Threat to low-risk birth environments

Emma Smith discusses the effect of the current staffing crisis on low-risk birth environments, and explores how the challenges that they face may be overcome

I inwardly sigh as I receive the call at the end of my shift that the birth centre where I work is having to be diverted yet again. While the night team head to the labour ward because of high acuity, I feel sad and deflated as I turn off lights, divert the phones and place a 'closed' sign on the birth centre door. On my drive home, I start to imagine women going into labour overnight and heading into the unit, keenly anticipating the birth centre as the place they will labour. I imagine the lump in the throat swallowed back, the shoulders drooping and the disappointed eyes as they are informed of its temporary closure for the shift and their questions, 'is there no chance of it being open at all?' or 'is there a pool available?' Frustration takes hold of me, and a lump threatens to form in my throat when I imagine the answers they are likely to receive: 'there aren't enough midwives to staff the birth centre tonight' and 'I'm afraid the pool room is already in use'. I think back to the conversations I have had with women who tell me the feelings of dread and panic when they heard they could not use a pool, the birth centre was not open, or there was no community midwife available to attend their planned home birth. These familiar cases have led me to a conclusion: low-risk labour care is at threat with detrimental consequences.

Current staffing crisis

While all areas of maternity services are currently struggling, the past 3 years in the UK have placed the provision of low-risk labour care at a serious disadvantage (National Institute for Health and Care Excellent (NICE), 2023). Many units found that they were unable to safely provide a home birth service during the COVID-19 pandemic and made the difficult decision to suspend it. The maternity staffing crisis during that time, and following it, has meant that many units are having to divert their birth centre midwives to where acuity is at its highest and their birth centres are temporarily closed (NICE, 2023). Women are finding themselves limited for choice and are forced to give birth in a setting not of their choosing. Other than being extremely disappointing for these women, there are numerous disadvantages to labouring in high-risk environments if not clinically indicated.

Birthplace study findings

The findings of the Birthplace study (Birthplace in England Collaborative Group, 2011) confirmed the safety and numerous benefits for low-risk women who labour in a midwifery-led setting, such as home births and midwifery-led units. It was noted that for nulliparous and multiparous women who planned birth in midwifery-led units, the rate of interventions such as caesarean sections and episiotomies were reduced, and they had a higher rate of spontaneous vaginal births (Birthplace in England Collaborative Group, 2011). As much as interventions are important and sometimes necessary, many interventions increase the risk of further complications for women and babies.

Interventions and their risks

Women are more likely to receive continuous fetal monitoring or cardiotocography on an obstetric-led unit, which is associated with a rise in interventions, appearing to make little difference in preventing adverse neonatal outcomes (Goer and Romano, 2012; Alfirevic et al, 2017; Politi et al, 2023). As a result of its association with increased interventions, NICE (2022) does not recommend routine cardiotocography for low-risk women in labour. However, cardiotocography is still used unnecessarily (Jepsen et al, 2022).

Women are more likely to have higher use of water immersion in midwifery-led units and in home settings (Bączek et al, 2020; Burns et al, 2022), but those who labour in obstetric-led units are less likely to access a birthing pool (Milosevic et al, 2019). Numerous benefits to both mother and babies are evident when water immersion is used in labour, such as reduced epidural and opioid use, reduced episiotomies, higher rates of spontaneous vaginal births, a shorter labour and increased maternal satisfaction (Henderson et al, 2014; Lukasse et al, 2014; Ulfsdottir et al, 2018; Burns et al, 2022; Reviriego-Rodrigo et al, 2023). If being on an obstetric-led unit equals reduced access to water immersion, then it is safe to say that more women will opt for epidurals. I have heard women speak of their dismay at hearing that they cannot access a birthing pool on an obstetric-led unit and having fears that they will struggle to cope without it, meaning that they opt for an epidural.

