Midwifery at a Glance

Edited by
Eleanor Forrest

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at a Glance

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WILEY Blackwell

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About the companion website

This book is accompanied by a companion website:

www.wiley.com/go/forrest/midwifery

The website includes over 260 interactive multiple-choice questions

Introduction

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1 Historical overview of midwifery

Table 1.1 Major historical events in midwifery during the 20th and 21st centuries.

Date	Development	Recommendations/Effects
1902	Midwives Act	Central Midwives Board (CMB) in England and Wales formed to provide a roll of certified midwives – included those registered with the London Obstetrical Society and bona fide midwives 3-month training for entrants to midwifery; examinations conducted and certificates issued Local supervision of midwives established to ensure high quality care
1915		Legal regulation of midwifery in Scotland. Provision of antenatal care; compulsory notification of birth
1916		Training doubled to 6 months for direct entrants; 4-month training for nurse entrants
1918	Amendment to Midwives Act	Local authority responsible for paying doctor's fee and mileage; statutory provision of a midwife's stationery; CMB powers to suspend and remove midwives from the roll
1922		Legal regulation of midwifery in Northern Ireland
1926	Amendment to Midwives Act	12-month training for direct entrants: 6-month training for nurse entrants Midwife Teachers Certificate established
1936	Midwives Act	Adequate salaried domiciliary midwifery service; working conditions improved Improved provision of antenatal care Qualifications for Supervisor of Midwives prescribed. End of bona fide midwives
1938		Training doubled to 2 years for direct entrants; 1 year for SRNs Training divided into two parts; length of part 1 determined by previous experience of applicant; part 2 – 6 months for all pupils
1941		Midwives Institute became the College of Midwives, gaining Royal Charter in 1947
1943	Rushcliffe Report	Identification of midwifery as a distinct profession from nurisng and salary scale greater in recognition of responsibility of the work. Recommended caseload of 66 confinements a year without a pupil; 90 a year with a pupil; 96-hour fortnight for hospital midwives-
1952	CEMD commenced	Confidential Enquiry into Maternal Deaths (CEMD) – enquiries around maternal deaths and triennial report produced to save lives of women and babies, reduce complications and improve quality of maternity care
1968		Single period midwifery training – parts 1 and 2 phased out
1970	Peel Report	Recommended 100% availability of beds for hospital confinement Consequent effect of this was majority of care provided within hospital with a more medicalised approach; increased use of technology including induction of labour, use of cardiotocography, intrauterine pressure monitoring-1978 – first IVF baby born
1972	Briggs Report	Midwives would be expected to complete nurse training prior to 1 year post-registration midwifery; led to Nurses, Midwives and Health Visitors Act 1979
1979	Demise of CMB	Formation of United Kingdom Central Council for Nurses, Midwives and Health Visitors, with four National Boards (e.g. English National Board)
1980	Short Report	Actions to reduce high perinatal and neonatal mortality rates
1981		3-year training for direct entrants: 18-month training for nurse entrants Changes implemented in line with European Directives 1980
1992	Winterton Report	Midwives the key professionals to care for the majority of women with normal pregnancies and births; obstetricians to look after the few women who have complicated pregnancies. No evidence to suggest that home birth is unsafe for healthy women and every woman should know of their right to choose a home birth
1993	DH Changing Childbirth Report	Followed findings of Winterton Report, and established 3 'Cs': Choice (of type of care), Control (of what is happening by participating in decisions) and Continuity (knowing a small group of professionals who will care throughout her maternity experience) as dominating principles for women during pregnancy and birth (chaired by Baroness Cumberldge)
1996		Health authorities assume responsibility for supervision of midwives
2002	NMC formed	Regulatory funtion of United Kingdom Central Council for Nurses, Midwives and Health Visitors replaced by Nursing and Midwifery Council (NMC)
2007	Maternity Matters	High quality, safe and accessible maternity service through a new national choice guarantee, together with improved access to services and continuity of midwifery care and support
2010	Midwifery 2020	Vision of the midwife as lead professional for women with normal pregnancies and to work as the key co-ordinator with the multidisciplinary team for women with complex needs. Development of a greater public health role and provision of innovative, evidence-based, cost effective, high quality care for women, responsive to change-
2011	MINT Report	Evaluation of contribution and impact of midwife teachers on care provided by students and newly qualified midwives and demonstration of fitness for practice-
2012	MBRRACE	Mothers and Babies Reducing Risk through Audits and Confidential Enquiries replaces CEMD
2015	Kirkup Report	Recommended removal of supervision of midwifery from NMC regulatory framework
2016	Better Births	*Better Births: Improving Outcomes of Maternity Services in England – A Five Year Forward View of Maternity Care* (chaired by Baroness Cumberldge)

