in their community to offer a seamless service for the benefit of all. As one young woman said, "Coming to the group has been the best thing I've ever done — why isn't there one in every town?"

Footnote

The work of the Blandford Breastfeeding Support Group and the Bosom Buddy Network is currently being expanded into Bemerton Heath, Salisbury, and is the subject of an evaluation funded by the Department of Health, led by Professor Jo Alexander of Bournemouth University.

Key project workers

Mandy Grant, National Childbirth Trust breastfeeding counsellor; Nickie Griffiths, La Leche League trainee breastfeeding counsellor; Tricia Anderson, midwife; Margaret Burton, health visitor; with unstinting support from 63 Bosom Buddies!

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'Perineal pampering' — before, during and after birth

If babies needed hands to guide them out, wouldn't women be born with an extra pair attached to their inner thighs?

The topic of perineal care is enormous, and has been a source of heated debate for centuries. This paper highlights some of the issues and questions for debate in this area, although it serves as an overview of 'hot topics' rather than an in-depth analysis of all of the issues. The history of perineal care offers an important insight into current practices and perceptions, and even a brief exploration of the research in this area highlights how little we know about the physiology of birth and the quantity and scale of the questions which need to be answered before we make any generalisations about appropriate midwifery practice in this area. The focus of the study day at which this paper was presented was postnatal care. However, as it is impossible to view perineal care only from a postnatal perspective, in isolation from events during pregnancy, labour and birth, this article will be more wide-reaching.

The evening before the study day, when Jane Evans and I were discussing the introductory statement, the issue arose as to whether women really needed their midwives to perform routine manual perineal manoeuvres. Jane suggested that the labia act as a 'guiding' mechanism for the baby and the question arose as to how confined we are by the ideas that we have been taught, and by the concepts of 'care' and 'practice' — which both seem to imply action on the part of the midwife. The term 'perineal care' itself implies action and one may be more immediately drawn to thoughts of manual or other interventions rather than issues of maternal positioning, rapport or enabling relaxation through verbal or non-verbal means. Should we be trying to 'sit back and watch' more of the time, or do we somehow feel obliged to manually participate in the birth of the baby — and for what reasons?

Historical issues

A quick reading of almost any midwifery or obstetric textbook will reveal the current trends in perineal care and — throughout history — an almost limitless supply of ways to manually handle the perineum, anus, vulva and presenting part. Thankfully, we have moved away from Playfair's[1] reporting of the suggestion that we should assist the woman to relax by inserting, 'one or two fingers of the left hand ...into the rectum' and using them to 'hook up' and pull the perineum forward over the baby's head. (I have yet to meet a woman who would find this relaxing, especially during the second stage of labour.) Yet myriad other practices remain and, as Renfrew[2] notes, the area of perineal care is characterised by 'strong opinions and sparse data'.

Floud[3] presents a comprehensive overview of the history of perineal care and finds that, in the past, manual interference in normal labour was 'deplored' by professional birth attendants, who considered their role to be one of patiently watching and waiting. As many midwives know, the perineum only became visible after Louis XIV persuaded his partner onto her back so that he could watch the birth of their baby and Floud shows that many of the manoeuvres which have been described over the last few decades are simply not possible if women adopt upright positions during the second stage. These

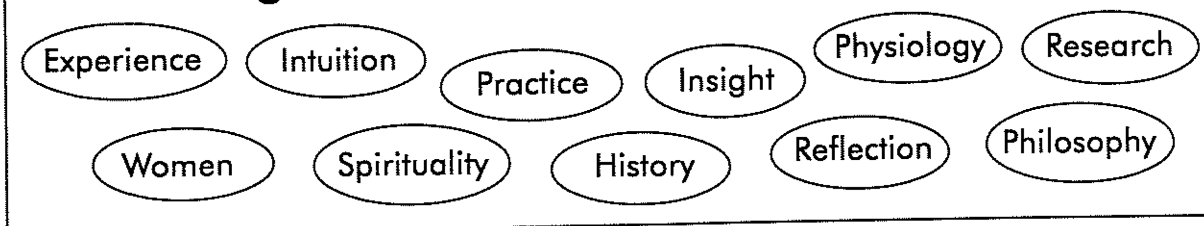

Fig 1. Sources of midwifery evidence

findings make the question of what we do with our hands at the point of birth secondary to the fact that, if more women were enabled to adopt the upright positions which are known to facilitate physiological birth, we would more often than not find ourselves unable to do anything with our hands other than hold them ready to 'catch'.

