2015 England Transcultural Trip

Journal 1
By Brittany Ziller

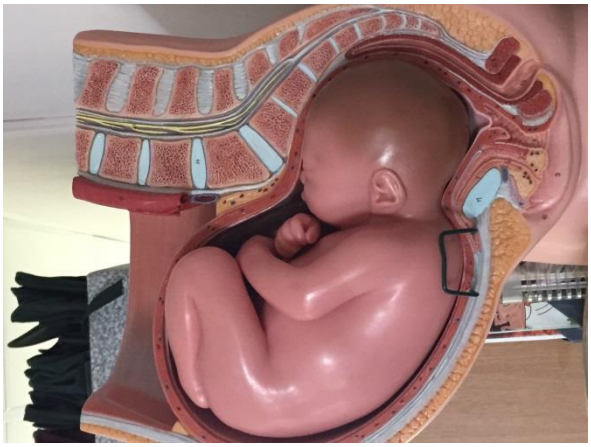
England proved to be full of many surprises! While attending midwifery classes at Brighton University, I noticed that the students were all women, at a mixture of ages from their 20's through their 40's and the class size is small, about 15-20 students. There were learning tools for each student at their desk, such as a plush baby and a plush pelvis. Training and education as a nurse is not as broad as the program here at Illinois State University, however, entry into their midwifery program is just as competitive. Some of the new information the students were getting that day from their instructors, was information we had already attained in our Maternal/Infant course.

The students were shocked to learn that becoming a midwife in the U.S. requires a RN certification prepared at a baccalaureate level and completion of a master's program specific to midwifery to total a minimum of six years, and to also learn that midwives are not completely autonomous in the U.S. as they are in the UK.

The cost of our education also took them back, as their education is paid for by tax dollars and is essentially at no cost to them.

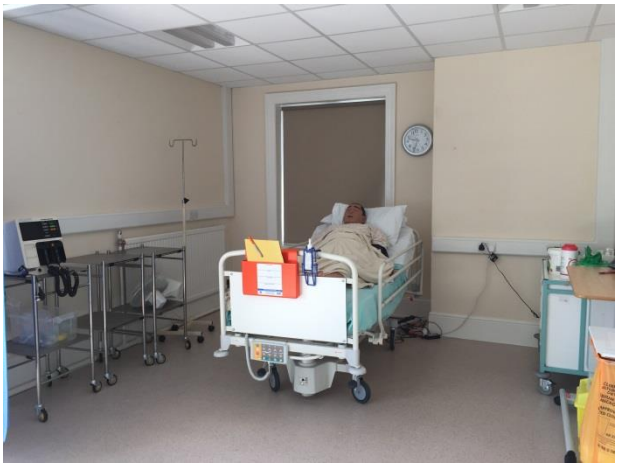
Some students will be done with their training in their very early 20's and I asked them if they ran into resistance in the community due to being young in years and practicing such an advanced career. I was surprised and impressed to hear that they did not, that midwives are much respected and that patients seek out their advice. However, the instructors did stress to the students that a large portion of their job is a struggle between maintaining control of the situation and letting the mom and baby follow their own course. As midwives at a delivery, the laboring woman is considered the professional and they attain to her cues and what she wants.

Although there are clearly differences in our educational paths, it was clear that dedication and stress as a nursing student in general is transcultural as they prepared for their tests and simulations.



Anatomy study diagram

NRP practice



Student's Sim Lab

Home Birth Sim Lab

Journal 2
By Brittany Ziller

I feel that I was able to gain a better understanding of medical practice and familial norms during my time following the nursing staff and the midwives. The majority of the prenatal and postnatal women that were seen were women in their late teens to early twenties and in their mid-thirties with planned pregnancies. Most women were not married but were in a relationship, with said person referred to as 'partner' regardless of gender. The mothers of the expecting women were very active in the pregnancies, with some attending the pre- and postnatal visits and some attending the deliveries. A few of the women planned on living with their mothers during the last few weeks of their pregnancy for additional support.

Similar to the U.S., birthing plans are encouraged with the expectant moms and during the preregistration a history is taken. Women are educated on nutrition, exercise, and required lab and ultrasound testing. They are also screened for physical and chemical abuse, and are asked if they plan to breast or 'artificially' feed their newborn. I found it extremely interesting that they used the term 'artificial' to describe formula, as there seems to be a large misconception that breast milk and formula are equal and, in my opinion, calling it something unnatural makes a person think twice about their choices. The UK, like the U.S., is working on getting more mothers to breastfeed their babies. Postpartum women are checked to make sure they are healing well and questioned about problems they may be having. They are also questioned about the newborn's feeding, sleeping, bowel and bladder habits, and educated about any abnormalities to be mindful of, and when to call the physician. Men enjoy two weeks of paternity leave offered in their country.

Some differences lay in the certain processes of things, such as length of hospital stay. In the U.S., a women stays in the delivery unit for 24-72 hours depending on the terms of the delivery, whereas, in the UK, many moms and babies leave in as little as six

hours post-delivery. Newborns in the UK only receive vitamin K after delivery and the most thorough newborn physical is done on day three instead of the day of delivery.