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Midwifery is one of the oldest occupations in the world, if considered simply as the presence of a woman accompanying another woman during her childbearing event, with knowledge passed from one generation to another. The term midwife is understood to mean 'with woman' but older terms have existed such as 'howdie' in Scotland. Midwives' status in the community rose and fell over the centuries, influenced by medical men and concern over their mysterious powers. Soranus of Ephesus (2nd century AD) is credited with writing the first textbook on midwifery, which described desirable characteristics of a good midwife to be 'literate, with her wits about her, good memory, loving work, respectable, not unduly handicapped as regards her senses, sound of limb, robust, long slim fingers and short nails, soft hands, free from superstition and of sympathetic disposition.' The contemporary concept of a 'good midwife' is related to the complementary areas of theoretical knowledge and skilled competence underpinned by lifelong learning, communication skills, and personal qualities including emotional intelligence, with a midwife's professionalism being central to women's empowerment during childbirth. However, often women became midwives by default of attending a birth with a midwife and then being asked to attend others.

The first school to train midwives was founded in Edinburgh in 1726, followed by Glasgow in 1739, with others following in England. However, training was mainly under the auspices of the Faculty of Physicians and Surgeons. The 18th century also saw the rise of male midwives among controversy regarding their role in attending women. Smellie (c. 1750) provided anatomical knowledge that contributed to understanding the mechanism of normal labour, while Chamberlen (c. 1733) used forceps to aid delivery of a live baby rather than just to extract the often dead fetus. During the 19th century, educated middle class women tried to improve the status of midwifery as a profession through the eradication of caricatures such as the uneducated, drunken Sarah Gamp portrayed by Charles Dickens. The Ladies Obstetrical College (1846) was formed by these educated women, offering theoretical and practical training, but was disbanded due to puerperal fever. The London Obstetrical Society Examining Board (1872) required candidates for midwifery to be aged between 21 and 30 years and have proof of attending a minimum of 25 cases; however only six took the exam.

Rosalind Paget and Zepherina Veitch were influential women in the establishment of the Midwives Institute (1881; to become the Royal College of Midwives (RCM)), which campaigned for the registration of midwives, culminating in the Midwives Act 1902 (England and Wales) which specified the education and training, registration and certification, supervision and control of midwifery practice. Therefore it was not until the 20th century that legislation existed to regulate midwifery practice. The roll of qualified midwives maintained by the Central Midwives Board (CMB), included women who already possessed a recognised qualification in midwifery and women of good character who had already practiced as a midwife for at least 1 year (bona fide midwives). Legislation laid down several aspects of midwifery practice and rules concerning equipment, clothing and standards of hygiene that were considered essential, which continued until the 1970s.

Improvements in midwifery practice focused on strategies to reduce maternal and perinatal mortality rates, aided by social and environmental and technological advances, combined with changes in working practices and education and training for midwives. Pressure groups such as the Association of Radical Midwives (ARM) and the National Childbirth Trust (NCT), together with the RCM as a professional and trade union-affiliated organisation, through various reports and campaigns, have influenced both the provision of care and status of the midwife as professionals (Table 1.1).

Changes in the regulatory body (CMB to UK Central Council (UKCC) to Nursing Midwifery Council (NMC)) over the years have seen modifications to the *Midwives Rules and Standards* (NMC, 2012) and *The Code* (NMC, 2015) to less specified activity with greater use of professional knowledge and competence. Supervision of midwives increased after 1996, with their role and function being prescribed within the *Midwives Rules and Standards*; however recent investigations into the practice of midwifery supervision (such as Morecombe Bay and Guernsey) have led to the demise of this within the regulatory function of the NMC (Chapter 5).

In 1986, Project 2000 recommended a 3-year curriculum, with midwifery being seen as a branch of nursing. This was fiercely rejected by the profession and a year later the RCM advocated a 3-year curriculum for midwifery in the UK with direct entrant midwifery, which was supported by the English National Board in 1988. Whilst two hospitals continued some direct entrant training (Edgware and Derby), in 1989 seven 'midwifery schools' commenced 3-year direct entrant midwifery training, and by 1994 there were 35 three-year pre-registration programmes, at both degree and diploma level, linked to higher education institutions. The formation of the UKCC in 1989 had led to removal of the requirements for specified hours of medical practitioner input into the midwifery curriculum and examination. By 2009, the NMC, within their standards for pre-registration midwifery education, stipulated that midwifery should became an all degree profession.

Midwifery remains an important occupation and is highly valued by women. However, constant tension between personal qualities, as aligned to the NHS values and the six 'C's of Care (Chapter 2), and professional competencies of midwives and other occupations have all had an impact on the status of midwifery and the autonomy and control of midwives. Changes in relation to the skill mix in maternity services and in midwifery supervision and the future of the *Midwives Rules and Standards* have set the scene for the potential of professional control remaining an important issue in the future of midwifery practice.