While epidurals can offer a fantastic form of analgesia and do have benefits, they carry disadvantages. Epidurals increase the rate of instrumental birth (Antonakou and Papoutsis, 2016; Anim-Somuah et al, 2018; Penuela et al, 2019), in turn increasing the incidence of perineal trauma, postpartum haemorrhage

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and potential trauma to the baby (Gurol-Urganci et al, 2013; Royal College of Obstetricians and Gynaecologists, 2015a; 2020), making neonatal jaundice and feeding problems more likely (Peters et al, 2018). There is also evidence to suggest that epidurals may increase the rate of caesarean sections (Fieni et al, 2022; Goer, 2022) although sources differ on this statement and practitioners disagree over it.

Caesarean sections in themselves carry risks such as postpartum haemorrhage, infection, damage to surrounding internal organs, and deep-vein thrombosis (NHS, 2023). Having an emergency caesarean section increases the likelihood of having one in subsequent pregnancies, increasing the risk of uterine rupture, scar tissue and internal adhesions, erratic placentation, postpartum haemorrhage and stillbirth (O'Neill et al, 2014; Royal College of Obstetricians and Gynaecologists, 2015b). Emerging evidence indicates that caesarean sections may also affect the baby's short and long-term health (Moncrieff, 2018), potentially causing respiratory problems, altered immunity and obesity (Sandall et al, 2018). With current rates of caesarean sections soaring (World Health Organization, 2021), the unavailability of low-risk birthing environments is surely only contributing to this number.

Effects of intervention on maternal mental health

Instrumental births and emergency caesarean sections are also associated with poor maternal mental health, particularly with conditions such as childbirth-related post-traumatic stress disorder (Kitzinger, 2006; Dekel et al, 2019), which can have a detrimental effect on a mother's relationship with their baby and other family relationships (Kitzinger, 2006; Skinner and Dietz, 2014). Poor bonding between mother and child can affect a baby's overall wellbeing and future health (Cook et al, 2018; Royal College of Midwives, 2019a). Considering that interventions such as operative births are associated with mental health problems (Dekel et al, 2019) and that the Mothers and Babies: Reducing Risk Through Audits and Confidential Enquires Across The UK(2022) report listed suicide as one of the leading causes of maternal death, more priority should be placed on protecting low-risk birth.

Satisfaction rates in midwifery-led units and home births

Midwifery-led units and home environments are associated with higher rates of maternal satisfaction and an overall positive birthing experience, in contrast to obstetric-led units (McNeils, 2013; Cross-Sudworth et al, 2018; Bączek et al, 2020). The power and importance of oxytocin in labour is known, as well as how factors such as bright lights and a 'clinical looking' environment can 'frighten' oxytocin away (Goldkuhl et al, 2022). These feelings of satisfaction and relaxation may contribute to a surge in and maintenance of natural oxytocin, hopefully reducing the need for synthetic oxytocin and its associated interventions.

> **Staff have found the closure of midwifery-led units and suspension of home births frustrating and disheartening as women are unable to access the care they deserve**

It seems that the 'cascade of intervention,' a phrase that many midwives will be familiar with, may be triggered by women being unable to access midwifery-led units and home births. The closure of low-risk birthing environments clearly has an impact on the health of women and babies. These impacts have a clear ripple effect, potentially affecting a mother and baby's health far into the future.

Effects on midwives

There are potential effects to mothers and babies, but does limiting low-risk birthing environments affect midwives? The WHELM study (Royal College of Midwives, 2019b) found that a lack of staffing and resources contributed to poor mental health among midwives. McGrory et al (2022) highlighted how the suspension of home births and midwifery-led units closure contributed to staff stress.

Anecdotally, I know that staff have found the closure of midwifery-led units and suspension of home births frustrating and disheartening as women are unable to access the care they deserve. While low-risk labour care may not be every midwife's passion or area of interest, not being able to provide care they feel is important would no doubt cause frustration in any midwife. As a midwife on a midwifery-led unit, I have found that my feelings of burnout start to surface when women are not able to access the birth centre. I can become despondent and workplace satisfaction takes a dip. Mental fatigue can set in and the wearying feeling of 'oh no, not again' surges when the midwifery-led unit is frequently on divert. It would be interesting to know if there is a link between rising levels of intervention in maternity care and poor mental health among midwives.

