwifery-led units is less than in hospitals and homebirths are the least expensive of all.

Some may worry, however, about another finding from the Birthplace Study; that of high transfer rates. This applies particularly to first-time mothers with a large number of them requiring transfer from their chosen place of birth to hospital. The Birthplace

Cathy Warwick

General Secretary of the Royal College of Midwives

Study reports that ‘for nulliparous women, the peri-partum transfer rate was 45% for planned homebirths, 36% for planned freestanding midwifery unit births and 40% for planned alongside midwifery unit births.’ Some might argue that this fact means we should limit our ambitions to ‘turn the tanker around’ to women having their second and subsequent babies or at the very least limit the choice for first-time mothers to an alongside midwifery unit.

I would argue differently. We must remember that the study is based on choice of place of birth, not actual place of birth. This means that even when women do have to transfer, it is with the same positive results as those who actually deliver in the place of their choice. Being able to choose to give birth locally is important to many women and the development of homebirth services or freestanding midwifery units can ensure that more women can give birth locally. This is extremely important when it seems inevitable that small obstetric units will have to combine with larger units to ensure safe medical staffing.

This does not mean we can be complacent about transfer rates—an important area for future research and audit. What the Birthplace Study gives us is a fantastic evidence base from which to start. Why are the rates so high? Does this reflect protocols that are too stringent? Should these, gradually and with careful monitoring, change?

Alternatively, do they reflect the fact that the majority of midwives have had their experience in obstetric units and may need to develop their skills at supporting women to labour in a non-technological environment? We must find out what issues are at play, and in the meantime it is our responsibility to ensure that transfer is efficient, effective and supportive of the mother.

### Enabling informed choice

But there is another problematic message from Birthplace: ‘For women having a first baby, a planned homebirth increases the risk for the baby’. This increase in poor neonatal outcomes is small, but, like transfer, this finding has led to suggestions that the choice of homebirth should not be available to first-time mothers. The difficulty with this position is that it ignores two critical facts. One is that whatever professionals believe and whatever serv-

‘If we sit back and ignore the findings of the Birthplace Study into the outcomes for 65 000 women, how can we possibly argue that we really want maternity care in the UK to be of the highest quality?’

ices are offered, women will continue to choose homebirth and I believe we have a responsibility to ensure their births are as safe as possible. The second is that we cannot assure an individual woman that the outcome for her or her baby will be better in hospital. The Birthplace Study shows quite clearly that things go wrong for babies (albeit in different measures) wherever women choose to give birth, and for the mother, interventions in an obstetric unit will be greater. The role of professionals is not to tell people what to do but to make sure they have the information they need to make informed choices. Once again for each woman it is a question of balancing risk—we cannot advise the mother whether she will sadly be one of the 9.3 women per 1000 choosing to deliver at home, or one of the 5.3 women per 1000 choosing to deliver in an obstetric unit, whose babies will not do well. Again, this is an area where more research is needed. One question may be whether or not strict entry criteria for free standing midwifery-led units results in women with marginal risk factors choosing to stay at home, where these do not apply.

### Planning for development

So what I think we should now be doing is, on the basis of strong evidence, motoring ahead with the development of midwife-led units and homebirth services. We need to plan this capacity as a starting point on the assumption that at least 30% of births will take place outside obstetric units. For multiparous women these services should be, I believe, increasingly presented as the default option. This shift makes economic sense in that it frees up capacity in obstetric units for those who need that care, and will result in lower rates of intervention which again reduces costs. Of course, there may be capital costs in developing midwifery-led units but if we cannot afford these then we can develop homebirth services which

have no capital costs associated with them. We must also make sure that changes to the system by which commissioners pay trusts do not disincentivise evidence-based service provision.

As more and more women give birth out of hospital there are of course challenges that sit alongside of that. The workforce will need to be properly prepared for such a shift. Education and training must start to adapt to a very different service configuration. Some widely-held beliefs such as the necessity for two midwives at every homebirth or a midwife on duty at a freestanding midwifery-led unit 24/7 when birth numbers are low must be challenged and examined. We also must have enough midwives to ensure the viability of such services and we must recognize the experience of midwives working independently. Ongoing audit and further research is essential. As we change focus and scale-up midwifery-led services, safety must be maintained and even improved. Three critical questions seem to be, how can we reduce transfer rates? How can we improve the neonatal outcomes for first-time mothers having homebirths? How can we reduce intervention rates for first- and second-time mothers choosing hospital birth?

Such challenges should not, however, detract from the fact that change is imperative. If we sit back and ignore the findings of the Birthplace Study into the outcomes for 65 000 women, how can we possibly argue that we really want maternity care in the UK to be of the highest quality? **BJM**

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# The Birthplace Study: Turning the tide of childbirth

## Abstract

The publication of the Birthplace Study should herald a major shift in the provision and organization of maternity services, in particular the expansion of births outside obstetric units or at home. The media portrayal of the findings were disappointing as the focus was very much on the homebirth findings in relation to first-time mothers and did not promote the unequivocal evidence that delivery in a midwifery-led unit is safe. The adverse outcomes for low-risk women who choose to give birth in an obstetric unit were glossed over as if of limited significance. Based on the findings of the study, maternity service commissioners and providers need to develop a strategy to ensure low-risk women are given informed choice with respect to place of birth and that recourses are available to support this. This study provides us with a really good opportunity to turn the tide of childbirth.

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This article sets out to provide some contextual background to today's state of maternity care in England which has impacted on changes to provision and choices. The commentary provides a personal professional account and reflection from the perspective of three midwives in England and presents their reaction to, and their vision for, the possibilities for change in response to the recent publication of the Birthplace Study (Birthplace in England Collaborative Group, 2011).

## Tracing the path of birthplace settings

Concerns about the safety of different birthplace settings, in particular giving birth outside a consultant-led unit, has had a significant impact on the organization and provision of maternity care, as well as the uptake of alternative birth settings by women. These concerns were fuelled by the publication of the Peel report in 1970 which called for 100% of births to take place in hospital (Ministry of Health, 1970). Successive government reports throughout the 1980s and 1990s continued to advocate birth in obstetric units for the safety of mothers and babies (Tew, 1980; Oakley, 1984). The report of the Maternity Services Advisory Committee (1984: 23), which set out the government's policy direction at the time stated, 'As unforeseen complications can occur in any birth, every mother should be encouraged to have her

baby in a maternity unit where emergency facilities are readily available'.

Although a number of authors (Tew, 1980; 1995; Oakley, 1984; Campbell and MacFarlane, 1994) questioned the wisdom of these policy recommendations and challenged the assumptions and evidence underpinning them, births outside obstetric units rapidly declined. Concurrent with these changes, birth became more medicalized, with inevitable and dramatic increases in caesarean section rates and reductions in normal birth rates (Oakley, 1984; Campbell and MacFarlane, 1994; Garcia et al, 1990; Tew, 1995).

Unanswered questions with respect to safety of different birth settings has also had a significant impact on the attitude of midwives, obstetricians and GPs towards childbirth. A study by Mead and Kornbrot (2004) found that midwives had an increased perception of risk in childbirth which negatively affected their perception of birth outside hospital. This is not surprising, given that the majority of midwives in practice today have had limited experience in caring for and supporting women birthing outside the hospital setting. Given this, neither is it unexpected that confidence of women and midwives in normal birth has been eroded.

The Report of the Expert Committee (Department of Health (DH), 1993) heralded a profound shift in policy direction for maternity care to focus on choice, continuity and control. Choice in relation to birthplace setting was to include birth at home, a birth centre or a consultant-led unit. Despite these recommendations and the subsequent recommendations of the *The National Service Framework* (DH, 2004) and *Maternity Matters* (DH, 2007), guaranteeing a full range of choice by 2009, the report by the Care Quality Commission (Redshaw and Heikkila, 2010) highlighted that nearly half of women surveyed did not feel they were given sufficient information to make an informed choice. Furthermore, a study by the National Childbirth Trust (NCT) (Dodwell and Gibson, 2009) reported that nearly 40% of women did not have access to any real choice of birth setting. These findings are not surprising; the ongoing debate about the safety of births outside hospitals has resulted in service providers and

commissioners being cautious about expanding the provision of birth centres, particularly stand-alone facilities, and as a result midwives struggle to give informed choice or promote these options to women.

### The findings of the Birthplace Study

The long-awaited Birthplace Study (Birthplace in England Collaborative Group, 2011) was finally published on the 25 November 2011 and no doubt, like us, midwives up and down the country were awaiting the findings with anticipation. At midnight these were made available on the National Perinatal Epidemiology Unit (NPEU) website where the results were published via a link to the paper in the *British Medical Journal*. Waiting for the publication of the results and the anticipation and implications of the findings felt like waiting for Santa at Christmas! To us, the results would mean one of two things for women and midwives. For women, it could mean that their future choices with respect to place of birth had the potential to be either extended or restricted. For midwives and midwifery practice, it could mean that the role of midwives as lead professionals within the maternity services in their own right, could be secured or questioned.

The joy on reading the results was immense; the findings clearly endorsed current policy of offering low-risk women a full range of birthplace choices and that midwifery-led care and birth in midwife-led units and at home was safe for the mother and the baby. Indeed, the results discredited previous policy recommendations promoting birth in obstetric units. The Birthplace Study found that low-risk women who planned to give birth in a consultant-led unit are three times more likely to have an emergency caesarean section, more than twice as likely to have their baby delivered by a forceps or vacuum extractor, twice as likely to need a blood transfusion and more likely to require admission to intensive care and have serious perineal trauma, compared to the low-risk women who chose birth at home or in a midwife-led unit (Birthplace in England Collaborative Group, 2011).

The study also showed that the rate of 'normal birth' differed significantly between the different birth settings, accounting for 56% of low-risk women who choose an obstetric unit compared to 76% for women choosing an alongside unit, 83% of women in a freestanding unit and 88% of women choosing to give birth at home. In addition, the cost-effectiveness analysis also showed that the cost of births for low-risk women in obstetric units was significantly higher, with the cost of birth at home lowest, ranging from £1631

for planned birth in an obstetric unit to £1067 for planned birth at home (Birthplace in England Collaborative Group, 2011).