2 NHS values

Box 2.1 The NHS principles.

- To provide a comprehensive service to all
- Care is based on clinical need, not ability to pay
- Aspires to the highest standards of excellence and professionalism
- The patient is at the heart of everything the NHS does
- To work across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and wider population
- Committed to providing best value for taxpayers' money and most effective, fair and sustainable use of finite resources
- To be accountable to the public, communities and patients it serves

Box 2.3 Recent inquiry and review summaries into the NHS.
Source: http://www.midstaffspublicinquiry.com, https://www.england.nhs.uk/2013/12/sir-bruce-keogh-7ds/, https://www.gov.uk/government/publications/berwick-review-into-patient-safety. Licensed under Open Governement License v3.0.

Francis Inquiry February 2013
- A public inquiry into the failings at Mid Staffordshire NHS foundation Trust made 290 recommendations for improvement. At the heart of these was a need to develop: a culture of openness and transparency; a system of accountability for all; a system for promoting clinical leadership and emphasis on always putting patients first (www.midstaffspublicinquiry.com)

Keogh Review July 2013
- A review of 14 hospital trusts with a persistently high mortality rate of which 11 hospitals were put into special measures. 8 key ambitions set out for improving care and this has informed the Care Quality Commission in developing its process of inspecting all trusts throughout England (www.nhs.uk/NHSEngland/bruce-keogh-review)

Berwick Review August 2013
- In response to the Francis inquiry this review explored how 'zero harm' could be made a reality in the NHS. 10 recommendations made with core themes around transparency, continual learning, leadership, regulation and seeking patient and carer opinions (www.gov.uk/government/publications/berwick-review-into-patient-safety)

Box 2.2 NHS Scotland – 10 essential shared capabilities supporting person-centred approaches.

- Working in partnership
- Respecting diversity
- Practising ethically
- Challenging inequality
- Promoting recovery, wellbeing and self-management
- Identifying people's needs and strengths
- Providing person-centred care
- Making a difference
- Promoting safety and risk enablement
- Personal development and learning

Box 2.4 Chief nurse's 6 'C's of care. Source: NHS. Licensed under Open Gov License v3.0.

- Care
- Compassion
- Commitment
- Courage
- Communication
- Competence

CNO and DH CN (2012) Compassion in Practice. Commissioning Board. Leeds https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

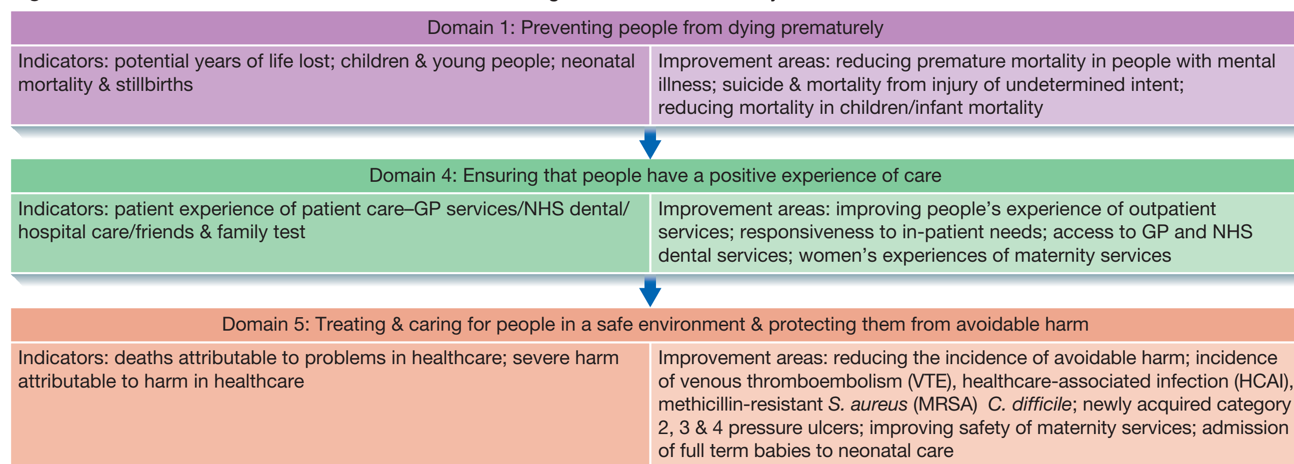
Box 2.5 NMC 4 'P's for professional standards.

- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust

Box 2.6 Remit of the National Institute for Health and Care Excellence. Source: https://www.nice.org.uk.