During birth: research and other evidence

Despite this, the HOOP trial[4] was still carried out in order to evaluate the practices of midwives having their 'hands on' or 'hands poised'. While the results showed that three per cent more women experienced 'some pain in the previous 24 hours' in the 'hands poised' than the 'hands on' group, there were no differences in the 'mild', 'moderate' or 'severe' pain ratings, perhaps reflecting the difficulties that emerge when trying to quantify something as individual and intangible as pain. The women in the 'hands poised' group were also slightly more likely to have their placenta manually removed although, as this outcome is the result of a clinical decision — which may differ according to practitioner — it is not as effective an outcome measure as something which is not generally open to individual interpretation (such as the gender of a baby).

It should be acknowledged that it is far easier to find sources of potential bias in a research trial than it is to set up a trial which is beyond criticism, and the HOOP trial has been a valuable addition to the knowledge base in this area in a number of ways, not least of which is the discussion and debate it has generated. Discussion with some of the midwives who participated in this trial revealed that they had reflected on their practice and were generating more knowledge through their experiences; it is my hope that some of them will publish their thoughts in order to continue and expand this debate. Research is only one of the forms of evidence available to women and midwives. Indeed, other forms of evidence may better serve to answer questions which are outside the boundaries of research; some of these are listed in figure 1.

Hartley[5] explored the knowledge held in this area by experienced midwives; most of the midwives she talked to stressed the fact that there are no 'absolute rules' to be followed in this area of practice. They stressed that the needs and desires of the woman and the positions she chose for the second stage were a priority, and the rapport between women and midwife was considered of paramount importance. One midwife discussed the concept of 'masterly inactivity', although a number of 'tricks of the trade' were discussed as options for times when the midwife felt that some kind of 'activity' was warranted. One of the major implications of this paper concerns the usefulness of reflection on practice in developing our knowledge base and learning from our own experience and that of others.

One of the key issues in current research in this area is consideration of the cultural norms and context in which midwifery practice and maternity care is based. A systematic review of the practice of 'non-suturing' is being carried out, on the basis that the authors suggest that:

'Some midwives have begun to restrict their use of suturing ...despite the fact that there is no reliable evidence about risks and benefits of non-suturing compared to suturing. The change in practice may affect the health of large numbers of women.'[6]

Only in a culture where technology and intervention are seen as the norm is there a need to prove that it is safe (or not a potential cause of relative ill health) to omit the intervention which has become the norm. This is true even (and is commonly the case) when the intervention was originally brought into practice with no real evidence of its value. In a culture that is reliant on technology and intervention, the burden of proof remains on those who still believe that women's bodies are capable of developing, nurturing, birthing and healing without routine assistance. We need to recognise that research studies are based in the cultural norms of our society and that the philosophical focus of these can tell us a lot about the 'way women birth' and what is valued in that society.

Perineal care before birth

I learned early on in my experience as a midwife in the USA that there were some fundamental differences between midwifery there and midwifery in the UK. One of the most apparent of these concerned the issue of perineal massage during pregnancy. In the

UK, I had never met a midwife who did any more than offer women a 'handout' on this, sometimes apologetically, perhaps explaining that it may or may not work, but it was the women's 'informed choice' to consider it as an option. In the US (at least in the states where I worked), I rarely met a midwife who did not spend at least twenty minutes discussing this during an antenatal visit, sometimes adding detailed diagrams or an actual demonstration. Clearly, a significant difference in approach.

Subsequent discussions with the midwives who were recommending this revealed that, while some were aware that the evidence on whether this practice made a difference to the state of the perineum at and following the birth was mixed,[7,8] they had other reasons for suggesting it as an addition to 'pregnancy lifestyle'. Some felt that it helped women 'get in touch' with their bodies, and learn about the sensations they might feel during the birth. Others feel that it causes women, many of whom work into late pregnancy, to slow down and 'connect' with their baby. While it is absolutely important to make sure this is an informed choice, and may be truly beneficial for a particular woman, perhaps we should take care not to assume that there has to be a 'physical' justification for a particular practice, or that this takes precedence over other needs.

There seems to be more of a move towards evaluating the practice of antenatal perineal massage over the last few years, despite the inherent difficulties of carrying out such research. There are several issues to consider with such studies:

Is the research studying physiological birth or birth which is being 'managed'? While it is acknowledged that the majority of women may not experience physiological birth in the UK, this does not change the fact that carrying out research in a context of 'management' renders the research less than useful on a more general basis. So many variables may enter the equation that the findings can ultimately be meaningless.