Effects on student midwives

Restricting low-risk birthing environments also places student midwives at a clear disadvantage (Warwick, 2012; Nash, 2020), as they are less likely to have exposure to 'normal' labour and birth without interventions. I often describe the care provided on a midwifery-led unit or at a home birth as 'the bread and butter of midwifery' to students who feel nervous about working in these settings. This is the care that has been around for centuries; that trust in a woman's body, that reliance on your own senses of listening, touching, watching and trying tricks as old as the hills to enhance the physiological process. While that is not to say that midwives do not or cannot use these skills in a high-risk environment, much more reliance may be placed on machines and interventions. What better way for a student to learn these basics first and then have a solid

foundation to work up from to the more complex aspects of midwifery?

Many students have expressed to me poor exposure to and lack of confidence over intermittent auscultation and feel more confident with continuous fetal monitoring. Several students I have come across are close to qualifying and have never witnessed a water birth. This is concerning, considering that we are trying to develop midwives who should feel confident and be able to deliver safe care in all settings.

Are we unwittingly raising a generation of midwives not confident with providing low-risk labour care? Throughout history, midwives have been experts in physiological labour and birth. What does this mean for the future of maternity services and the wider health of women and babies? Warwick (2012) stated that if practitioners lack confidence in low-risk labour care, then it affects the likelihood of women being offered it. Will women continue to be provided with the choice they legally have a right to?

What can be done?

On taking a step back and surveying the sobering evidence, it is easy to become downhearted when considering where maternity services are currently at. More midwives and more funding come to mind as the immediate solution. While this is vital, changes cannot happen overnight. So what can be done in the meantime? Is there a way we can still protect low-risk birth and its environment?

Sadly, because of staffing problems across the country, there are times that despite everyone's best efforts, a midwifery-led unit may be closed or home birth services not always available. There is a phrase used by the army, 'adapt and overcome', and this could not be truer for the midwifery profession now. Midwives may find themselves called to be more adaptable and create a low-risk environment in a high-risk one, calling for a heavy dose of creativity. To do this, the following questions may need to be asked:

- Does the bed need to be in the centre of the room?
- Do the lights need to be so bright, or are there softer ones available?
- If accessing the pool is not an option, can the labouring woman still access some form of hydrotherapy, such as a shower or bath?

We should not forget that 'midwifery is an art'. Making changes may not come easily, so along with creativity, I am prescribing an even stronger dose of courage; something we are encouraged to uphold in the NHS Professionals (2023) '6 Cs of care'. It takes courage to make changes, to take a woman off an unnecessary cardiotocography, to change an obstetric-led unit room, to challenge an obstetrician, and to speak up when a woman is not being listened to or has not been provided with choice. Support from the whole multidisciplinary team is required to make these changes

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happen. It takes senior midwives instilling confidence in other midwives to facilitate physiological birth. It takes obstetricians recognising the 'sacredness' of the birthing room, respecting the importance of an undisturbed birthing environment, and minimising intervention where possible.

Conclusions

The fight is on for low-risk birth, maybe in a way it never has been before. There have always been challenges to facilitating low-risk birth, but the threat seems to have increased. The unavailability of low-risk birthing environments has more of an impact on maternal and infant health than we realise, with consequences that may stretch far into the future. It also threatens the wellbeing of midwives, potentially creating midwives unskilled in low-risk labour. It might sound like stating the obvious to say that urgent change is needed. It is realistic to say that these changes are unlikely to happen quickly. However, we need to take courage in our capability as midwives to facilitate birth, no matter the setting, and our ability to create, challenge, and protect. Now is the time to start raising our voices and shouting about this important aspect of maternity care for the sake of women and babies. **BJM**

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