NICE provides national guidance and advice to improve health and social care. It achieves this by:
- Producing evidence-based guidance and advice for health, public health and social care practitioners
- Developing legally binding quality standards for those providing and commissioning health, public health and social care services
- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care (www.nice.org.uk)

Figure 2.1 NHS Outcomes Framework 2016/17 showing relevance to midwifery.



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The NHS was founded in 1947 to improve health and wellbeing within a common set of principles. The NHS Constitution was first published in 2009 by the Department of Health as part of a 10-year plan to provide the highest quality of care and service for patients in England. Updated in 2015, it explicitly states the principles (Box 2.1), values and pledges that patients, the public and staff can expect from the NHS and what the NHS expects from them in return.

NHS Scotland has published the 10 Essential Shared Capabilities supporting person-centred approaches to care (Box 2.2) that has themes comparable to the NHS Constitution. Following the failings at the Mid Staffordshire NHS Foundation Trust, it is vital that everyone involved in the NHS learns from the findings of the subsequent Francis Inquiry and Keogh and Berwick Reviews (Box 2.3). The NHS values describe how everyone using or working within the NHS should be treated and the updated constitution reflects that the NHS's most important value is for patients to be at the heart of everything the NHS does.

Six values

The six NHS values are respect and dignity; compassion; working together for patients; improving lives; everyone counts; and commitment to quality of care. These apply to all recipients and providers of care and describe the aspiration to facilitate co-operative working at all levels of the NHS.

Applied to midwifery practice these values can be considered as:

1 **Respect and dignity** – every person is valued as an individual and respect is given to their aspirations and commitments in life, and their priorities, needs, abilities and limits should be understood, irrespective of whether they are a mother/baby, family member or staff. Care should be provided with honesty and integrity and listening to the views of others, for example when formulating a birth plan, to enhance provision of safe and effective care.

2 **Compassion** – midwives should respond with humanity and kindness to each mother's need, pain or distress and find things that will provide comfort and relieve suffering to mothers and their families but also their colleagues, for example during labour and in times of bereavement.

3 **Working together for patients** – mothers, babies and their family come first in everything a midwife does. Collaboration with the multidisciplinary team and networking plus seeking the views of service users will contribute to effective care delivery.

4 **Improving lives** – the public health role of the midwife and health promotion can affect the mother's health. Midwives can innovate and improve care to improve health and wellbeing plus the mother's experience of the NHS, for example establishing teams to support vulnerable women.

5 **Everyone counts** – midwives should maximise resources for the benefit of the whole community of mothers, babies and their families, whatever their social or educational background, their race, religion or culture; for example all women should have equal access to antenatal classes.

6 **Commitment to quality of care** – midwives must provide safe and effective care. The right care, in the right way at the right time is dependent upon midwives' knowledge and skills, communication and competence and ability to work with others. Midwives should offer evidence-based care, for example using National Institute for Health and Care Excellence (NICE) guidance and participate in clinical audits.

Six 'C's

In 2012 the Chief Nursing Officer for England launched a vision for nurses and midwives entitled Compassion in Practice, to provide for basic human needs with care and compassion; all patients can expect to receive such care within the NHS. This applies to midwives as well as nursing. The 6 'C's – care, compassion, commitment, courage, communication and competence – are the core elements of the vision (Box 2.4). Care is the core business of midwives, which improves the lives of mothers, babies and their families. Mothers expect care to be right for them, consistently, throughout every stage of their childbearing process. Compassion is how care is given through relationships based on empathy, respect and dignity – it can also be described as emotional intelligence, and is central to how people perceive their care.

The 6 'C's reaffirm the qualities and standards that the public can expect from midwives, and those in the profession are aware that no matter how midwifery changes, the six values remain at the core. If midwives work in accordance with the 4 'P's of professional practice (Box 2.5) as defined by the Nursing and Midwifery Council (NMC) in *The Code* (NMC, 2015), their practice will be congruent with the NHS principles and values. This will enable practitioners to maintain their professional knowledge and competence to perform safely but also report when care does not fulfil these standards.

Quality is defined as excellence in patient safety, clinical effectiveness and patient experience and is an organising principle of the NHS. Clinically effective care delivery is supported through the remit of NICE (Box 2.6) and numerous guidelines support midwives and their colleagues in the delivery of high-quality care, for example intrapartum care and antenatal and postnatal mental health. An effective healthcare system should: (i) prevent people from dying prematurely, (ii) improve the quality of life for people living with long-term health conditions, and (iii) aid recovery for those with ill health. The NHS Outcomes Framework identifies five overall principles, three of which relate to midwifery care (domains 1, 4 and 5) (Figure 2.1).

The NHS values require the development of a culture where it is the 'norm' to Observe others, Praise good practice, Challenge poor practice and Escalate concerns readily (OPCE). Adherence to this will improve outcomes and satisfaction for mothers and their families.