Reassured with the findings, we retired to bed restfully, rising early to tune in to breakfast TV, with excited anticipation of how the press would report the good news. Our excitement was soon quashed as the headlines flashed (BBC News, 2011):

***'Women should not have right to home birth if at risk'***

***'Home birth 'carries higher risk' for first-time mothers'.***

The 'lower intervention rates' for women who planned birth in midwifery-led units or at home was mentioned but glossed over as if of limited significance. Thinking that we had misinterpreted the results, we returned to the website and were comforted by the fact that we had not been dreaming, recalling the axiom 'Good news is bad news' when it comes to the media.

### The reaction of the Royal Colleges

Disappointed with the stance taken by the press coverage, we subsequently reviewed the information and commentary on the Birthplace Study on the Royal College of Obstetricians and Gynaecologists (RCOG) (2011) and the Royal College of Midwives (RCM) (2011) websites.

The RCM reported the results as detailed on the NPEU website. Some of the key messages on their website were similar to that reported by NPEU in that giving birth was generally safe, and births in midwifery-led units 'appear to be safe offering benefits to the mother'. The benefits reported included fewer 'interventions' and 'intrapartum sections' and 'more normal births' (RCM, 2011). The increased adverse perinatal outcome events per 1000 planned home births for nulliparous women was detailed, and the RCM (2011) advised that:

***'Nulliparous women approaching their delivery date should be offered the opportunity to talk to a midwife about the Birthplace findings and—if they wish—can reconsider their plans'.***

The commentary made no mention (as does the report) as to the possible reasons for this finding or what needs to be done to reduce this risk for this group of women. Whilst advising that midwives should offer this group of women an opportunity

to reconsider their plans for place of birth, the increased adverse outcomes for low-risk women choosing to give birth in an obstetric unit did not warrant any such recommendation. The authors believe that this group of women should also be given an opportunity to reconsider their plans for place of birth based on these findings.

This is disappointing given the RCM's commitment to normal birth, safer birth and providing professional leadership for midwifery—the study clearly showed that the births in midwifery-led units or at home were as safe for babies and significantly safer for the mother, and this contrasts with the reporting of the RCM of such births only 'appearing' to be safe. However, the RCM (2011) commentary ended on a more positive note:

*'This study has important and wide-reaching implications for planning and delivering maternity services and the RCM will be using the results as we influence developments in maternity services.'*

Further exposition and analysis of the implications is warranted, and to date this has not been undertaken.

In contrast, the RCOG (2011) gave a more detailed overview and commentary on the results that was unsurprisingly focused on the increased risk of adverse perinatal outcome for nulliparous women giving birth at home and the peripartum transfer rates for nulliparous women who planned to give birth at home or freestanding birth units and its 'logistics'. As in the RCM coverage, the 'lower intervention rates' of this group of women was mentioned but not detailed. In contrast to the RCM, the President of the RCOG, Dr Tony Falconer, did provide an analysis of study findings stating that the study raised 'questions about the right birth location' for nulliparous women and that '... the high transfer rates from FMU

[free-standing midwifery units] and AMUs [alongside midwifery units] for first-time mothers pose serious logistical problems' adding that 'the close proximity of AMUs provides easier transfer thereby reducing stress and anxiety' (RCOG, 2011). The RCOG President acknowledged that further work was required to identify why adverse perinatal outcomes for nulliparous women choosing to give birth at home were higher, as well as adverse outcomes for low-risk women giving birth in obstetric units. The statement concluded with 'the need to concentrate obstetric care for the expanding numbers of complex pregnancies and also for the women bring transferred from other birth locations' (RCOG, 2011), calling for an expansion in numbers of consultant obstetricians to provide continuous presence on the labour wards. Disappointingly, no demands were made in the response to the Birthplace Study by either College to increase the numbers of midwives, as yet.

### Turning the tide

Concern about the safety of different birthplace settings, in particular births outside consultant-led units, has had a significant impact on the number of women choosing to give birth in these settings. Local audits have consistently shown that approximately 60% of women booking to give birth at Barnet and Chase Farm are 'low-risk' at booking, reducing to about 50% at labour (Rogers, 2011). Despite this in our unit the overall percentage of women giving births outside of the obstetric unit is approximately 15%, with less than 1% of women giving birth at home. The reasons for this are complex and multifactorial, but given the results of a mapping exercise performed by the Birthplace team (Redshaw et al, 2011), the local findings at this trust would not be dissimilar to many other maternity services across the UK. There is no doubt that unanswered questions and a lack of evidence base in relation to the safety of different birth settings has until now had a significant impact on the ability of midwives, obstetricians and GPs to positively promote and recommend these options to women.

The Birthplace Study supports the findings of our own local study of birth outcomes for low-risk women choosing to give birth at our freestanding birth centre over an 8-year period (Rogers et al, 2011) and provides robust evidence to enable midwives to really give informed choice to low-risk women. Midwives can now positively promote birth outside consultant-led units for this group of women, which is not only safe for their baby, but associated with significant less serious morbidities for the women themselves. This should also

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help organizations to address some of the concerns about the safety and capacity of overstretched consultant-led labour wards, making birth safer for the women and the families that require this level of care, and for the women who will require transfer from home or from a birth centre.

Despite current policy to promote normal birth (Maternity Care Working Party, 2007), choice of birthplace setting and to reduce NHS costs, the findings of the Healthcare Commission (2008) report and the Care Quality Commission (Redshaw and Heikkila, 2010) report show that significant numbers of women are not being given choice in relation to place of birth. Until now, we lacked robust evidence to facilitate real choice in relation to all birth settings and many midwives could be forgiven for being influenced by the dominant 'dogma' that giving birth in hospital or near an obstetric unit was safer for the mother and baby, 'just in case'. The body of evidence to challenge this is growing and the current consultation (Nursing and Midwifery Council (NMC), 2011) on revisions to the Midwives Rules and Standards further endorse this. Draft Rule 5 relating to scope of practice recognizes the midwife as 'the lead professional for all healthy women with straightforward pregnancies' (NMC, 2011: 5). In the future, midwives will no longer be able to interpret the offer of choice for low-risk women as being an optional extra—from 2012, this will become a statutory requirement in our regulatory framework.

The findings of the Birthplace Study, coupled with those of many previous studies showing significantly lower rates of interventions, significantly higher better psychological outcomes, maternal satisfaction, breast rates and women's sense of empowerment for women choosing birth outside consultant units, means that we should expect and see a significant shift in how many maternity services are organized and where women choose to give birth (Saunders et al, 2000; Walsh and Downe, 2004; Hodnett et al, 2010).

### Achieving change

To achieve this will be no mean feat and for some trusts this will require significant investment in providing resources/facilities for women to birth outside of obstetric units. For others, it will mean developing and implementing a strategy to ensure that low-risk women are directed off of consultant-led labour wards. Local actions to achieve this that are being adopted or considered at one NHS hospital trust include the following initiatives:

- Breakfast/lunchtime meetings for all staff presenting the Birthplace Study findings and



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*The potential for change is in our hands, but we cannot be complacent; driving change forward will require strong leadership, commitment and tenacity.*

giving them an opportunity to discuss local implications

- Workshops for midwives to help them offer and promote choice in light of these results
- New information leaflet for all low-risk women showing the findings
- Posters to be displayed showing results in facilities that women use
- Workshops for all low-risk women and their families focusing on place of birth and promoting informed choice and addressing issues/concerns about transfer
- Focus supervisory review around midwives' knowledge and understanding of the study and its impact on their practice
- Rewards for midwives' teams that have done most to turn the current situation around
- Booking low-risk women by default either at home or in one of our birth centres
- Providing continuity of care by a known midwife when intrapartum transfer is required.

Publications such as *The Safety of Maternity Service in England* (Smith and Dixon, 2007), *Safe Births* (King's Fund, 2008) together with reports by the Healthcare Commission (2008), Care Quality Commission (2011a; 2011b) and those of the NMC (McKenzie, 2010) have raised concerns about the safety of women on many labour wards. A major factor affecting the safety of our labour wards, according to these reports, relate to capacity, staffing and the ability to provide one-to-one care in labour. The Birthplace Study provides us with an opportunity to improve the safety of women on many labour wards by addressing concerns about capacity (Birthplace in England Collaborative Group, 2011). This can only be



## Key points

- This commentary provides a personal professional account and reflection from the perspective of three midwives in England in response to the recent publication of the Birthplace Study
- The ongoing debate about the safety of births outside hospitals has resulted in service providers and commissioners being cautious about expanding the provision of birth centres, particularly stand-alone facilities
- The Birthplace Study findings clearly show that midwifery-led care and birth in midwife-led units and at home was safe for the mother and the baby, with lower intervention rates for women birthing in midwifery-led units or at home
- While we should now expect to see a significant shift in how many maternity services are organized and where women choose to give birth, achieving this will be no mean feat and for some trusts this will require significant investment in providing resources/facilities for women to birth outside of obstetric units

achieved in an overstretched NHS and maternity service by ensuring that the services provided are cost-effective and make the most efficient use of the limited resources available, including the expertise of the professionals involved. This will mean directing and offering low-risk women birthplace choices to include home, AMUs or FMUs and retaining the capacity on our consultant labour wards for women and their babies with, or experiencing complications. Mary Newburn from the NCT commented in *The Guardian* that the research findings of Birthplace Study 'should drive an expansion in midwife-led care, either at birth centres or at home for the half of women expected to have a low-risk birth' (Newburn, 2011).

As professionals, we all need to work together to make birth safe for all women, be they deemed high risk or low risk. Like our obstetric colleagues, midwives should now be demanding increased provision for women to give birth outside obstetric units as well as an expansion in the number of midwives, consultant midwives and supervisors of midwives to lead services for low-risk women outside of obstetric units as well as ensuring that women with complex pregnancy and women requiring intrapartum transfer receive the best possible standards of care in our consultant-led labour wards.

