Promoting normal birth through midwifery support in labour

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Promoting normal birth through the RCM UK PhD studentship

- Three year full-time salaried studentship
- Hosted by the NMAHPRU at the University of Stirling, Scotland
- Largest UK study of intrapartum support
- Largest observational study of labour care since 1989

The Royal College of Midwives

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The ‘SMILI’ study

- ‘SMILI’ ‘Supportive Midwifery in Labour Instrument’ new computer program developed to measure the quantity and quality of midwifery support in labour
- Systematic observation – trained midwife observer in the room
- Timed when the midwife was in and out of the room
- Recorded specific behaviours of the midwife – support and non-support, positive and negative
- Recorded outcomes – women’s views and other clinical outcomes

The Maternity Myths

Myth #1:

Women want caesareans

Myth #2:

Caesareans are as safe as normal birth

Myth #3:

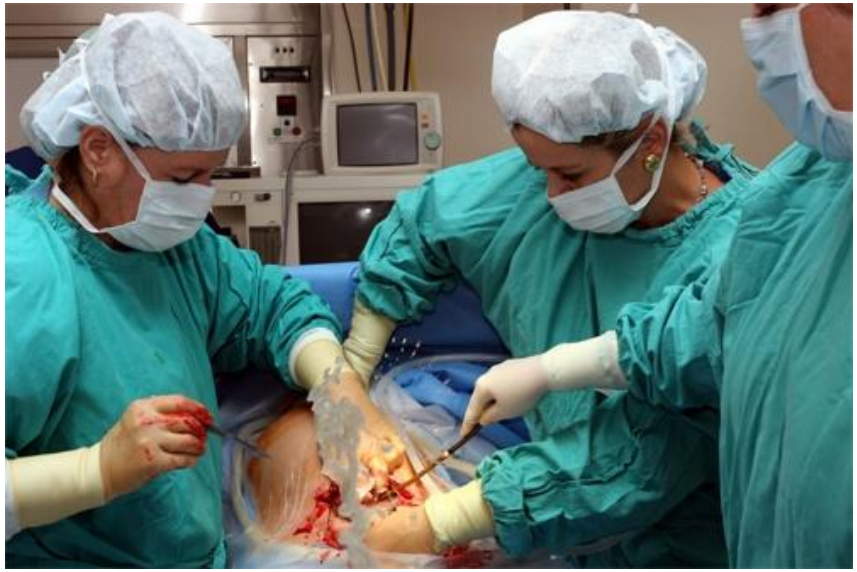
'Que Sera Sera' – Labour is physiologically programmed what midwives do makes no difference

Myth #4:

Continuous one to one midwife support is an expensive luxury

Myth #1: Women want caesareans

- A systematic review of worldwide studies indicate that only a small minority of women would prefer a caesarean to a vaginal birth (Mazzoni et al 2011)
- In the UK, maternal request is the primary indication for 7% of caesareans (RCOG 2001)- that is c. 1.6% of births
- In large representative samples, UK women express a preference for birth with as little medical intervention as necessary (Green et al 2003, Garcia et al 1998)



Myth #2: Caesareans are as safe as normal birth

- Elective caesarean has been estimated to pose a 2.84x greater risk of maternal death than vaginal birth (CEMACH 2007)
- Rates of severe maternal morbidity: 5.2 per 1000 for vaginal birth, 12.1 for elective cs, 27.2 for emergency cs (Pallasma 2008)
- Higher rates of neonatal and childhood morbidity with caesarean including longer NICU stays, food allergies, asthma and type 1 diabetes (Simones et al 2005, Hansen et al 2008, Knight et al 2008)
- In USA maternal mortality has risen from 6.6 per 100,000 in 1987 to 13.3 per 100,000 in 2006

- *'Caesarean delivery, even an elective one, carries a significantly higher risk of life-threatening maternal complications than vaginal delivery'*
- (Pallasma 2008)