3 Ethics

Figure 3.1 ICM International Code of Ethics.

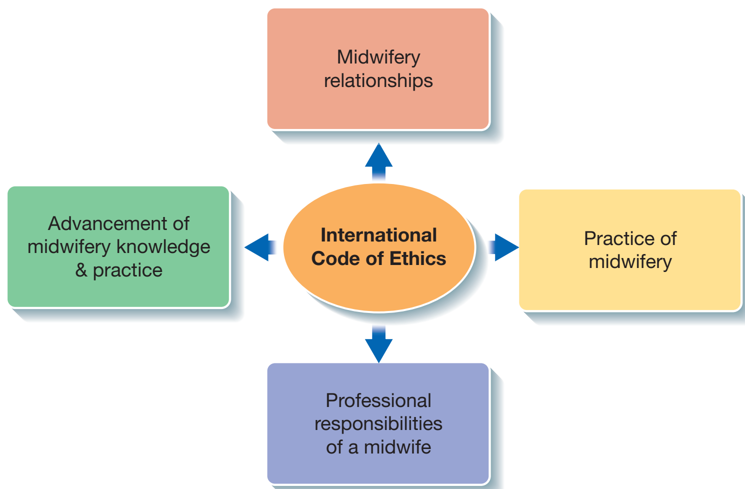


Figure 3.2 *The Code* (NMC, 2015).

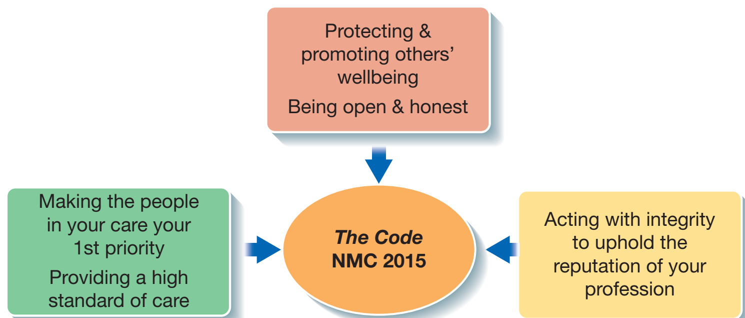
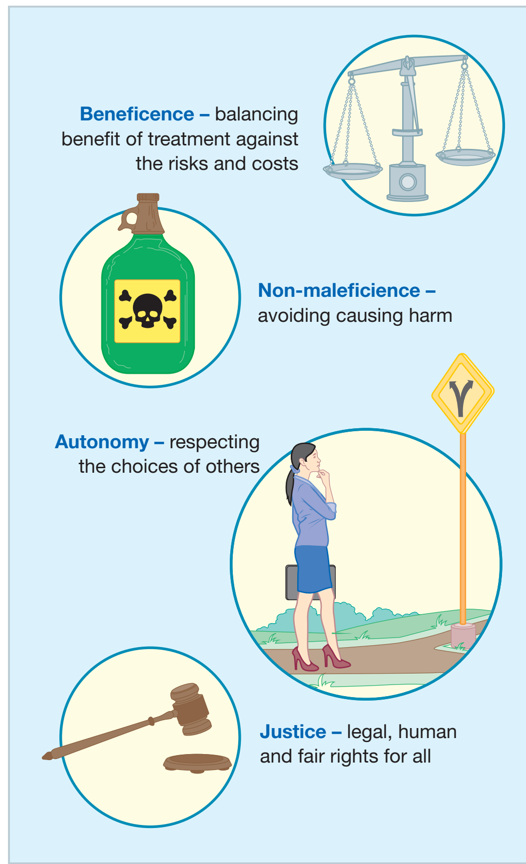


Figure 3.3 Beauchamp and Childress ethical principles.



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Ethics are pervasive in midwifery practice. Ethics is a term used to cover fundamental principles of what is right and wrong and what people should or ought to do. Ethical principles can be explored at the micro or macro level or from a personal, professional and societal viewpoint.

Micro and macro

Micro-level ethics promotes good interactions between women and midwives, based on mutual respect and trust. It offers all women equitable care and promotes truly individualised information so each woman can make the right choice according to her needs, religious beliefs and values. Macro-level ethics looks at policies, technologies and practices across the reproductive health span. These include issues of sexual consent, the rights of women to choose contraception, abortion or to be sterilised, or where to give birth to their baby.

Personal, professional and theoretical

Everyone has a right to their own ethical values and beliefs. Beliefs come from our parents, upbringing, schooling, education, religious figures and the media. Most people have views on what they believe to be morally right or wrong on issues such as life or death and reproductive choices.