Previous studies have shown that concerns about transfer has been a significant reason why women do not choose to give birth in a stand-alone unit or at home (Barber et al, 2006; Pitchforth et al, 2009; Rogers et al, 2011). Given that the Birthplace Study, as well other literature, has shown that transfer rates for nulliparous women during or after labour is about 40%, arguments that this group of

women should be advised to give birth in hospital or in a midwife-led unit adjacent to a consultant unit is likely and is the recommendation of the RCOG. Nevertheless, the Birthplace Study showed that maternal outcomes for nulliparous women choosing to give birth in a stand-alone unit were better than those choosing to give birth in an adjacent unit, with no difference in outcomes for the baby. The study by Rogers et al (2011) showed that, although the risk of transfer is extremely low for women expecting their second and subsequent babies, they were equally concerned about the risk of transfer. These findings demonstrate the need to ensure that women are adequately prepared about the possibility of transfer and are well supported during the transfer process. The work of Saunders et al (2000) and McCourt et al (2011) have shown that women adequately prepared about the possibility of transfer are less likely to be stressed or anxious when transfer is required.

At long last we have a real opportunity to narrow the gulf between the rhetoric of government policy, choice, normality and cost-effectiveness and the reality in practice by ensuring that low-risk women do not plan to give birth in an obstetric unit. The potential for change is in our hands, but we cannot be complacent—driving this forward will require strong leadership, commitment and tenacity. The first step is to address a generation of women and their families whom over the decades have been convinced that giving birth in hospital is the safest way, as well as examining some of our own prejudices.

**BJM**

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## STUDENT PAPERS

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# Perceptions of birth in a stand-alone centre compared to other options

In 2009, the Clinical Services Strategy of NHS Barnet, Enfield and Haringey (2009) was given endorsement by the Secretary of State following a review by an independent reconfiguration panel. The Strategy included the transfer of consultant-led services from the Chase Farm site and changing the current co-located birth centre, Ridgeway Birth Centre (RBC) to a stand-alone unit. In 2011, NHS London has given assurance for the strategy to be implemented. The impetus for moving the consultant-led obstetric service from the Chase Farm site has been driven by the need to ensure that national standards around consultant obstetric and paediatric cover are met.

A stand-alone birth centre is a community-based facility staffed and led by midwives (Stewart et al, 2005). There are no doctors on site. If an obstetric or paediatric review is necessary, transfer to the nearest obstetric unit is required. This would be by ambulance. In contrast, a co-located birth centre is situated adjacent to or on the same site as a consultant unit where ambulance transfers would not be required.

Offering choice to women in relation to place of birth is a key recommendation of current maternity service policies (Department of Health (DH), 2004; 2007a; 2007b; 2010; Darzi, 2008), although this element of choice needs to be balanced by the provision of a cost-effective service. Despite being committed to the development of a stand-alone unit, the implementation team were concerned about its viability and wanted further information on the choices local women would make if the present co-located birth centre was to become a stand-alone birth centre. Seeking the views of women and involving them in the planning and delivery of maternity services is also central to current NHS policy (DH, 2010), and was viewed by the implementation team to be critical for the successful implementation of the strategy.

## Methodology

A survey approach was perceived by the implementation team to be the most appropriate method to capture the views of a large group of women in the initial phase, as part of the work required to inform the implementation of the clinical service strategy. This method of data collection is recognized as

## Abstract

Promoting choice is central to current NHS policy. In seeking to better understand the choices women make, this study aimed to identify if women would choose to give birth in a stand-alone birth centre, and the factors influencing this choice. A survey approach was adopted, and 121 responses were obtained (a response rate of 53%). The majority (n=76, 62.8%) of responders would choose to have their baby in a stand-alone birth centre. The provision of a homely environment, opportunities for a natural birth, use of water in labour and accessibility were the main reasons given for choosing to give birth at a specific stand-alone birth centre. Compared to second or subsequent births, women expecting their first baby were six times more likely to give 'can use water in labour and birth' as a reason and this was significant (P=0.001). Among women who would not choose to deliver in a stand-alone birth centre, the main reasons were preference to give birth in a co-located unit and concerns over safety. There was no significant difference about concerns for transfer between primigravid women and multigravid women. Nevertheless, in contrast to previous studies, 87% of women perceived that birth in a stand-alone birth centre provided a safe alternative to a hospital birth or home birth. Women also stated that they would access a stand-alone birth centre for pregnancy testing, antenatal education and antenatal and postnatal care.

having the advantage of being able to recruit a large sample at a relatively low cost (Murphy-Black, 2000). The survey was conducted as part of the change management process required for relocating consultant-led services to Barnet and establishing a stand-alone birth centre on the Chase Farm site.

The main aims of the survey were to elicit the views of women with respect to where they would choose to have their baby if the Ridgeway Birth Centre was to become a stand-alone unit; the reasons for their choices; and their views about stand-alone birth centres compared to other options for place of birth. Secondary aims were to identify if there was any difference between the views of women expecting their first or subsequent babies. Additionally, the survey aimed to identify what other services women would like to see offered at the birth centre.

## Participants

Barnet and Chase Farm NHS hospitals has specific criteria for women booking to give birth at the present co-located birth centre and the stand-

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alone birth centre. Women who meet these criteria are perceived as low risk with an uncomplicated medical and obstetric history. These criteria are the same for women accessing either the stand-alone birth centre, the Edgware Birth Centre or the current co-located birth centre on the Chase Farm site. Therefore, only women suitable for giving birth, booked to give birth or who had birthed in the co-located unit on the Chase Farm site were included in the survey.

All women who were either booked, were considering booking or had given birth at the Ridgeway Birth Centre from 1 October 2009 to 31 October 2009 were offered a questionnaire by a member of staff to complete. These women were reassured that the information they provided on the questionnaire was completely confidential. Women were advised to place completed questionnaires in a sealed envelope and in a box provided at the birth centre.

### Questionnaire

The questionnaire provided detailed information to women with respect to the meaning of a stand-alone unit and how a stand-alone unit differs from the current unit on the floor above the consultant-led labour ward. Information was also given on estimated transfer times as well as the requirement for ambulance transfer.

The design of the questionnaire was based on one of the tools used in the study by Saunders et al (2000) as part of their evaluation of the Edgware Birth Centre, in which women were asked to rate their level of agreement with a number of statements on relative advantages and drawbacks about different options for place of birth. Women were also asked to make selections and 'tick' from a number of statements and the reasons for their choice. There was also an opportunity for them to elaborate if they were unsure or if there were other reasons for their choice than those stated. At the end of the questionnaire women had the opportunity to add further comments if they wished.

This questionnaire asked fixed questions which included queries about the women's parity,

whether they were pregnant or had just had a baby. Women were asked if they would choose to give birth in the Ridgeway Birth Centre if it was a stand-alone unit. Additionally, questions were added to the questionnaire to identify what other antenatal and postnatal services they would like to be available at the birth centre.

### Data analysis

Responses were entered on an Excel spreadsheet. Analysis was done based on parity and on whether the women were pregnant or had given birth at the Ridgeway Birth Centre. Categorical data were compared using the Chi-square ( $\chi^2$ ) or Fisher's exact test where appropriate. Continuous variables between groups were compared using the Student *t*-test or the Mann-Whitney U test where appropriate.  $P < 0.05$  was considered significant. Significant differences were quantified by calculating the odds ratios (OR) and 95% confidence intervals (CI). Statistical analyses were performed using the Stata statistical software package (Stata Corp., Texas, version 7.0).

### Results

Over the study period, 228 women were invited to complete the questionnaire and 121 (53%) women responded. The majority of women who completed the survey were pregnant ( $n=108$ ; 89.3%) and 13 women (10.7%) had just had a baby. Of this group, 76 women (62.8%) stated that they would give birth in the birth centre when it became stand alone, 23 women (19.0%) were unsure and 21 women (17.4%) would not. Of the 23 women who were unsure, 15 (65.2%) were expecting their first baby and 8 (34.8%) were expecting their second or subsequent baby. Twenty-one of the women who were unsure gave additional comments and the main concern for these women was the potential need for 'back up' if required and 'concern about transfer'.

Further analysis was undertaken according to the parity of the women (Table 1). There were no significant differences in the choices made between the parous and nulliparous women ( $P=0.1$ ).

### Choosing to give birth at a stand-alone unit

Table 2 details the reasons given by women for choosing to give birth at the birth centre when it becomes a stand-alone unit. The provision of a homely environment, opportunities for a natural birth, ability to use water in labour and accessibility were the main reasons given. Compared to women expecting second or subsequent babies, women expecting their first baby were six times more likely to give 'can use water in labour and birth' as a reason

**Table 1. Would you choose to have your baby in the birth centre if it was a stand-alone unit?**

	Nullipara (n=72) (%)	Multipara (n=49) (%)	Significance (P)
Yes	41 (56.9)	35 (71.4)	0.1
No	15 (20.8)	6 (12.2)	Non-significant
Unsure	15 (20.8)	8 (16.3)	Non-significant
No response	1 (1.4)	0 (0)	Non-significant

and this was significant ( $P=0.001$ ). On the other hand, multiparous women, not surprisingly, were 18 times more likely to give 'previous birth experience' as a reason for willingness to give birth at the stand-alone unit, and this was significant ( $P=0.01$ ).

### Choosing not to give birth at the unit

Table 3 details the reasons given by women for not choosing to give birth at the birth centre when it becomes a stand-alone unit. Preferences to give birth in a co-located unit and concerns over safety were the main reasons for not choosing to deliver at the Ridgeway Birth Centre when it becomes a stand-alone unit. There were no significant differences in the reasons given between women expecting their first or subsequent baby.

### Perceptions of the various options

Tables 4, 5 and 6 illustrate the respondents' level of agreement or disagreement with a series of statements that represented what they felt about different options for place of birth. The majority of women perceived that delivery in a stand-alone unit provided a safe and more natural alternative to a hospital or home birth. In addition, they felt that it was a more woman-focused service.

There was no significant difference in the perceived advantages of giving birth in a stand-alone unit between women having their first baby and women having their second or subsequent baby (Table 4).

Among women who would not choose to give birth at the Ridgeway Birth Centre, a significantly greater proportion of women having their first baby perceived that a stand-alone unit provides woman-centred care, has considerable advantages to a home birth and has a more homely and relaxed atmosphere compared to a hospital birth, when compared to women having their second or subsequent babies (Table 5).

Among women who were unsure, there was no significant difference in the perceived advantages of giving birth in a stand-alone unit between women having their first baby and women having their second or subsequent baby (Table 6). Nevertheless, nearly 90% of this group believed that giving birth in a stand-alone unit offered considerable advantages over birth at home.

