Removing babies from mothers at birth: Midwives' experiences

Abstract

It is evident from a review of the literature that looking after the psychological and emotional needs of women who have their baby removed at birth is a vital part of midwifery care in the childbirth continuum. This review reports on the experiences of midwives who have provided care and emotional support to mothers who have had their baby removed at birth and the challenges they have encountered from doing so. BNI, CINAHL, EMBASE, Google Scholar, Maternity and Infant Care and PsycInfo were searched for articles published until January 2014 and findings suggest that providing care and emotional support to women who have had their babies removed at birth remains one of the most challenging aspects of contemporary midwifery practice. It is anticipated that this study will raise awareness of the challenges associated with providing care and emotional support for women whose babies have been removed at birth and contribute to the evidence base for best practice.

Keywords: Midwives, Experiences, Removed, Birth, Babies

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Midwives provide a universal service, their knowledge and expertise in assessing and monitoring the health and wellbeing of a pregnant woman and her unborn baby means that they have an important role to play in all stages of family support and child protection. The requirement to visit new babies at home means that midwives are ideally placed to identify any needs or familial stresses, without the negative connotations often associated with receiving services from other agencies, such as social care (Solon, 2013). Midwives may be required to provide 'intrapartum care to women whose previous history warrants the infant's removal at birth' (Powell, 2007: 63) and while this is acknowledged as a vital part of midwifery care in the childbirth continuum, it is reported to be one of the most challenging aspects of clinical practice (Powell, 2007).

This study aims to explore midwives' experiences of providing care to mothers whose babies have been removed at birth and to raise awareness of the challenges associated with providing care and emotional support for these women. The study will also assess and challenge current evidence in order for education and training in this important area of practice to be developed.

Methods

Search strategy

Relevant papers were obtained by undertaking a search of the literature. Criteria for the search were any trials or studies, written in English that explored midwives' experiences of providing care to women who were having or had had their babies removed compulsorily at birth. The search strategy was informed by using a PICO template (Richardson et al, 1995). The population (P) group selected were midwives. The intervention (I) would be having had personal experience of providing care to women who had their baby removed at birth. For the purpose of this study the definition of experience of 'babies removed at birth' will be providing midwifery care to a mother who has experienced having personally had her baby compulsorily removed at birth. There is no direct comparison (C) with any other population group and the outcome (O) measures were personal experiences of midwives. A number of alternative terms are used in the literature for example, baby, infant and child. However, for the purpose of this study they will be referred to under the term baby or babies. No historical limits were placed on this review as it was important to ensure as wide a search as possible and to see when the topic first became of interest to researchers.

The following electronic databases were searched from the date when the database commenced up to January 2014: MEDLINE, EMBASE, CINAHL, BNI, Maternity and Infant Care, PsycINFO, and Google Scholar. Varying combinations of keywords included; Wom*, mother, bab*, infant, child*, remov*, taken, birth, 'removed at birth', lost, 'taken at birth', 'child protection', experience, post*.

Results

Following an extensive search of the literature, Wood (2008) and Everitt (2013) were the only two authors found, to date, that have reported directly on midwives' experiences of providing care to women who are likely to, or have had, their babies compulsorily removed at birth.

Wood (2008), as part of a Master's degree, explored the lived experience of midwives in the UK undertaking child protection activity and

the provision of support for vulnerable families. The objectives of Wood's (2008) study were to raise awareness of the impact of engaging with child protection activity on midwives, and to identify any need for support or education, to ensure midwives were effective in safeguarding newborns from harm and upholding their duty of care to the women.

Wood (2008) identified the following emerging themes: identification of vulnerable families, gut feelings and instincts, understanding the role of the midwife, and collaborative working and support. While the majority of data collected by Wood (2008) were related to many aspects of the child protection work of midwives, the question 'have you ever provided care for women whose babies were likely to be or had been removed at birth' generated the biggest response. The main themes of midwives' comments in relation to this question, were: the need for clarification as to whose role it was to facilitate the actual removal of babies from their mothers, the lack of support they had received during and after the process, feeling afraid and fearful for personal safety, and the comparison of providing support to this group of women as similar to that of mothers whose babies have died or were stillborn.

Wood (2008) concludes that the results of her research provide justification that more in-depth studies are needed in order to research the support and training needs of midwives who provide care for women whose babies are likely to be or have been removed at birth and the support needs of the mothers they provide care to.

Everitt (2013) is a clinical midwifery consultant who provides care to vulnerable women and families in a public hospital in Sydney, Australia and as part of her MSc studies replicated an aspect of Wood's (2008) study which aimed to explore the experience of midwives who were involved in removing babies at birth or in the postnatal period. The research objectives were, to explore the involvement of midwives in the process of providing care to women whose babies were removed at birth, the emotional aspect of doing so and the coping strategies midwives employed when providing this care. Both Everitt (2013) and Wood (2008) used semi-structured, face-to-face interviews to collect data.