As midwives our personal beliefs need to be set aside when offering professional midwifery care and information to pregnant women or new mothers. Across the globe each country will have their own professional code of ethics which generally follow those produced by the International Confederation of Midwives (ICM) based around four concepts (Figure 3.1). In the UK, the Nursing and Midwifery Council publishes *The Code* (NMC, 2015) which includes the ethical principles nurses and midwives must understand and adhere to (Figure 3.2). These include: making the people in your care your first priority, protecting and promoting others' wellbeing, providing a high standard of care, being open and honest and acting with integrity to uphold the reputation of your profession. Key terms like gaining informed consent and maintaining professional barriers and confidentiality are explained in further detail. How you offer informed consent to any treatment or intervention in midwifery, from screening tests to suturing, matters. What you say and how you say it either enables or acts as a barrier to empowering the individual women to make autonomous decisions about what is acceptable to her. Doing or saying what we think is right is not acceptable, we need to give women the evidence, carefully describing the risks and benefits so they can make their own decisions whether to accept or decline care options.

There are only two areas of professional practice where your views as a person matter. The term used is contentious objection and the two practices are: providing abortion care and technological procedures to achieve a pregnancy. However, if the woman needs emergency treatment in either case, the midwife has a duty to provide this, regardless of their personal views.

Theoretically, one of the most prevalent ethical frameworks used in healthcare was devised by Beauchamp and Childress (Figure 3.3). Their four principles were originally non-hierarchical, meaning each principle had equal weight, but now the principle of respect for autonomy is seen as paramount.

Autonomy

The word originates from the Greek for self-govern. It is often applied to midwifery practice but in ethics it means the individual is capable to decide for themselves what matter in their life. The moral obligation of a midwife regarding autonomy of another person is to respect their choices. In order for women to make informed choices the midwife imparts information that must be factual and complete. The midwife's role is not to bombard individual women with information but to have conversations in language they understand so they can choose which care and which tests they want and where to have their baby. Not giving enough information is not acceptable, it assumes you are treating the woman as a child (paternalism) and disengages the woman and her family actively in her care decisions. Legally, information is required prior to consent, whether this is to take a blood pressure measurement, an ultrasound scan or examination. If a woman lacks autonomy, her competence or capacity to consent to care may be undertaken by another person in her best interest. This is unusual in midwifery.

Beneficence

In order to act for the benefit of others, all the evidence must be considered. As a midwife it is your obligation to maintain contemporaneous research knowledge. As a practitioner you will know smoking in pregnancy is harmful to the woman and her developing fetus. You have a responsibility to offer smoking cessation advice (beneficence) but the woman has the right to decide whether to take this advice or not (autonomy). Her right to autonomy must be upheld, but you still have a duty to promote wellbeing. Open and honest interaction between you and the woman regarding her choices and informing her of the benefits of smoking cessation are required. The woman cannot choose to quit if she does not know the benefits of cessation for her and the baby.

Non-maleficience

Avoiding harm to others seems simple enough, yet there are many interventions in midwifery that may cause harm which should be considered. For example, a vaginal examination may be offered, especially in labour. This may be uncomfortable and an invasion of the woman's personal body, yet the information gained from performing a vaginal examination may be needed to offer her care options. So the benefit of undertaking this exam may outweigh the harm it causes. However, some women may experience significant harm from having this exam, so the concept of non-maleficience is not always straightforward. A woman may decline blood products due to her religious beliefs; although the blood may do no physical harm, her moral beliefs would be harmed in accepting it. All midwifery interventions require consideration for potential harm for individuals.

Justice

This is concerned with the distribution of healthcare, to make sure that everyone has access to a fair system. As midwives you have an obligation to treat all women equally.

4 Role of the midwife

Figure 4.1 Guidance for midwifery practice. Source: data from *The Code: Nursing and Midwifery Council* (NMC, 2015).

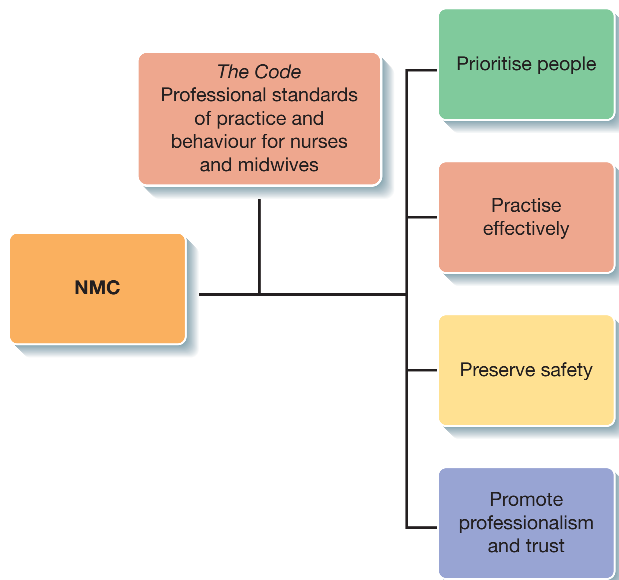


Figure 4.3 The Royal College of Midwives. Source: The Royal College of Midwives (RCM, 2016).