### Other services requested

Women were asked to indicate from a list of potential services what other services they would use at a stand-alone birth centre. The women could also list other services not already mentioned on the questionnaire (Table 7). Pregnancy and birth information, antenatal care and antenatal classes were

**Table 2. Reasons for choosing to use the birth centre when it becomes a stand-alone unit**

Reason	Total (n=76) (%)	First baby (n=41) (%)	Second or subsequent baby (n=35)	Odds ratio (95% CI); Significance (P)
Easy to get to	41 (53.9)	21 (51.2)	20 (57.1)	P=0.2
Physical environment	33 (43.4)	22 (53.7)	11 (31.4)	P=0.3
Previous bad experience	2 (2.6)	0 (0.0)	2 (5.7)	
Previous good experience	21 (27.6)	2 (4.9)	19 (54.3)	18.5 (4.8–11.1) P<0.001*
Can use water in labour and for birth	37 (48.7)	28 (68.3)	9 (25.7)	6.2 (2.2–6.9); P<0.001*
Wants natural childbirth	53 (69.7)	32 (78.0)	21 (60.0)	P=0.8
Homely/small	51 (67.1)	32 (78.0)	19 (54.3)	P=0.49
Family can be involved	51 (67.1)	30 (73.2)	21 (60.0)	P=0.94
Other	10 (13.2)	7 (17.1)	3 (8.6)	P=0.5

**Table 3. Reasons for not choosing to use the birth centre when it becomes a stand-alone unit**

Reason	Total (n=21) (%)	First baby (n=15) (%)	Second or subsequent baby (n=6)	Significance (P)
Difficult to get to		0 (0.0)	0 (0.0)	Non-significant
Want an epidural		0 (0.0)	0 (0.0)	Non-significant
Feel safer	14 (66.7)	9 (60.0)	5 (83.3)	0.7
Previous bad experience	1 (4.8)		1 (16.7)	Non-significant
Previous good experience		0 (0.0)	0 (0.0)	Non-significant
Physical environment	1 (4.8)	1 (6.7)		Non-significant
Pressure from partner/family/friends	2 (9.5)	1 (6.7)	1 (16.7)	0.9
Would prefer a midwife-led unit on the same site as the hospital labour ward	17 (81.0)	13 (86.7)	4 (66.7)	0.6
Concern about transfer	8 (38.1)	7 (46.7)	1 (16.7)	0.4

the leading services that women would choose to have if offered, and contraceptive advice was the least attractive choice.



**Table 4. Statements ticked for those women who would choose to have their baby in a stand-alone birth centre (first baby, n=41; second or subsequent baby, n=35)**

Statement: The SABC...	Strongly agree/agree (%)				Neither agree or disagree (%)			Strongly disagree/disagree (%)		
	All	First	Second	P	All	First	Second	All	First	Second
provides women-centred care	70 (92.1)	37 (90.2)	33 (94.3)	0.5	2 (2.6)	0 (0.0)	2 (5.7)	0 (0.0)	0 (0.0)	0 (0.0)
provides a safe alternative to a hospital birth	66 (86.9)	38 (92.7)	28 (80.0)	0.1	7 (9.2)	1 (2.4)	6 (17.1)	0 (0.0)	0 (0.0)	0 (0.0)
provides a more natural alternative to a hospital birth	69 (90.8)	35 (85.4)	34 (97.1)	0.1	3 (3.9)	2 (4.9)	1 (2.9)	0 (0.0)	0 (0.0)	0 (0.0)
has considerable advantages to a hospital birth	60 (78.9)	31 (75.6)	29 (82.9)	0.4	13 (17.1)	7 (17.1)	6 (17.1)	0 (0.0)	0 (0.0)	0 (0.0)
provides a safe alternative to home birth	68 (89.5)	37 (90.2)	31 (88.6)	0.8	4 (5.3)	2 (4.9)	2 (5.7)	1 (1.3)	0 (0.0)	1 (2.9)
has considerable advantages to a home birth	69 (90.8)	37 (90.2)	32 (91.4)	0.8	5 (6.6)	3 (7.3)	2 (5.7)	1 (1.3)	0 (0.0)	1 (2.9)
has a more homely/relaxed atmosphere compared to a hospital birth	73 (96.1)	38 (92.7)	35 (100.0)	0.1	1 (1.3)	1 (2.4)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)

SABC = Stand-alone birth centre; P = P value

## Discussion

Women and their partners should be able to choose where they give birth, including birth supported by a midwife in a local facility such as a designated local midwifery unit or birth centre (DH, 2007a; 2007b). With the exception of some studies (Barber et al, 2006; Houghton et al, 2008; Pitchforth et al, 2009), there has been a paucity of literature exploring women's choices for place of birth and the factors that influence their choice. This is surprising given the current emphasis on promoting choice. It is unlikely that health professionals can adequately promote choice if they do not have an understanding of the factors that influence it.

In seeking to understand through this study whether women would choose to give birth in a stand-alone unit when the consultant-led service is relocated, and the factors that influences this choice, 62.8% of respondents stated that they would use the birth centre when it became stand-alone, 19.0% were unsure and 17.4% stated that they would not. Therefore, relocating services would be likely to reduce choice and accessibility to birth in a local unit for some women.

The current study is unique in that the data is analysed in relation to whether the women were expecting their first, second or subsequent babies. Several previous studies have demonstrated that antenatal and intrapartum transfer rates are significantly higher for women expecting their first babies (Stewart et al, 2005; Rogers et al, 2010). In the study by Rogers et al (2010), the transfer rate was eight times higher in the primigravid cohort (35.9% vs. 4.61%).

Concern over the need to transfer is a major reason for women not choosing to give birth at home or in a stand-alone unit (Barber et al, 2006; Houghton et al, 2008; Pitchforth et al, 2009). It could be expected that women having a second or subsequent baby would be less concerned about the need for transfer, as this may be less likely. Conversely, this study showed that there were no significant differences in the reasons why women expecting their first or second baby would choose, or not choose, to give birth in a stand-alone unit.

These findings suggest that information given to women needs to be reviewed to reflect transfer rates according to parity.

**Table 5. Statements ticked for those women who would not choose to have their baby in a stand-alone birth centre (first baby, n = 15; second or subsequent baby, n = 6)**

Statement: The SABC...	Strongly agree/agree (%)				Neither agree or disagree (%)			Strongly disagree/disagree (%)		
	All	First	Second	P	All	First	Second	All	First	Second
provides women-centred care	13 (62.0)	12 (80.0)	1 (16.7)	0.01*	5 (23.8)	3 (20.0)	2 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)
provides a safe alternative to a hospital birth	6 (28.6)	6 (40.0)	0 (0.0)	0.09	6 (28.6)	6 (40.0)	0 (0.0)	4 (19.0)	2 (13.3)	2 (33.3)
provides a more natural alternative to a hospital birth	14 (66.7)	12 (80.0)	2 (33.3)	0.05	4 (19.0)	2 (13.3)	2 (33.3)	1 (4.8)	1 (6.7)	0 (0.0)
has considerable advantages to a hospital birth	9 (42.9)	8 (53.3)	1 (16.7)	0.13	6 (28.6)	4 (26.7)	2 (33.3)	3 (14.3)	3 (20.0)	0 (0.0)
provides a safe alternative to home birth	14 (66.7)	12 (80.0)	2 (33.3)	0.05	3 (14.3)	2 (13.3)	1 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)
has considerable advantages to a home birth	14 (66.7)	13 (86.7)	1 (16.7)	0.005*	4 (19.0)	1 (6.7)	0 (0.0)	1 (4.8)	1 (6.7)	0 (0.0)
has a more homely/relaxed atmosphere compared to a hospital birth	15 (71.4)	13 (86.7)	2 (33.3)	0.02*	2 (13.3)	2 (13.3)	1 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)

SABC=Stand-alone birth centre; P=P value

### Homely facilities and natural birth

The study by Saunders et al (2000) reported five main reasons for choosing to give birth in a stand-alone unit. These reasons include:

- A homely atmosphere
- Freedom to do what feels right
- Having their own room
- Having more facilities than they would at home (such as a pool)
- The midwives are always there.

Similarly, Singh and Newburn (2006) reported that women who gave birth at home or in a birth centre felt they were more likely to have access to better facilities. A survey by the National Childbirth Trust (NCT) (Newburn and Singh, 2003) also reported that women who had used a freestanding birth centre consistently reported having a greater sense of freedom, privacy and autonomy than those who used a hospital obstetric unit.

The present study confirms these findings with the majority of women perceiving the environment of care at the birth centre more attractive than a hospital. They believed the environment to be more homely and the opportunities to use water for labour and delivery significantly

greater. Significantly more primigravid women (69%) than multigravid women (26%) stated that the reason they would choose to give birth at the Ridgeway Birth Centre was being able to use water for labour and birth. Having their family involved and accessibility were other important factors given by both groups.

Seventy-eight percent of women expecting their first baby and 60% of women expecting their second baby believed that having their baby in the birth centre would mean that they were likely to have a natural childbirth. This belief has previously been identified in a Cochrane review (Hodnett et al, 2005) which concluded that 'home-like' vs. institutional settings for birth results in modest benefits including decreased medical intervention, higher rates of spontaneous vaginal birth, and breastfeeding. The National Institute for Health and Clinical Excellence (NICE) (2007) also concluded that those women who give birth in a midwife-led unit are more likely to have a normal birth.

