

In 1818, the first successful human blood transfusion was given to a woman who had a postpartum haemorrhage. Since then, our knowledge has developed to the extent that several hundred thousand litres of blood and tens of thousands of doses of anti-D are injected into pregnant woman and new mothers in the UK each year. Because of the sheer volume of such activity, blood transfusion and anti-D administration are relatively routine events for many midwives, especially those who work in hospitals.

Although some women choose to decline blood products, the majority of recipients view these substances as very welcome and potentially lifesaving. However, there has always been a need for those of us who administer these substances to consider the potential for immediate as well as long-term risks of such interventions, and the latest National Audit (2005) has highlighted that there is still room for improvement in relation to reducing the immediate risks of transfusion.

Transfusion Risks

These risks, although rare, can be potentially serious and include intravascular haemolytic reactions, which can lead to shock and dyspnoea; febrile non-haemolytic reactions, where the recipient develops antibodies to antigens in the donated blood; allergic reactions, including anaphylaxis; and septic reactions, which occur most commonly with transfusion of platelets and result from accidental bacterial contamination.

Careful observation and access to emergency equipment can reduce the impact of these risks, yet the audit report found that, in 34 per cent of transfusion episodes, recipients' vital signs were not monitored in the half hour following transfusion. Even more worryingly, only 56 per cent of sites offered appropriate induction training to staff. It is important to acknowledge that childbearing women represent a fairly small proportion of the people who receive blood. Only four per cent of the transfusion episodes audited took place

in maternity units and the report only mentions nurses, so we have no way of knowing from this how midwives rate by comparison. However, some interesting issues arise from this area, especially in relation to our increased efforts to acknowledge the normality of childbirth.

Women, Blood and Barcodes

These days, bags of blood come with an individual barcode and, in some areas, hospital patients now sport barcodes on their identity bracelets which staff can check with supermarket-type scanners. Bracelets and barcodes are deemed positive as far as transfusion risk management is concerned; they reduce the risk of errors in identification, especially where people are unconscious.

Most women receiving blood products in and around childbirth are, however, not unconscious, and a number of people have questioned the need for ID bracelets. Robbie Davis-Floyd (1992) wrote about how hospital admission procedures can be seen as a way to contain and control women, and bracelets may send a message to the woman that she is now the 'property' of the hospital. Indeed, in many units, pregnant and birthing women are no longer 'labelled' on admission, and are given an ID bracelet only if they have surgery. Yet is there a chance that this woman-friendly policy could contribute towards transfusion errors, especially if the error might have been picked up by a barcode scan but not by a name check? There is clearly a need to think through some of these issues, and to consider how we can ensure maximum safety for those women who may need and want to have blood products, but in ways that don't force them into taking a 'patient' role or compromise their ability to speak for themselves.

Medicalisation and Normalisation

Many midwives attend women in their homes, or in community settings, and many areas now offer services like anti-D administration in the

community. But is this appropriate, given the potential problems that can occasionally result? Just as some midwives won't give pethidine at home births because of the potential for neonatal respiratory problems, others are beginning to question whether anti-D should be given at home or in community settings. This is generally because, while they are not keen on the idea of sending a woman to the hospital soon after a home birth just to get postnatal anti-D, they are even less keen on the prospect of having to treat a woman for anaphylactic shock in her living room. This action also serves to remind women that blood products are not to be taken lightly; that, while our ability and knowledge has greatly advanced, blood does not come without risk.

This issue raises the ever-present question of how we strike a balance between honouring the psycho-socio-spiritual aspects of birth and ensuring that we are not exposing women to unnecessary risk. Perhaps, in seeking this balance, it is just as important to challenge the normalisation of the 'medical' as it is to challenge the medicalisation of the 'normal'?

REFERENCES

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