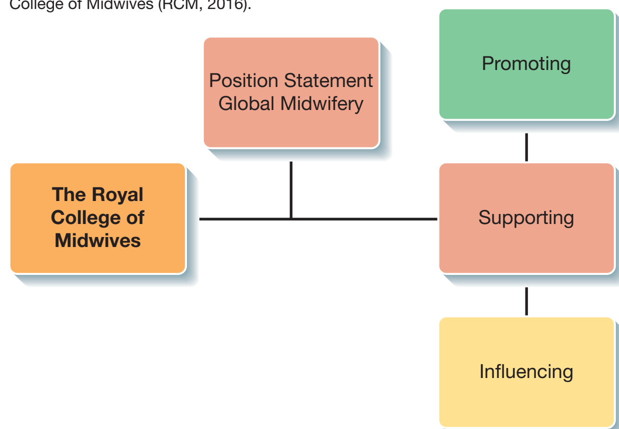
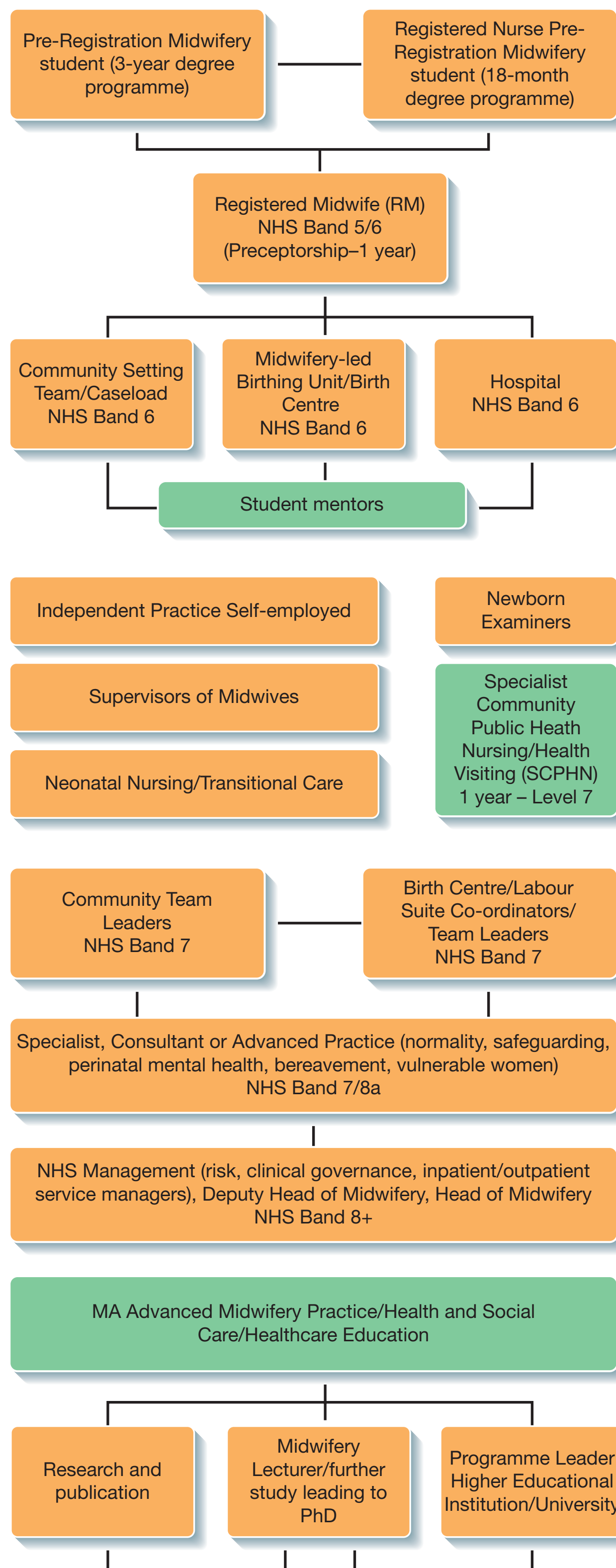


Figure 4.2 Midwife career pathway.



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Definition

The International Confederation of Midwives (ICM) represents the midwifery profession worldwide. For the title 'midwife' to be used; a person must demonstrate competency in the practice of midwifery through the acquisition of specific skills, leading to qualification by a recognised midwifery education programme.