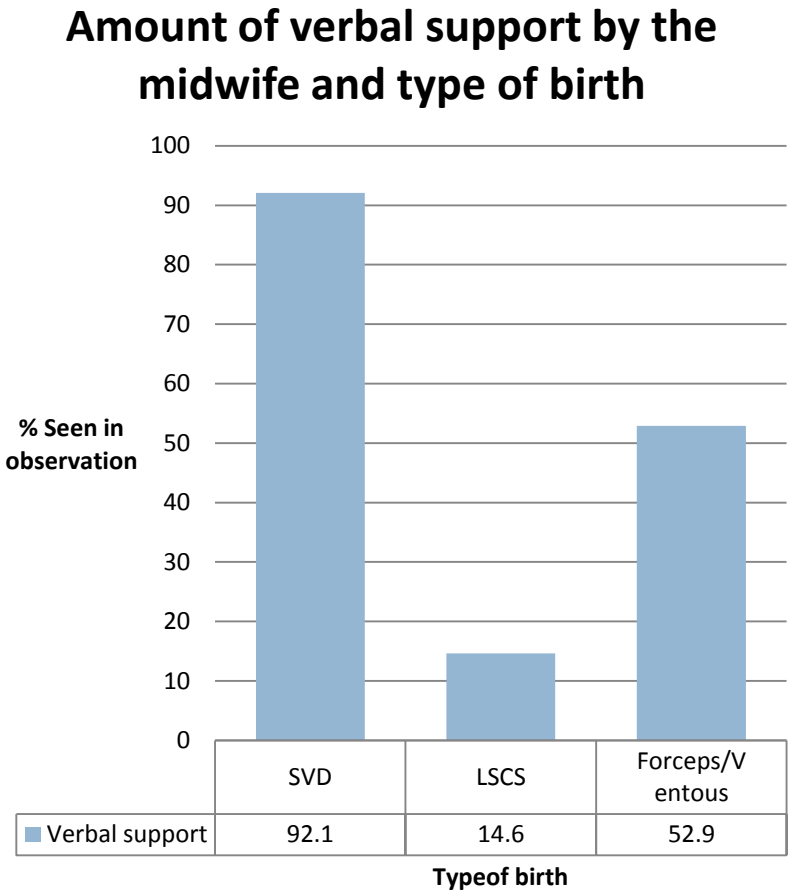
Myth #3: ‘Que Sera Sera’

Systematic review of 21 Randomised controlled trials of Continuous v Intermittent support:

- Reduces LSCS rates by 10 – 51%
- Reduces Analgesia by 13 – 36%
- Reduces women’s dissatisfaction by 27%
- Labour is shortened, by 44 – 170 minutes (Hodnett et al 2011)

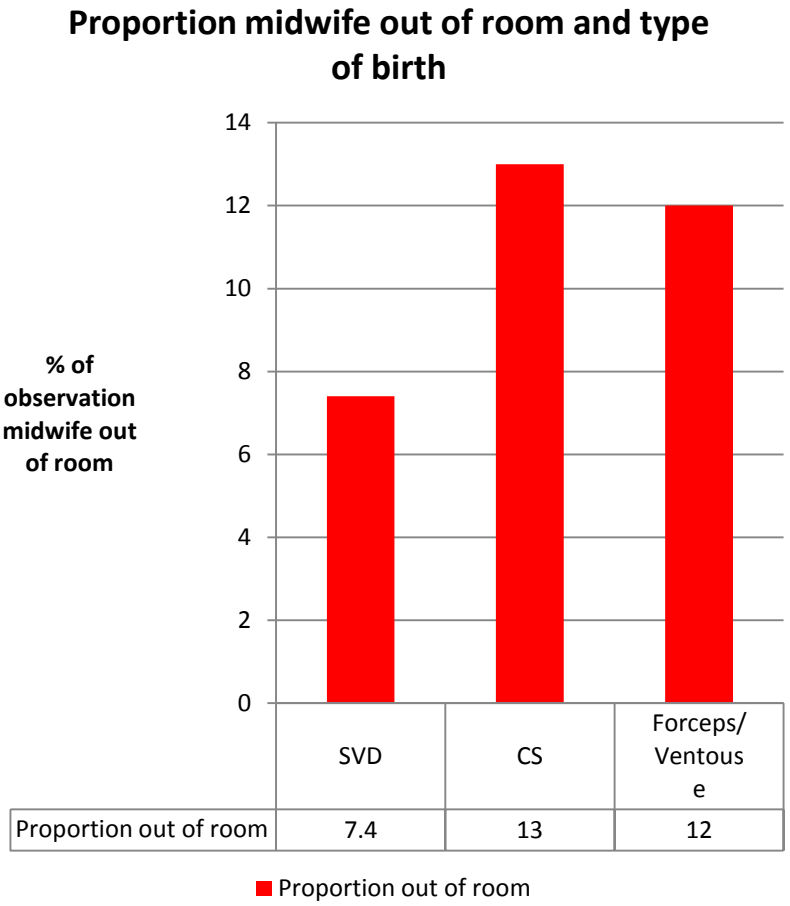
Does the midwife make a difference? The 'SMILI' study