### Safety and cost-effectiveness

Concern about the safety and cost-effectiveness of stand-alone units are major factors inhibiting

**Table 6. Statements ticked for those women who were unsure about having their baby in a stand-alone birth centre (first baby, n = 15; second or subsequent baby, n = 8)**

Statement: The SABC...	Strongly agree/agree (%)				Neither agree or disagree (%)			Strongly disagree/disagree (%)		
	All	First	Second	P	All	First	Second	All	First	Second
provides women-centred care	22 (95.7)	14 (93.3)	8 (100.0)	0.6	1 (4.3)	1 (6.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
provides a safe alternative to a hospital birth	14 (60.9)	10 (66.7)	4 (50.0)	0.2	7 (30.4)	3 (20.0)	4 (50.0)	2 (8.7)	2 (13.3)	0 (0.0)
provides a more natural alternative to a hospital birth	21 (91.3)	14 (93.3)	7 (87.5)	0.47	5 (21.7)	1 (6.7)	4 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)
has considerable advantages to a hospital birth	15 (65.2)	10 (66.7)	5 (62.5)	0.1	8 (34.8)	5 (33.3)	3 (37.5)	0 (0.0)	0 (0.0)	0 (0.0)
provides a safe alternative to home birth	21 (91.3)	13 (86.7)	8 (100.0)	0.4	2 (8.7)	2 (13.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
has considerable advantages to a home birth	20 (87.0)	13 (86.7)	7 (87.5)	0.47	6 (26.1)	2 (13.3)	4 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)
has a more homely/relaxed atmosphere compared to a hospital birth	21 (91.3)	14 (93.3)	7 (87.5)	0.4	1 (6.7)	1 (6.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)

SABC = Stand-alone birth centre; P = P value

their development and arguments for closing existing units. Opponents of stand-alone units argue that insufficient women would choose to give birth there because of concerns about safety. In a study by Houghton et al (2008) the majority of participants believed hospital births were safer than birth at home. Similarly, Barber et al

(2006) reported that women felt having access to clinical equipment made them feel more secure in the birth environment and therefore would choose a hospital birth over a home/birth centre. These views are also shared by the participants of a study undertaken by Pitchforth et al (2009) who found that women perceived obstetric-led care as 'covering every eventuality'. These views echo the reasons given by some women in the current survey as to why they would choose not to give birth in a stand-alone unit and are reflected in the following quotations made by participants:

*'I would not feel comfortable giving birth at a stand-alone midwifery unit knowing that if there were any complications I'd need an ambulance transfer'.*

*'I would consider it to be too risky to give birth in a midwife-led unit without the backup'.*

Feeling safe and concern around transfer were the main reasons given for choosing not to give birth in a stand-alone unit. These beliefs are not

**Table 7. Additional services women would use (n=121)**

Service	Yes (%)	No (%)	No response (%)
Pregnancy testing	69 (57.0)	35 (29.0)	17 (14.0)
Antenatal care	109 (90.1)	3 (2.5)	9 (7.4)
Antenatal classes	109 (90.1)	4 (3.3)	8 (6.6)
Pregnancy/birth information	110 (91.0)	4 (3.3)	7 (5.8)
Meet other women	92 (76.0)	15 (12.4)	14 (11.6)
Postnatal care	102 (84.3)	7 (5.8)	12 (9.9)
Breastfeeding support	105 (86.8)	7 (5.8)	9 (7.4)
6-8 week postnatal check	98 (81.0)	8 (6.6)	15 (12.4)
Contraceptive advice	79 (65.3)	24 (19.8)	18 (14.9)

unique to women accessing the service but are also held by many health professionals offering obstetric-led care and appear firmly held despite the lack of robust evidence around the safety and cost-effectiveness of different models of maternity care (Stewart et al, 2005; NICE, 2007; Rogers et al, 2010). Health professionals are currently awaiting the findings of the National Perinatal Epidemiology Unit (NPEU) study to address concerns about the safety of different birth settings.

Nevertheless, in contrast to the findings of Barber et al (2006), Houghton et al (2008) and Pitchforth et al (2009), the majority of women in this study (62.8%) stated that they would give birth in a stand-alone unit with 87% of women surveyed believing that a stand-alone unit provides a safe alternative to a hospital birth. These women also maintained that a stand-alone birth provides woman-centred care and has a more relaxed, homely atmosphere. Although 87% of women believed a stand-alone unit to be a safe alternative to a hospital birth, only 62.8% stated they would give birth there. Concern over the need for transfer as opposed to the safety of a stand-alone unit was the main reason given by those women who, although believing a stand-alone unit was a safe alternative to a hospital birth, would not wish to give birth there.

A large number of the women in the survey (87%) felt that a stand-alone birth centre had considerable advantages over a home birth—while the reasons for this were not explored in the survey, the findings are comparable to other studies. In the evaluation of the Edgware Birth Centre undertaken by Saunders et al (2000), the women interviewed described positives as being the facilities at the birth centre (birthing pool and stool) and the fact that the midwives were always there, ready and waiting, when compared to home births.

The evaluation also found that almost a third of the women had considered a home birth at some stage in pregnancy but had changed their mind, the most common reason being concerns about safety, and many had decided to choose the birth centre because it was more home-like than a conventional hospital birth. Similarly, a study by Newburn and Singh (2003) which explored women's views about the design and facilities in maternity units identified that a large number of women said that access to a birth pool was highly important and felt that this was more likely in a midwife-led unit compared to birth at home or in hospital.

The Healthcare Commission (2007) survey reported that the average number of births per

‘Eighty-seven per cent of women surveyed believed that a stand-alone unit provides a safe alternative to a hospital birth.’

year in stand-alone birth centres was 190, equating to about 2% of all births in the UK. These figures call into question the cost-effectiveness of stand-alone birth centres. A report by O'Sullivan and Tyler (2007) for the Royal College of Midwives concluded that birth centres delivering less than 300 births a year are unlikely to be financially viable unless undertaking 'significant other community midwifery activities for women not birthing at the unit'. Women in the present study stated that they would use the birth centre for a wide variety of services other than giving birth, including pregnancy testing, antenatal and postnatal care, breastfeeding support and the 6–8 weeks postnatal check. With the drive toward provision of services within the community and the need to ensure financial viability, extending services in stand-alone birth centres to other groups of women may be necessary.

### Limitations

These results need to be interpreted with caution as all of the women in this study were either booked or considering booking at the birth centre. The use of questionnaires does have its disadvantages, in particular the number of responses, which in this study was 53%, which is viewed as an acceptable response rate—Rees (2003) suggested that where the response rate falls below 50% it is difficult to be certain that the responses received are representative of the sample. Other limitations of the survey are that the majority of the respondents were antenatal women, so women who had given birth were poorly represented. A qualitative study is proposed to explore women's views in more depth, particularly exploring what informs women's perceptions of safety and concerns about transfer and beliefs about the safety and advantages of different birth settings including birth at home. The authors would also like to undertake a more indepth exploration of why women would not use a stand-alone birth centre even though they believed it to be a safe option. Furthermore, as this survey was conducted as part of the change management the findings can only be applied to this Trust, although the findings do support results in previous, more general studies.



## Key points

- The majority of respondents (n=76; 62.8%) would choose to have their baby in a stand-alone birth centre
- Among women who would not choose to deliver in a stand-alone birth centre, the main reasons were preference to give birth in a co-located unit and concerns over transfer
- The majority of women perceived that delivery in a stand-alone unit provided a safe and more natural alternative to a hospital or home birth
- The provision of a homely environment, opportunities for a natural birth, ability to use water in labour and accessibility were the main reasons cited for choosing to give birth at a stand-alone birth centre
- Pregnancy and birth information, antenatal care and antenatal classes were the leading services that women would choose to have at the stand-alone birth centre if offered, and contraceptive advice was the least attractive choice

## Conclusions

National choice guarantees for maternity include choice in relation to where to give birth (DH, 2004; Darzi, 2008). To date, there is a lack of robust evidence to inform policies or decisions around models of care particularly in relation to what women would choose and the reasons for the choices made. An integral requirement for promoting choice and for informing service re-configurations is reliable data on what women want and options they would choose if these choices were available.

This study has highlighted the fact that the option to give birth in a co-located unit may not be available locally to those women who expressed a preference for this, once services are relocated. However, this shows that the majority of women would choose to give birth in a stand-alone birth centre, perceiving it to be a safe alternative to a hospital birth. There was no significant difference between the views of women expecting their first or subsequent babies. Women in this study also reported that birth in a stand-alone unit or co-located midwifery-led unit offered greater advantages than having a home birth. The main attractions of a birth centre for women related to the environment of care and opportunity for natural childbirth—although these should be available to women irrespective of where they choose to give birth.

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# Supervisory issues: lessons to learn from a home birth

By **Jamie Richardson**

## Abstract

**This is a reflective article exploring the supervisory issues surrounding a planned home birth through use of a case study. Issues from the case study, such as decision making and record keeping, are highlighted and analysed and recommendations for practice are included.**

**T**his reflective article aims to examine the supervisory issues surrounding a planned home birth. It was used as a presentation to student supervisors, and an evaluation was conducted. The reflective model used is Macdonald (2004) which can be directly applied to midwifery practice. This model consists of: the scenario, the analysis, and the plan of action/evaluation. All names in the case study (*Box 1*) have been changed for the purpose of confidentiality (Nursing and Midwifery Council (NMC), 2008).

## Analysis

### *Feelings*

It is important to understand the feelings of Sheila, her colleagues and Mary. Sheila reflected on this scenario and felt that when she was attending the home birth she did not think about the risks associated with being on the top floor of a tower block. She felt disbelief and shock about the outcome of the artificial rupture of membranes (ARM), but she knew that she needed to be calm and manage the situation to the best of her ability with the resources available. Sheila was concerned about Mary and her husband Mark. They also appeared to be in shock. Sheila knew of the importance of debriefing for all involved, but there were more immediate procedures that had to be followed in relation to record keeping and risk analysis.

### *Safety of home birth*

Perhaps the first questions to ask are, 'was it safe for Mary to have a home birth?' and 'what is the meaning of risk?' Definitions of risk vary but generally a risk is something bad happening. However, risk is also viewed as a negative outcome which can be turned into opportunities (Giddens, 1999). Giddens (1999) suggests that society has become immersed in the concept of risk, and that risk is both external, such as natural disasters, and manufactured, for example pollution. When applying this concept to the scenario, was

Mary subjected to a manufactured risk or an external risk?

It is important to analyse the record keeping and the assessment of the environment. In supporting maternal choice, was Mary put at risk? Olsen and Jewels (2009) performed a meta-analysis of observation to assess the effects of planned home birth compared to hospital birth on the rates of interventions, complications and morbidity as determined in randomized trials. The meta-analysis concluded that there is no strong evidence for women in the low risk category to routinely give birth in hospital as there was no increase in morbidity, complications and interventions in the home birth group and that imposing restrictions on place of birth can do more harm (Enkin et al, 1995).