With a technique such as perineal massage, the immediate question concerns how we quantify that technique, in order to ensure that everybody is doing the same thing and that variation between women is not affecting the research. Yet how can everybody 'do the same thing' when no two women's hands, fingers, perinea or external genitalia are the same shape and size? It would seem to me that the amount of individual variation would be enough to introduce the possibility of bias into such a study and render it less than helpful from the outset.

Even if the above issues could be dealt with, I would be surprised if the best-designed study came up with an absolute 'answer' that highlighted something (eg perineal massage) as being good for all women 'on a routine basis'. Research and inquiry carried out in the last ten years has increasingly shown that no intervention is beneficial on a routine basis; all have their uses, but application to the population of childbearing women as a whole is ultimately more detrimental than beneficial. For this reason, among many others, it is imperative that we begin to move away from a system (of either thought or care) which looks for absolute or 'umbrella' answers. We might instead look toward capturing and reflecting upon women's knowledge and midwives' experience as relatively untapped sources of information.

Postnatal perineal care

A short 'straw poll' amongst midwives, student midwives and midwife teachers revealed the following list of practices which they had — either now or in the past — suggested to women as ways of relieving pain and promoting postnatal perineal healing: these are shown in figure 2.

Figure 2: Postnatal perineal care suggestions*

Lavender / camomile baths
Arnica tablets or oils
Ice packs / frozen ice in gloves / iced sanitary towels (wrapped in something to prevent burns; sometime suggested with oils or herbs added)
Salt baths
Drying the perineum with a hairdryer
Massaging the perineum with oil
Herbal baths
Comfrey or calendula (herbal) salve
Rubber rings
Exposing to the air / air drying
Vulval toilet

* One midwife, after seeing this list, told me how disappointed she was that the simple practice of removing any sutures was not suggested. While I felt that this was probably because of the way I had worded the question, I wanted to acknowledge her comment and the importance of this as a simple measure which can provide immense relief to women.

A brief analysis of this list shows that the suggestion fall into five main categories; adding heat, adding cold, keeping the perineum wet, keeping the perineum dry, and adding substances. I can't think of a lot else that one could do with the perineum, so the list probably reflects all of the potential options, regardless of efficacy! Some of the suggestions (eg drying with a hairdryer, sitting on a rubber ring) are known — particularly by those who suggested them as historical additions to the list — as being potentially more harmful than beneficial. Others have yet to be evaluated on a large scale, although, as before, I have little doubt that midwives possess the knowledge and experience needed to do this; it is simply a case of bringing this evidence together in appropriate and meaningful ways.

Lewis[9] conducted a study whose implications may be useful for all midwives to consider in relation to their own practice. She helped midwives to audit their 'perineal management' using diaries kept by women. Not only did the episiotomy rate fall from 17.5% to 11% and the rate of not-suturing rise from 20% to 80%, but midwives were able to reflect upon their practice in relation to the woman's experience, something which midwives working in systems without continuity of partnership are not often given the opportunity to do. Incidentally, over the past few years I have heard several cases of units which audited and 'displayed' the episiotomy rates of individual midwives, often with great success in reducing these rates. One of the major findings of Lewis' research was that women wanted to be more realistically informed about postnatal perineal healing; some had little idea of what to expect.

The women in this study stated that they liked keeping the diaries which they were asked to write in for the research — perhaps this was being used as a form of journalling, or postnatal debriefing? We all know that women love — and need — to talk through their birth experiences, and Lewis has found an effective way of auditing practice in a way which may also be helpful to women in relation to their mothering journey. One women emphasised the importance of the perineum by saying:

"I appreciate the attention you are giving the subject. Typically, those areas which are exclusively female are not attended by 'the system'. I am aware that the perineum and surrounding area is crucially important to most women's sense of well-being and sense of self. I had no idea before this experience (of birth) how every movement — sitting up, getting into bed etc, is felt in this central point."[9]

Perineal 'pampering'?

Finally, in the same way that others have challenged the terminology we use as midwives, I would like to return to the question of how we are using the term 'perineal care', and whether this implies midwifery 'management' of the perineum as opposed to the woman being empowered to decide for herself how she wishes to care for her perineum, perhaps in the same way that she chooses how to care for her hair, or skin. We all have different preferences as to the type of soap, shampoo and creams we like to use, and which best suit our skin type — why should the perineum be any different?! With this in mind, we need to beware of implying that we need to 'care for', 'guard' or 'protect' this part of the body (which is then presumably not capable of 'caring for' or 'protecting' itself). Used improperly, the term may imply both a need for action rather than passivity and that this action should be taken by the midwife, rather than the birthing woman.