Chapman (2003: 116) also offers some insight into the experiences of providing care to women whose babies are removed at birth by describing the removal of babies at birth as 'the most forceful statutory intervention of the state into family life'. In part two of a series of comment articles focusing on the implication of national policy on child protection, Chapman (2003) explained how 5 years on, she remained personally and professionally affected by the emotional impact of her involvement in providing care to women who had their babies removed at birth.

Discussion

Whose job is it to remove babies?

While midwives in both studies (Wood, 2008; Everitt, 2013) felt that providing care to this group of women was intrinsic to their role, many midwives believed that their involvement in the actual act of removing babies at birth, or in the immediate postnatal period, challenged the dynamics of the midwife–woman relationship in a negative way. The meaning of the word midwife is to be 'with woman' and this ethos is intrinsic to the midwife–woman relationship that underpins midwifery practice (Everitt, 2013).

Wood (2008: 310) found that participants in her study felt that it was unnatural to 'deliver a baby then subsequently remove it [from the mother]'. Midwives in both studies also talked about the 'betrayal' they felt to women at this time and that they further believed it was an issue of trust that would damage relationships with women they then were expected to care for (Wood, 2008; Everitt, 2013). Robinson (2009) agrees and warns midwives that they are at risk of losing the extensive trust that women place in them by undertaking the role she describes as 'health police'.

The challenge of maintaining a child focus, while delivering women-centred care is a midwifery dilemma further described by Powell (2007). Lupton et al (2001) claims that there may also be ethical conflicts between the role of the midwife as support for women and their responsibility to report concerns about safeguarding issues. A likely cause of this perceived omission is attributed to a pre-registration midwifery programme that has a crowded and adult-centric curriculum lacking the child-centred approach required for effective safeguarding practice (Powell, 2007). Therefore, in practice, the midwife may become so focused on the needs of the woman, that she inadvertently fails to recognise the importance of placing the child's wellbeing first.

There was little evidence found of this in Everitt's (2013) and Wood's (2008) research, with many midwives openly acknowledging that while this element of their job remained challenging, they never lost sight that protecting the child was the most important thing and that they were clear of the different roles they play in the provision of care for the mother and ensuring the safeguarding of children.

'In my head I know it's for the best reason for the child, for the safety of the child but there is still a woman who has had her baby removed, a woman with dreams.' (Everitt, 2013; (Midwife 4))

The failure to lose sight of the child is not a single agency issue, and in the recent serious case reviews of Peter Connelly, more commonly known as Baby P, and Daniel Pelka, significant evidence was presented that the social worker and teachers involved consistently placed unfounded trust and belief in the mothers' accounts of how the children had suffered their injuries or the causal factors of the symptoms they presented with (Lock, 2013). This over-identification with the parents whose account of possible explanations was perceived to be plausible played a detrimental effect on the health and ultimately lives of these children. Therefore, it can be argued that the profession of health care worker cannot be a predictor of the inability to put the needs of a child before the needs of the adult.

The midwives in Wood's (2008) and Everitt's (2013) studies expressed the view that other professionals, in particular social workers, are better suited to facilitating the actual removal of babies at birth as this then leaves midwives in a position of being able to provide support without being involved in the process. While this sounds reasonable, the care provided by the midwife will undoubtedly be short-lived and and therefore the woman's ability to develop relationships with social workers is greater as they will be expected to provide support for the family for an extensive period of time. Therefore, it is suggested that social workers too are in a difficult position and may also not be best placed to remove the child. This ongoing debate requires formal multidisciplinary research before assumptions can be made and until then we must maintain the ethos that it remains a 'shared responsibility' with each case judged on the actual situation presented. However, the emotional impact of facilitating the removal of babies from mothers is acknowledged and should not be underestimated (Wood, 2008).

Emotional work

Midwives are expected to engage in all aspects of child protection work including providing care to an increasing number of women who have their babies compulsorily removed at birth (Powell, 2007) and, while no midwife would dispute that protecting children from harm is 'everyone's responsibility' (Department for Education (DfE), 2013), it remains one of the most challenging aspects of clinical practice (Powell, 2011). Wood (2008) agrees, and describes it as the most distressing and challenging task of clinical practice a midwife can be asked to do. Chapman (2002) and Fraser (2003) report that midwives feel out of their depth in child protection practice and can often feel 'unsettled', 'upset' and will experience high levels of stress. One midwife in Everitt's (2013) study said:

'The baby was in the crib and I was the one who actually had to roll the cot away from the mother and take her baby. I remember saying to her. 'Do you want to give the baby a cuddle or a kiss, or whatever' and she didn't and she was crying by that stage and I was trying very hard not to cry.' (Everitt, 2013; (Midwife 3)).

Hunter (2010) also acknowledges that there are still many areas of midwives' 'emotion work' that remain 'under investigated' and 'unrecognised', and midwives' experiences of engaging with child protection activity is one of them.

Everitt's (2013) study reports the experience of removing babies at birth as 'gruelling', with the less experienced midwives appearing to be more frustrated, shocked and distressed. This correlation between years in the job and ability to detach from the emotional aspect of removing babies is echoed in Hunter (2001) who also found in her study of 'emotional labour' in the workplace, that the less senior a midwife was the more emotional distress she encountered.