### *Decision making*

Decision making is an everyday occurrence in midwifery practice. Historically midwives have not been known for using evidence to make decisions, but have tended to rely on medical staff (Lewis and Drife, 2001). With the implementation of national guidelines and also the changes within maternity services (Department of Health (DH), 2007), this appears to have changed. Making a decision is a complex process and hindsight enables us to evaluate and reflect on our thought processes. These processes involve human emotions and can often be influenced by our own personal beliefs, background and perception (Higgs and Jones, 2000). At the time Sheila felt she had made the right decision in relation to the ARM and her management of the cord prolapse, but it is important that Sheila understood what steps and processes were used in making that decision, for example, the best available evidence.

### *Artificial rupture of membranes (ARM)*

There have been varying systematic reviews surrounding management relating to an ARM. Smyth et al (2009) determined the effectiveness and safety of amniotomy for decreasing the time of labours that start spontaneously, and decreasing the time of labours that have started spontaneously but have become prolonged. Performing an amniotomy is thought to release chemicals and hormones that stimulate uterine contractions and therefore improve labour progress (Frigoletto, 1995). In this instance the idea was to stimulate labour to increase contractions as there was a delay in the contractions and cervical dilatation.

There is much debate surrounding ARM and the concept of normal labour; a woman who has made steady progress over twenty hours with no compromise to her or the baby does not require an intervention (Nielson, 2003). Robertson (1997) suggests that the progress of labour should not be based on the premise that all labours are the same, but should take into account the individual woman and her baby's well-being. Sheila made the decision to perform an ARM owing

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to Mary's lack of progress, but she explained to Mary that the intervention may not decrease the time of labour. When performing an ARM there is a 50% risk of cord prolapse (Usta et al, 1999). On reflection this may have not been the most appropriate management, but there was no indication that a cord prolapse would occur because the fetal head had been engaged in the pelvis since 37 weeks of pregnancy.

### *Management of cord prolapse*

The Royal College of Obstetricians and Gynaecologists (RCOG, 2008) have developed a *Green-top guideline* to inform practitioners of the best available evidence surrounding the management of a cord prolapse. Cord prolapse has been defined as the umbilical cord beside the presenting part (occult) or past the presenting part with ruptured membranes (Lin, 2006). In this case study it was the latter. The overall incidence of cord prolapse is between 0.1–0.6% (Woo et al, 1983). Delay in transfer appears to be the major contributing factor in perinatal death (Murphy and MacKensie, 1995) in this scenario as there was an hour delay before transfer to the hospital.

Was the cord prolapse in this case study managed effectively and did it follow the guidelines? RCOG (2008) states that the following in the management of cord prolapse within a hospital setting, but it should be adapted for the home environment:

- Emergency aid should be called. In the case study a paramedic ambulance was requested
- To prevent vasospasm and cord occlusion there should be minimal handling of the cord. In the case study there was minimal handling of the cord
- To prevent cord compression the presenting part should be elevated manually or by filling the maternal bladder with fluid to aid elevation. This is recommended in the home setting owing to the length of time needed to transfer to hospital. Sheila decided to elevate the presenting part manually as she was in the home until help arrived
- Mary was put in the knee to chest position to help reduce the risk of descent and pressure on the presenting part, but the evidence suggests that this management needs further studies to evaluate its effectiveness
- Warm swabs were placed around the umbilical cord to prevent vasospasm, but there is no evidence to support this practice (Koonings et al, 1990)
- Caesarean section or instrumental delivery is the preferred option for delivery. Mary was fully dilated on arrival at hospital, therefore a forceps delivery was performed in the operating theatres.

The evidence suggests that Mary was not put at an increased risk but there are varying issues relating to supervision and the need for an assessment of the home before the delivery so that Mary could have been given an informed choice on place of birth. As stated in *Midwives rules 6* (2004: 16), a midwife:

*'Should work in partnership with the woman and her family.'*

This is also underpinned in the competencies for supervision. Working in partnership is about giving the woman all the required information so that she can make an informed decision.

### **Box 1. Case study**

Mary had booked for a home birth and rang the delivery suite on a Saturday night. She was 40 weeks gestation and had been contracting every 5 minutes for 4 hours. She was being supported by her husband, Mark. Sheila, a senior midwife, volunteered to attend to the woman and perform an assessment. Sheila collected all the necessary equipment and drove to the woman's home. The woman lived on the top floor of a tower block, which had stair and lift access. Sheila performed a full assessment and found the woman to be 8 cm dilated. Sheila called the delivery suite co-ordinator to report on Mary's progress and decided to remain with the woman as she was in established labour. It was normal practice to call a second midwife when the woman was close to the second stage of labour, i.e. 8–9 cms dilated. During the labour the uterine contractions were occurring less frequently (1:10), and there was no change in the cervical assessment after 1 hour. The woman had been mobilizing with the aim of stimulating the uterine contractions and encouraging descent of the baby's head. The midwife discussed performing an artificial rupture of membranes (ARM) with Mary to accelerate the labour. Mary consented to an ARM, and during the procedure a cord prolapse occurred. Mary was assisted into the all fours position with her head down, and Sheila continued to put pressure on the baby's head to prevent further occlusion of the umbilical cord. Sheila asked Mark to telephone the delivery suite co-ordinator. A second midwife and paramedic ambulance was called. The second midwife arrived in 5 minutes and warm swabs were placed around the cord. The first ambulance crew arrived in 10 minutes, and it was discovered that the ambulance trolley would not fit in the lift as a portable chair was contraindicated. A second ambulance crew was called to assist in the transfer of Mary to the ambulance trolley. Sheila remained with her fingers applying pressure to the baby's head to prevent occlusion of the cord. The second ambulance crew arrived after a further 10 minutes and Mary was dragged on a blanket to the lift and transferred to the ambulance trolley on the ground floor. Once in the cold air the cord collapsed; auscultation of the fetal heart was 40 beats per minute. One hour had elapsed and the transfer occurred via the accident and emergency department to the obstetric theatres. The baby was delivered by forceps and had an Apgar score of 1 at 5 minutes. The baby was transferred to the neonatal intensive care unit and died 10 hours following delivery.

### *Record keeping*

There was no documentation in Mary's notes of any discussion of the plans for home birth or an assessment of the home, which may have highlighted the issues of transfer. It is stated in the *Midwives Rule 9, Code of Professional Conduct* (2008) and *Guidelines for record keeping* (2009: 21):

- '1. A practising midwife shall keep, as contemporaneously as is reasonable, continuous and detailed records of observations made, care given.*
- 2. You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been.*
- 3. You should record details of any assessments and reviews undertaken and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.'*

In view of the above this guideline was not adhered to in relation to record keeping as there was no evidence in Mary's notes of any discussions surrounding the home birth. The *Guidelines for record keeping* (2009: 2) also states:

*'Records should identify any risks or problems that have arisen and show the action to deal with them.'*

It would have been appropriate to have discussed the issue surrounding transfer of Mary to the obstetric unit. Even knowing that there could be difficulty in transfer she may still have decided to continue with the planned home birth, but her decision would have been fully informed. There were no guidelines within the maternity unit relating to discussion surrounding home birth and in the competencies for supervision it states:

*'Demonstrate the ability to source literature, research and professional evidence to underpin strategy and service development and assist with the development of evidenced based guidelines, policies and standards for maternity provision.'* (NMC, 2006: 11)

## Action plan/evaluation

Following the incident Sheila went back to the unit and had a debriefing with her supervisor of midwives. She then completed her maternal records, rather than completing them during her next shift, to enable her to provide as accurate an account of events as possible.

This incident was investigated as a Serious Untoward Incident (SUI) as part of the risk management reporting system. Subsequently after examination of the evidence it was not considered an SUI, owing to the correct management of the obstetric emergency. It was investigated by the team of supervisors, however, as there were issues relating to practice that needed to be addressed.

- 1) The community midwives were spoken to in relation to their record keeping and the planned home birth, and teaching was conducted on the importance of record keeping in relation to the NMC guidelines. This was then cascaded to all members of staff to reduce the risk of further incidences of inadequate record keeping. The maternity notes were provided with a section surrounding the discussion of home birth. This was also addressed in record keeping audits in compliance with record keeping guidelines
- 2) A meeting was arranged with the ambulance crew about the management and time delay in transfer to the obstetric unit. It was concluded that there needed to be an immediate transfer to the obstetric unit rather than waiting for the second ambulance crew
- 3) Two community midwives now attended home births, even though the second midwife arrived in 5 minutes it was discussed from a safety and risk issue that two being

present is safer for the woman and midwives.

- 4) The issue surrounding transfer to the obstetric unit via the accident and emergency department was changed so that obstetric cases transferred into hospital are allowed to enter the main entrance to enable a speedier transfer to the labour ward.
- 5) Sheila and a supervisor performed a postnatal visit to Mary to facilitate her debriefing and offer support as appropriate. This provided a forum for Mary to engage actively with the maternity services.
- 6) The case was presented by Sheila at a Perinatal Mortality meeting where cases where the baby has died are discussed with a view to improving practice. This enabled a group discussion of the issues and provided a forum for learning. Sheila was commended by a registrar for her management of the case. It was concluded that women who plan a home birth on a first floor and above should be discouraged from a home birth.

As long as women have all the information and are aware of the risks they should be able to make their own decision.

## Conclusion

This scenario provided a foundation for learning in the management of cord prolapse within the home environment. It sparked debate within the maternity unit on the safety of home birth and the importance of record keeping. Sheila did feel that even though there was a very sad outcome, there were areas that were examined to improve the service for women and, in relation to supervision, that provided a foundation for safety and protecting the public.

**BJM**

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## Key Points

- Supervision provides an effective framework in supporting midwives and also protecting the public.
- Reflection is an important tool in self-evaluation.
- Using the best available evidence and critiquing that evidence provides an effective learning environment within the clinical area.
- Record Keeping is an important part of the role of the midwife.
- Decision making processes influence care of women.



# Ideals, expectations and reality: Challenges for student midwives

## Abstract

This article looks at the way in which student midwives begin their training with certain expectations and ideals about the normality of the birth process. It considers how these expectations can be challenged by the reality of the hospital/medical environment, and considers whether students adapt their expectations accordingly. This article considers the challenges of promoting and practising normal birth against an increasingly medical backdrop, and examines culture within midwifery and in particular how this can affect student midwives.