- Statistically significant correlations:
- The more emotional support given by the midwife the more likely the woman was to have a vaginal birth
- Where emotional support was recorded less than the study average, women 2x as likely to have a forceps or ventouse



Does the midwife make a difference? The 'SMILI' study

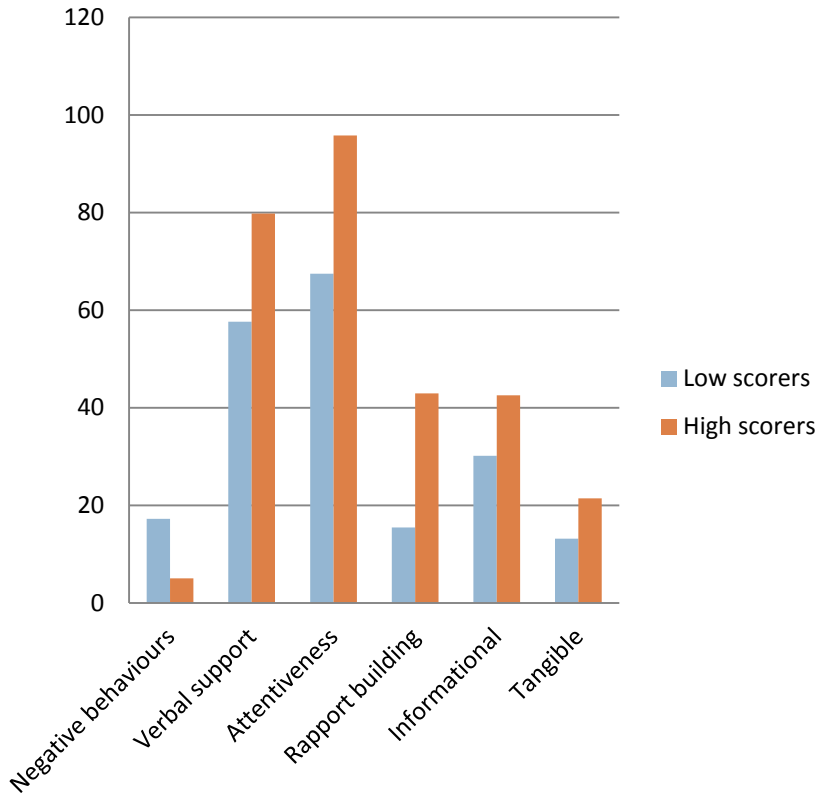
- Statistically significant correlations:
- The proportion of time the midwife was out of the room and the type of birth
- The longer the midwife was out of the room the more likely the woman was to have an operative delivery



Does the midwife make a difference?

The ‘SMILI’ study

Comparison of behaviours for midwives scored high and low by women



What women thought

- Women rated midwives lower where they had shown negative behaviours
- Women rated the support they had received higher when the midwife gave more verbal support, was more responsive to contractions, built rapport, gave more positive information and tangible support
- Support outweighed care pathway and medical interventions in their satisfaction

Myth #4: Continuous one to one midwifery support in labour why bother?

- High quality one to one midwifery support can:
- Reduce medical interventions including caesarean sections
- Reduce costs (LSCS costs 3x a vaginal birth)
- Reduce complaints and dissatisfaction
- Reduce PTSD (Post-traumatic stress disorder)

What is high quality intrapartum midwifery support? The Evidence . . .

- ‘The Less we do the more we give?’ (Leap 1998)
- Women don’t need support they need the space protected (Odent 2011)

What is high quality midwifery support in labour? The Evidence

- ‘The more we give, the more we give’ (Ross-Davie, 2011)
- Stay in the room
- Build rapport
- Give praise, encouragement and reassurance
- Involve the partner

A Huge Thank you

- To the women and their partners who agreed to have us observe their labours
- The volunteer observers Mary McElligott, Karen King and Margaret Little
- The midwives who let us observe their care
- The managers, consultant midwives and maternity unit midwives
- My supervisors
- The Royal College of Midwives

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