Wood (2008) also reported that the findings of her study were 'disturbing' and that future research needs to be specifically focused directly on midwives' experiences of caring for mothers' whose babies are removed at birth and the impact on them of doing so.

Feelings

Midwives in Wood's (2008) and Everitt's (2013) study reported feeling threatened and fearful for their personal safety following involvement in removing babies from the mother at birth. Both population groups also reported having been personally threatened. However, midwives were empathetic towards the parents who expressed anger and violence towards them by justifying it as:

'just the emotion, they're upset that you're taking their baby' (Everitt, 2013; (Midwife 7)).

Particpiants also felt guilty about playing a part in, what they described as, 'causing a bereavement' to the women they were caring for (Wood, 2008) and midwives in both studies described the reactions of women whose babies had been removed as mirroring that of women whose babies had died, defining at as 'deep grief' (Wood, 2008; Everitt, 2013). However, while they drew on their clinical experiences of providing care to a woman whose baby had died, they were not supported with the services and networks that this group of women had access to and were, therefore, left feeling helpless in the wake of the 'mother's trauma' (Wood, 2008). Chapman (2003) further states that women who have their babies removed at birth are denied and deprived of the services and support networks that are available to other women. The midwives in Everitt's (2013) study expressed concern that they discharge women home in obvious 'acute distress' with no support. They add that these are also the group of women that often discharge themselves, don't access postnatal care and remain unaware of the potential for bleeding and infection risk as part of their postnatal recovery. Chapman (2003) concludes that the emotional impact and cost to the health and wellbeing of mothers who have their babies removed at birth is in urgent need of research.

Midwives can be left feeling emotionally scarred and vulnerable having provided care to this group of women and can also feel that they have struggled to meet the needs of women while maintaining child-focused practice (Wood, 2008). Chapman (2003) further identifies the need for clinical supervision and support for midwives who engage with child protection activity.

Collaborative working and support

Feeling unsupported by other professionals during the removal process was highlighted by midwives in Wood's (2008) study. However, they did feel supported by each other. Conversely, Everitt (2013), found that many midwives reported positive working relationships with other professionals including social workers.

Furthermore, in Everitt's (2013) study, midwives expressed empathy towards social workers and acknowledged that their roles were 'challenging' and 'terrible' and would often involve making 'life changing' decisions. The acceptance and understanding of other professionals' roles in safeguarding practice is acknowledged as pivotal to effective safeguarding practice (DfE, 2013). However, the midwives felt that the empathy and understanding of their role was not always reciprocated, with reports from midwives who felt that their professional opinions surrounding the decision to remove babies from mothers were not taken into account, which left them feeling disempowered and believing that, ultimately social workers had the 'final say' (Everitt, 2013). They also reported disparity across cases for reasons of removal by describing the decision making process as 'flipping a coin' but did acknowledge that they may not have been privilege to all of the information surrounding the mothers' parenting ability.

Training needs

Midwives in both studies felt that they had not received adequate training particularly in the removal of babies at birth and were left feeling unsure as to what they should do (Wood, 2008; Everitt, 2013). Acknowledging this, Wood (2008) recommended that the removal of babies at birth should be mandatory on pre-registration curriculums in addition to follow-up training in the clinical setting.

Student midwives do receive safeguarding and child protection training as part of their midwifery programme and the training standards for pre-registration midwifery education (Nursing and Midwifery Council (NMC), 2009) state that student midwives should be proficient by the end of their training to be able to intervene, refer appropriately, and work collaboratively with other agencies and professionals when safeguarding and protecting children. However, it offers no guidance as to specific content for inclusion within the curriculum. In fact, safeguarding is only mentioned in the essential skills cluster as part of the communication domain (NMC, 2009). Therefore, it is argued that dependent on the higher education institute, geographical location of clinical placements and individual interpretation of subject leaders this content is variable and not consistent.

Key points

- There is a dearth of knowledge with regards to the needs of mothers who have their baby removed at birth
- Midwives feel that involvement in removing babies at birth challenges the midwife–mother relationship in a negative way
- It is one of the most challenging aspects of contemporary clinical practice
- Midwives feel that they are not adequately trained in this area
- Further research is needed to gain greater insight into the experiences of midwives who provide care to this vulnerable group of women

Limitations

The limited amount of research available for inclusion in the review and the small sample sizes in both studies make it difficult to generalise the findings to the wider population.

Conclusion

Providing care and emotional support to women who have had their babies removed at birth is one of the most challenging aspects of contemporary midwifery practice. However, despite the increase in numbers of babies being removed from mothers at birth, the impact of this intervention on the midwives that provide care for them remains unclear.

Further research is needed to gain greater insight into the experiences of midwives who have provided care for women whose babies have been removed in order to contribute to the evidence base for best practice and support their emotional wellbeing and ongoing professional development. **BJM**

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