First year student midwives generally embark on their midwifery studies with excitement and anticipation at what lies ahead. For a great majority of these students, this initial excitement is tempered with a degree of anxiety as they begin the process of the university application, in the knowledge that the university will be inundated with applications for the same course. Such is the interest and excitement generated by the application process that in preparation for interview, many potential student midwives use internet sites and discussion forums for help and advice from like-minded hopefuls. For many of these prospective students, the commitment, drive and aspiration for a career in midwifery is evident both in this desire for information and advice, and in repeated university submissions in the face of unsuccessful applications.

Often, new student midwives begin their studies with ideas and opinions concerning midwifery, along with expectations regarding the normality of the birth experience and the way in which labour and birth is supported and practised. Such expectations are invariably challenged when the student undertakes her/his first hospital-based placement (McCall et al, 2009;

Carolan, 2010) and experiences, for the first time, the reality of labour and birth on the delivery suite. For example, the hospital environment embraces the notion of an ideal timescale for the progress of labour; the performance of regular physical examinations to record both maternal observations and the rate of cervical dilatation; and the presence of a bed in which women are often directed to give birth in a supine position (Fraser and Hughes, 2009). On the hospital postnatal ward, often the realities of practice mean that the ward is full to capacity, and there are too few midwives to offer quality of care to newly-delivered mothers and their babies (McLachlan et al, 2008).

While many studies have been undertaken examining the culture of midwifery and its impact on practising midwives (Kirkham and Stapleton, 2000; Ball et al, 2002; Bosanquet, 2002; Hunter, 2005; Keating and Fleming, 2009), there are fewer studies examining culture, socialization and student midwives. In particular, there appears to be a lack of research assessing the way in which the medical nature of midwifery affects student midwives' experiences in terms of the expectations with which they come to their midwifery studies.

This article will therefore seek to address whether midwifery students attempt to align their early ideals and expectations with the reality of clinical practice, and if it is possible for students to maintain these

expectations and to practise normal birth in an often medically-dominated culture.

## Literature review

It is evident that the topic of culture and socialization within nursing and midwifery has generated much interest and debate. However, there appears to be a lack of data that specifically addresses the way in which student midwives' expectations are affected by midwifery culture. It is apparent that much of the existing literature tends to focus on the nursing profession, resulting in a dearth of evidence concerning culture, socialization and direct entry student midwives. Finally, of the literature examined, only three recent studies were identified that related to British student midwives' views (Baird, 2007; Fraser and Hughes, 2009; Kroll et al, 2009).

The literature concerning the culture of midwifery is, by necessity, qualitative in nature, and usually adopts an ethnographic approach, generally accepted to be the most appropriate way in which to monitor and research culture (Morse and Field, 1996; Hughes et al, 2002). Ethnography is itself sub-divided into separate categories, with critical ethnography advocated to assess the impact of power within the culture of organizations (Cluett and Bluff, 2006).

Many studies follow a focus group approach to their research, in which participants are grouped together to share experiences with the researcher. This approach is endorsed as offering the optimum and most time-efficient method for the discovery of consensus of opinion (Hughes et al, 2002). However, within the group context, there is always the possibility that those with the loudest voices and strongest opinions will ensure they are heard, and this may be to the detriment of the more reticent members of the group (Siebold, 2005). Further, it is possible that the group dynamic may begin to dominate and influence individuals' opinions so

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that they may, ultimately, offer a different perspective to that which they originally held (Cluett and Bluff, 2006).

As a result of the intensity of the research process and the quantity of data collected in ethnographic studies, it is necessary to limit the numbers of participants, often to less than 30 (Hughes et al, 2002). While the benefits of this type of research lie within the rich data collected, given such small sample sizes, extrapolating findings to the wider midwifery population can present something of a challenge.

## Ideals and expectations

### Emotional support

Carolan (2010) researched the views of 41 new Australian midwifery students, and sought to ascertain their ideas of what constituted a 'good midwife'. Attributes considered to be of key importance were communication skills, empathy, a passion for the role, and the ability to support women in the pursuit of natural birth. Contrasting with qualified and practising midwives, the students considered that emotional support was central to the midwife-mother relationship, and appeared to rate this of greater importance than clinical skills and knowledge. Carolan (2010) argued that this approach lends itself to disappointment when the students experience the reality of the clinical skills required in midwifery, against their preconceived ideas of the midwife as primarily supportive and emotional. The aims of midwifery training are to equip students with a range of both clinical and emotional skills which together shape a qualified midwife capable of delivering holistic care. It therefore seems that the opinions expressed in Carolan's study suggest a certain amount of naïveté among those students.

### Applying theory to practice

Perhaps central to the difficulties faced by students is the gap between theory

and practice (Baird, 2007). Following the publication of the Peach Report in 1999 (UK Central Council, 1999), the focus of midwifery training moved from 'hands on' learning in the hospital to academic learning at universities, in order to bridge a perceived gap between theory and practice (Turner et al, 2003). This change of focus was prompted by concerns that midwifery students were inadequately prepared for practice, and according to Baird (2007) has contributed to midwifery students developing skills such as critical thought and an enhanced ability to problem solve. Conversely, Meakin (2003) observed that the disparity between the university classroom and the hospital ward remains in evidence. She argued that this disparity has resulted from the profession's attempt to deliver to its students the highest academic standards reflecting evidence-based practice, against a backdrop of shortages of midwives and insufficient or inadequate resources (Royal College of Midwives (RCM), 2010). In such circumstances, the provision of evidence-based care is challenging. For the student midwife, therefore, the conundrum remains the delivery of evidence-based practice in an environment that is often not conducive to the provision of such care.

In her research involving American student midwives, Siebold (2005) emphasized the need to ensure that midwifery training adequately prepares students for the realities of practice. She concluded with the comments of one student who articulated the need for students and midwives to work together to change practice. This comment suggested that students were indeed changing their expectations to align with the reality of clinical practice. This finding accords with other literature that demonstrates how student midwives 'learn unwritten rules' and 'play the game' to adapt to the reality of the culture within midwifery (Begley, 2002; Bosanquet, 2002; Hunter, 2004; Hunter, 2005).

## Promoting normal birth in a medical environment

If student midwives are expected to uphold the ethos of normal, low-tech, non-interventional birth, then the balance of clinical placements needs to be addressed. Many student midwives spend the majority of their clinical placements in hospital delivery suites and on antenatal and postnatal wards where the focus is very much on the medical management of labour and birth (Bosanquet, 2002). While it is acknowledged that many trusts do not have birth centres or midwifery-led units, all too often comparatively little placement time is devoted to the community, which may offer the student the only opportunity to experience low-tech, non-interventional birth in the home setting. In a similar vein, with the current emphasis on the promotion and preservation of normal birth, and the drive to empower women and place them at the centre of their own care (Department of Health (DH), 2004; 2007), it is surprising that experience in homebirth does not feature as a requirement by the Nursing and Midwifery Council (NMC) for pre-registration student midwives. Perhaps the inclusion of homebirth within the pre-registration requirements would encourage universities and trusts to provide students with additional community-based placements, thereby increasing students' experience of, and confidence in, the promotion of normal birth processes.

An exploratory study by Fraser and Hughes in 2009 investigated factors that influenced student midwives' perceptions of childbirth. They found that while student midwives expected and anticipated birth to be a normal event, they nevertheless held the assumption that the majority of births would take place in hospital. She suggested that while this is perhaps somewhat surprising, the majority of students had no knowledge or experience of homebirth, either personally, or through a family member (Fraser and Hughes, 2009).

These findings accord to some degree with DeJoy's study in 2010, in which American college students expressed the view that birth should take place in hospital. However, for these students, birth was not seen as a normal event, but as a time of danger and unpredictability. The students in this study had limited knowl-

“ If student midwives are expected to uphold the ethos of normal, low-tech, non-interventional birth, then the balance of clinical placements needs to be addressed. ”

edge of midwifery, and held the opinion that midwives only practised birth in the home and were therefore unprepared for childbirth complications. This perception led to an overall assessment of midwives as unsafe practitioners of childbirth, while the obstetrician and the role of technology were held in high regard, with the caesarean section seen as 'the single cure for every birth problem' (DeJoy, 2010: 119).

Naturally, the differences in the provision of healthcare between the US and the UK mean that these findings cannot be easily generalized to the British population. However, as is the case in Britain, there are increasing attempts in US society to promote the midwifery (as opposed to the medical) model for childbirth, and in such a climate, these findings make interesting and perhaps sober reading (DeJoy, 2010). The findings from both of these studies are testament to the decline in the rate of homebirths in England and Wales, which currently stands at 2.7% (Office for National Statistics, 2010), while the rate of caesarean section in America in 2006 stood at just under 32% (DeJoy, 2010).

Hunter (2004: 266) has described the differing approaches to care between community-based and hospital midwives as 'with woman' and 'with institution'. She noted that hospital-based midwives adopted a task-oriented approach to care, and observed midwives relishing the challenges presented by the necessity to prioritize care according to clinical need (Hunter, 2004). Some of these midwives therefore appeared to have accepted and adapted to the provision of medically-oriented midwifery without issue. Maintaining their focus on the completion of tasks during the course of a shift, motivation was seen as the ability to hand over to the next shift without the need to admit that tasks had not been completed (Hunter, 2004). Other midwives, however, reported feelings of frustration at their inability to follow a 'with woman' approach in the hospital setting. Such frustrations led to what Hunter describes as 'emotion work', in which midwives and midwifery students sought to reconcile the differences between the type of care they yearned to provide with that which was actually possible in the hospital environment (Hunter, 2005: 262).