This is in contrast to experiential suggestions by midwives that the 'ring of fire' felt by the woman as the baby crowns is a physiological mechanism which instinctively causes the woman to ease the baby out, thereby reducing the possibility of perineal damage and enabling her to feel in control of her baby's birth. Although some midwives have suggested to me that the sensation of burning causes some women to want to push harder, I wonder if the environment of birth, the attitude of the midwife or the hormones which are in play at the time (ie whether adrenaline is dominant rather than endorphins) can mitigate this? If we adopt a philosophy of 'watching and waiting' which enables the woman to follow her instincts, would the term 'attending the perineum' be more appropriate? This terminology would not rule out the occasional need to use midwifery skills for the woman who, for whatever reason, appears more likely to sustain a tear without assistance.

Perhaps the concept of 'perineal pampering' is not so far removed from the emphasis we need to place upon the woman having access to the range of possibilities which exist in this area before, during and after birth, and deciding which might be the most appropriate for her. As midwives, we may need to spend more time reflecting upon our own practice and discussing with colleagues the real experiences of the women we are with, in order not just to expand our knowledge base in this area but to focus on what works for different women at this time. Certainly, as far as the postnatal period is concerned, in the same way that we do all like different things in our bath, we might find that there are lots of 'answers' which apply to different kinds of women, in relation to their own needs, their bodies and the kind of birth they experience.

Without doubt, this debate will continue, and midwives will find answers which suit their own practice and the women they are with. While the body of literature on the subject is vast, and offers many perspectives, the time may have come to explore more of the experiential knowledge on this topic as well as utilising evidence from quantitative research. While we have spent years debating the relative merits of different substances, options and practices, we may have reached a stage where we no longer seek an 'absolute' answer which will fit every woman, but begin to explore how we can help women, as individuals, to find answers and options which work for them.

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Confidential enquiries into maternal deaths

Background

This article is a summary of a presentation at the MIDIRS Hot Topic study days in October 2000. The presentation focussed on the report *Why Mothers Die. The Confidential Enquiries into Maternal Deaths 1993-96.*[1] This article is constructed from those sections of the report which are of particular importance to midwives. Although it is not practical to consider the postnatal period in isolation, the article will specifically highlight any relevant postnatal issues for midwives. The article describes how midwives may, directly and indirectly, affect the safe outcome of pregnancy and how they can develop their wider public health role. As with previous confidential enquiries there are important lessons to be learnt by the different professionals contributing to the care of women and their babies. Putting these lessons into practice, however, has proved to be more difficult than most would expect. Midwives must play an active role in challenging poor practice and ensuring that recommendations from the report are incorporated into local policies and procedures.

The midwifery contribution to the enquiry

In the past the confidential enquiries have produced a predominately medical report. This may be understandable as maternal deaths are often seen as the results of medical complications of pregnancy. However, it may have resulted in a systematic bias in case assessments leading to under representation of the potential contribution of a different professional group. The position has now started to change through the introduction of regional midwifery assessors (RMAs). The first RMAs were appointed to the enquiry in 1993, to contribute to the professional assessment of maternal mortalities in their geographical area. It is apparent from case reviews that at the start of the triennium the RMA's expertise was not always called upon. This was due to several factors, such as indirect deaths not being considered appropriate for referral for midwifery assessment, slow implementation of the new system and the lack of understanding of reporting mechanisms. Although towards the end of the triennium this situation improved, further effort is required to ensure a midwifery perspective is gained in the majority of case reviews.

The role of the midwife in maternity care

The midwife's role in the provision of maternity care has long been established and even through an age of medicalisation, midwives have maintained their place as the most senior professional present at the majority of deliveries within the UK. They provide the professional lead at approximately 70% of all births and are present at around 99% of the remaining births.

Midwives provide or play a key role in maternity care provision and with a greater emphasis on continuity of care and carer, they may be able to provide a more holistic approach to care. Their knowledge and influence can greatly affect the outcome of pregnancy for mother and baby, and their role in health surveillance, education and promotion is invaluable.

With this in mind, it is important to discuss the effects and benefits of midwifery care when considering maternal mortality and morbidity, whether or not underlying medical conditions, or pregnancy related complications are present.

Recent developments in the philosophy underpinning maternity care, supported by national strategies and government policy,[2,3,4,5,6] have resulted in changing patterns of care delivery. Women should now be receiving appropriate and timely information concerning access to available services, health education and possible complications during and after pregnancy. They should also be the focus of care with midwives, general practitioners (GPs), and obstetricians working in a collaborative and cohesive manner. These changes have called for a re-