> *'The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures' (ICM, 2011).*

Midwives are also professionals who engage with women and their families. This is an insightful time and an opportunity to make a lasting, positive impact. The midwife is in a prime position to assume a wider public health role, including preconception care, health counselling and education for the woman, her partner and other children. As the midwife's role is complex, the midwife continuously must adapt to the needs of the woman and her family. Women want a midwife to be with them through all aspects of their care. The midwife must be the expert in normality and health promotion and the co-ordinator when care falls outside her remit; knowing when to refer to other professionals such as obstetricians, general practitioners, health visitors, social workers and specialist services (such as mental health).

Scope of practice

The majority of midwives (96%) in the UK work within the NHS, with the remainder working in a self-employed capacity as independent practitioners, often as part of a small team. However, all qualified midwives must be registered with and are regulated by the Nursing and Midwifery Council (NMC). Midwives have a direct responsibility to the women in their care and for actions taken when providing care – professional accountability. Fundamental to practising as a midwife is the commitment to upholding the professional standards set out by the NMC (2015), published in *The Code* (Figure 4.1). To maintain registration and continue to practice in the UK, a midwife, as of April 2016, must 'revalidate' with the NMC every 3 years. The NMC exists to protect the public and ensure that only those registered to practice midwifery can provide care in the UK. In serious cases, a midwife may have her registration suspended or revoked. Revalidation ensures not only that the public are safe from practitioners who have failed to meet the required standards of professionalism and competence, but maintains a culture of continued professional development and life-long learning for midwives, upholding a high, deeply respected public profile.

A midwife may work in a wide variety of settings, from community centres, to women's homes, stand-alone midwife-led birthing centres, co-located birthing units and hospitals. Her sphere of practice may include preconception care; she is the first point of contact for a woman upon conception, and for health promotion, education and support through the antenatal period, as well as clinical assessment and documentation. She is the primary care giver for a woman experiencing a normal pregnancy and documentation would include direct referral for ultrasound scans, all screening tests and referral to other practitioners, such as obstetricians. A midwife is the lead professional at a home birth or within a midwifery-led birthing centre/unit and a co-ordinator of care when a woman requires input from the medical team. Midwives provide immediate care to the newborn baby and must be competent in managing emergency situations. Midwives support women in the earliest days of parenting, ensuring this transition is a positive and life-affirming one, advising and offering support and education on breastfeeding, basic care and hygiene principles. The postpartum is an emotional and testing time for a new family, the midwife will care for a woman and her baby within the hospital environment and at home, typically for up to 10 days but this may be extended in some areas to 28 days postpartum. Midwives may look to progress in their career, entering varying levels of management, education and research (Figure 4.2).

In general, the midwifery model of care is social rather than medical and is underpinned by a philosophy of normality and the natural ability for the woman to give birth to her baby with minimum intervention, enhancing her wellbeing and feelings of empowerment, placing the woman at the centre of care. The midwife must then be competent in the planning, organisation and delivery of an individualised care plan, made with the woman at her first booking appointment and reviewed with the woman throughout her pregnancy. In this model, continuity is important. This may refer to continuity of carer or of care. A small team of midwives, based within a community setting, where their workload is organised by geographical location and where the midwifery team acts as the lead professional, may offer the greatest balance in ensuring the woman has such continuity of care, a deeper relationship with the midwives caring for her and the highest quality of care and satisfaction, maximising the chances of the best outcomes. The Royal College of Midwives is a professional organisation (Figure 4.3) and trade union that supports midwives in practice, providing legal and statutory information, guidance and support and works to promote the profession on an international level. The midwife has a unique place in society, working on a very personal level with women and their families, and much of the role cannot be quantified or measured because the midwife is as important emotionally to the individual woman as she is physically.

5 Drug exemptions

Figure 5.1 Illegal drugs.

CLASS A – morphine, diamorphine, heroin, ectasy, Lysergic Acid Diethylamine (LSD)

CLASS B – barbiturates, speed, cannabis, mephedrone, codeine

CLASS C – ketamine, gammahydroxybutrate (GHB), anabolic steriods, benzodiazepines

Box 5.1 Prescription only medicines (POMs).

- Diclofenac
- Hydrocortisone acetate
- Miconazole
- Nystatin
- Phytomenadione

Box 5.2 Exemptions from restriction on administration.

This list is subject to commercial availability and may change over time

- Adrenaline
- Anti D Immunoglobulin
- Carboprost
- Cyclizine lactate
- Diamorphine
- Ergometrine maleate
- Gelofusine
- Hartmann's solution
- Hepatitis B vaccine
- Hepatitis B immunoglobulin
- Lidocaine
- Lidocaine hydrochloride
- Morphine
- Naloxone hydrochloride
- Phytomenadione
- Prochloperazine
- Sodium chloride 0.9%

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