Recognition has been made in the literature of midwives covertly modifying



*Some studies have suggested the division of midwives into those skilled in providing high-tech, medicalized birth, and those with the skills to promote and deliver low-intervention, normal birth.*

hospital policy for the benefit of the woman, in what has been termed 'doing good by stealth' or 'playing the game' (Kirkham, 1999; Hunter, 2005; Keating and Fleming, 2009). In her study on autonomous practice, Baird (2007) referred to a midwife who, rather than conducting continuous cardiotocography (CTG) monitoring as dictated by hospital policy, allowed the woman to mobilize periodically without constant monitoring. In essence, the midwife used her clinical knowledge and skills to flout the hospital's policy requirement. Other studies convey similar findings such as underestimating the rate of cervical dilatation to 'buy time' against the hospital clock, and 'allowing' women to push during the second stage of labour for a period longer than the policies advocate (Hunter, 2004). Keating and Fleming (2009) found that midwives felt capable of adopting autonomous practice during night shifts, when medical staffing levels were generally lower, and midwives were therefore able to practise freely without the constant interruption of obstetricians. Such reports make difficult reading for students eager to practise with autonomy, and since students are continually exposed to practices such as these, it is plausible, if not inevitable, that students too will begin to practise in similar ways, and to conform to the culture around them (Bosanquet, 2002).

It is a worrying thought that with such emphasis on technology in the birthing process, there is the very real potential for student midwives to reach the point of qualification with little skill, and/or confidence, in normal, low-tech birth (Mander and Reid, 2002). Indeed, Hunter's study in 2004 went so far as to suggest the possibility of the division of midwives into those skilled in providing high-tech, medicalized birth and those with the skills and confidence to promote and deliver low-intervention, normal birth. While this may seem an entirely sensible suggestion given the current midwifery culture, this surely goes against the essence of midwifery itself. The prevailing nature and ethos of midwifery is to be 'with woman'; to provide all women with midwifery care, and to ensure that elements of normality are preserved for those women who are experiencing a high-tech, medically-managed birth (Lindsay, 2006). The creation of midwives who specialize in 'high risk' birth is tantamount to the role of the obstetric nurse, common to overtly medical cultures such as that in America (Thomas, 2002). It would further devalue the fundamental and essential midwifery skills of auscultation with a Pinard stethoscope; abdominal palpation of contractions and the type of calm, non-invasive care that Wylie and Bryce (2008: 6) referred to as 'masterly inactivity'.



Where, then, does this debate leave the student midwife, who is presumably anxious to practise normal, low-tech midwifery? Do students seek to work against the tide of medicalization and continue to uphold their idealist views to provide woman-centred care, or as Bosanquet (2002: 301) suggests, 'turn nasty' and practise 'highly routinized, impersonal care'?

Not only is the student midwife expected to conform to the culture within which she/he is working, but also to deliver individualized care to the women concerned. While the provision of woman-centred care may seem to suggest natural, normal birth, there is growing evidence to suggest that some women favour medical intervention (Anderson, 2004; Green and Baston, 2007). Fenwick et al (2008) examined the reasons for first-time mothers' requests for elective caesarean section. She found that a number of women were afraid of vaginal birth, and considered that a caesarean section would provide them with a safe option in a 'controlled, panic-free environment' (Fenwick et al, 2008: 3). These results are demonstrative of the powerful effects of the technocratic/medical approach to childbirth which has developed within midwifery since the publication of the Peel Report, which

advocated that all deliveries should take place within the hospital environment (DH, 1970). Fenwick et al (2008) concluded with a plea to midwives and health professionals to promote the normality of childbirth, acknowledging the importance of current endeavours in this regard including the Campaign for Normal Birth.

### Adapting to the midwifery culture

Kirkham's studies into the culture of midwifery make sombre reading, describing the culture as one of service and sacrifice, featuring guilt, self-blame and learned helplessness (Kirkham, 1999; Kirkham and Stapleton, 2000). Midwives described their complete commitment to their profession in terms of self-pressure or 'emotional blackmail' (Kirkham, 1999: 734), and felt that striving to achieve woman-centred care effectively ignored the needs of the 'other' woman involved—the midwife herself. Midwives reported expecting to receive blame during their work and did not anticipate receiving thanks or praise. These findings are in stark contrast to the feminist midwifery model, which seeks to refute a culture of blame and adopts mutual support techniques (Stephens, 2004).

Kirkham's study also highlighted the often uncomfortable differences that existed between midwives working in the hospital, and those based in the community (Kirkham, 1999). In a telling depiction, one community midwife likened her period of updating on the hospital delivery suite to that of a lioness approaching a new pack of lions, waiting for the attack. This is an incredibly sad description of the culture within midwifery (Kirkham, 1999). Yet, the midwives within this study reported that receiving praise and encouragement from their supervisors and managers greatly increased their confidence and feelings of self-worth (Kirkham and Stapleton, 2000). It is very disheartening that midwives experience such negativities within their daily work, yet quite amazing that the use of praise—such a simple measure—has the potential to greatly influence this negative culture. For the student midwife, then, undertaking clinical placements within the hospital environment means that she/he is continually exposed to and enveloped within the midwifery culture

illustrated here (Kirkham, 1999; Kirkham and Stapleton, 2000).

Further literature highlights that many midwives are disillusioned with the way midwifery is currently practised under the medical model, and often feel powerless to change practice (Ball et al, 2002; McTavish, 2010). Baird (2007) considered that such negativities and frustrations in qualified midwives must, in turn, affect students. It is not difficult to see how working within a culture in which such feelings are expressed, could easily perpetuate a cycle of negativities and frustration (Begley, 2002).

Literature examining student midwives' experiences in clinical placements illustrates that students often feel the need to be accepted and to 'fit in' (Yearley, 1999). In striving for acceptance, students reverted to what were seen as menial tasks such as making the tea (Yearley, 1999). Conversely, Kennard (2004)—herself a student midwife—argued that students should not be used as an 'extra pair of hands', expected to carry out duties such as cleaning and filing (Kennard, 2004: 550). She suggested that the midwifery hierarchy ranks older, more experienced midwives at the top, followed by junior midwives, healthcare assistants and finally, pre-registration students at the very bottom. Yearley's study (1999) found that some midwives were critical of the lack of clinical skills demonstrated by new direct entry student midwives, with one midwife referring to them as 'those girls from Tesco' (Yearley, 1999: 630). While it is accepted that these comments are not indicative of all midwives' opinions of direct entry students, Yearley's study perhaps reveals an element of animosity toward student midwives who are not formally nurse-trained and educated.

In her article considering the socialization of student midwives, Bosanquet (2002) suggested that, on entrance to the hospital culture, students move through a cycle of experiences that ultimately culminate in socialization into the organization's culture. This cyclical process has been described by van Gennep (1960) as 'rites of passage' involving separation, transition and incorporation. In separation, new student midwives lose their idealist notions and begin to adopt an attitude of negativity; behaviours which have also been recognized within the nursing profession



*Student midwives may sometimes feel that they are used as 'an extra pair of hands' for duties such as cleaning and filing.*



(Castledine, 2002). Transition involves the learning and adoption of new skills, not least the acceptance of the hierarchy, and the willingness to mould oneself to the organization's identity (Bosanquet, 2002). This metamorphosis is complete when the student has adapted to comply with the requirements of the organization, and has embraced what Helman (2009) described as a new social role. What is perhaps most impressive about these changes is that they are often either unrecognized or completely accepted by the student.

This suggests that the process of socialization is covert and subtle in nature (Wagner, 2001). Begley (2002) depicted how, in the process of socialization, students are moulded to accept the organization's hierarchy and culture. Students within this study recognized not only that their attitudes were changing to comply with the culture, but accepted that, as qualified midwives, they would then begin to perpetuate the cycle of change on new students. This portrays the very essence of the socialization of student midwives into the culture of midwifery.

## Conclusions

As noted earlier, it is evident that issues surrounding culture and socialization within the NHS midwifery service have generated much interest and debate. This article has sought to examine and analyse the way in which that culture affects student midwives in terms of their early expectations, and whether students align those expectations in accordance with the realities of current midwifery practice. This article has further attempted to consider the possibility and feasibility of students maintaining, following and promoting normal birth against an increasing medical culture.

While numerous studies have examined midwifery culture and highlighted the often difficult and frustrating circumstances within which midwives practise, it seems that none of these studies offer a practical solution to the problems identified. It is, perhaps, that the nature of these issues is so complex as to prevent the identification of simple resolutions. Hunter (2004) suggested effective use of education to equip and prepare student midwives for the realities of clinical practice. She also

## Key points

- New student midwives often begin their studies with ideas and opinions concerning midwifery, along with expectations regarding the normality of the birth experience and the way in which labour and birth is supported and practised
- Expectations are invariably challenged when the student undertakes her/his first hospital-based placement and experiences, for the first time, the reality of labour and birth on the delivery suite
- Through recognition of the present culture surrounding midwifery, students and midwives can work together to facilitate positive change
- Students should be provided with increased community-based placements to underline and emphasize the normality of pregnancy and birth outside the medical environment

advocated improved use of supervision to enable midwives to reconcile differences that result from conflicting perspectives. At first reading, the conclusions in this article appear to avoid the issues raised, by ignoring any modification in the organization of services, and placing responsibility for change with education and supervision. However, as noted above, the issues identified within the midwifery culture are not easily addressed or 'fixed'.

It is clear that in the progression through their midwifery training, student midwives face considerable challenges brought about by the culture in midwifery. Throughout training, students are required to meet a number of essential midwifery proficiencies, to learn and develop a wide range of clinical skills and to complete a rigorous programme of academic study. In researching this subject, it has become apparent that the student faces concurrent, but perhaps covert, challenges throughout training that are directly related to the culture within midwifery. However, it is contended that for some students, the process of professional socialization is so subtle in nature, that it is neither apparent nor challenged (Wagner, 2001). Yet, as Bosanquet (2002) argued, it is only through recognition of the present culture surrounding midwifery that students and midwives can work together to facilitate positive change.

The purpose of training is to prepare students to enter the midwifery profession as competent and skilled practitioners of normality, fit for purpose and entirely committed to support women and their partners throughout the childbirth experience

(NMC, 2004). Perhaps it is time to provide students with increased community-based placements to underline and emphasize the normality of pregnancy and birth outside the medical environment; to raise public awareness in normal birth; and to ensure students receive realistic education about the challenges of the hospital ward. Adopting these measures and acknowledging that the culture within midwifery can be challenging for students may begin to address attrition rates within midwifery and provide improved support to enable future generations of midwives to maintain their ideals, expectations and expertise in normal birth. **BJM**

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