Much of the role of the nurse and midwife seems transcultural with encouragement and education as their backbone of practice. Families also come in many different forms, and for the most part, they work closely with their midwife for the birth they wish to have.

Journal 1
By Ashley Kennedy

Once we were finally settled into our accommodations in Eastbourne, we were very excited to get a taste of what hospital life was like! The Eastbourne General District Hospital is an older hospital with many units, including a Midwifery Unit and a Maternity Day Unit. At the Maternity Day Unit, women will come in to have their vitals take, urine tested, fetal heart rate monitored, and their blood drawn if needed. The patients are usually anywhere between 10-38 weeks along in their pregnancies. Midwives see the patients that attend the Maternity Day Unit.

The Midwifery Unit is available to women with low-risk pregnancies that are in labor and getting ready to deliver. If a woman begins laboring at the Eastbourne Midwifery Unit and has a complication, if it is safe, they will be transferred to a neighboring town hospital known as Conquest Hospital. At the Conquest an obstetrician will then look after the woman. Since the Eastbourne Midwifery Unit can only accept low-risk deliveries, there is no obstetrician that works at the hospital. If there were an emergency that would not allow for transfer to the Conquest, the pediatricians at the hospital would be able to assist the midwives in the delivery. Stepping into this healthcare system is truly like stepping into another world! We were full of questions and surely got our fill of answers!

Another aspect of healthcare in England is the role of the midwife in the community. The Community Midwives are responsible for antenatal, labor and delivery, and postnatal care. Antenatal clinics are often held in a spare room at a general practitioners office. Women ranging from 10-38 weeks will arrive at scheduled appointments and have their vital signs taken, urine tested, fetal heart rate monitored, and blood taken if needed. The midwives will answer any questions or concerns the woman is having as well as conduct a risk assessment of the woman and pregnancy (looking at factors such as maternal and fetal condition). These appointments generally last twenty minutes and can cover topics such as exercise, food intake, and what to expect throughout pregnancy. Caring for a woman in labor is not always common for the Community Midwives; however, they are responsible for the care of a woman who wishes to deliver at home. This care can include some situations where the woman is low-risk and is not able to make it into the hospital. As for postnatal care, the midwives will go about the community and visit women after delivery. These visits are generally when the baby is three, six, and ten days old. At these appointments, the mother and baby are both assessed and monitored.

We are feeling so lucky to be able to experience and learn from all of this wonderful culture!

Journal 2
By Ashley Kennedy

Along with our hospital visits, we also were involved in the classes at the University of Brighton in Eastbourne. These classes were for the midwifery students and included topics such as fetal presentation, breech delivery, antepartum hemorrhage, postpartum hemorrhage, and much more. The class size was about 15-20 students which is much smaller than what we are accustomed to at Illinois State! The small class size contributed to a more laid-back environment and was much easier for the teacher to address students concerns than it is in at Illinois State.

No matter what class we were participating in the teachers stressed the idea of making sure the labor and delivery process was how the mother wishes it to be and is most comfortable for the mother. While the same idea is present in the United States, in England the midwives seem to be even more concerned and facilitative of this health care need. The concept of delivery in England was also something that differed from the United States. Most women in England prefer to have a vaginal delivery without any anesthesia/analgesia, if possible.

In the United States, I have observed that more women would prefer to have anesthesia/analgesia and some even prefer to have a cesarean section. Obviously there is a need to determine what the woman determines to be her preferred way of delivery no matter what the setting. It was a challenge to grasp how England and the United States (and many other countries) differ so much in attitudes and beliefs on labor and delivery. I tried to gain more knowledge and understand why there is a difference between the two countries. One difference I found was what the teachers, nurses, and midwives explained and taught their students and patients. Almost all healthcare workers I encountered in

England believed that pregnancy and delivery was a completely natural process that the body is able to handle itself, in most cases. While this is something the United States is fully aware of, I can't say I was ever taught the concept in such terms that the healthcare workers in England explained it.

As my career in nursing expands, I truly believe the attitude on delivery I experienced in England will impact the way I interact with my patients and even present information to them. I hope as more evidence-based practices are conducted, the United States moves towards the system England has in place and its many benefits for women delivering. Not only are we learning tons of midwifery theory, we are experiencing and learning their culture!

Journal 1
By Lindsey Hand

My first experience of what midwifery looks like in the UK occurred on our very first clinical day (which is actually called 'practice' in Great Britain). I was assigned to follow the community midwife, whose duties include antenatal checks, postnatal visits, and initial 'admission' of newly pregnant women into their records. I was anticipating this experience with pleasure, as I had never been into someone's home for healthcare-related reasons before. We began the day with the three postnatal visits listed in my community midwife's diary (recordkeeping in England is not as computerized as it is here in the U.S. at this time).

One of the primary professional belief systems impacting the delivery of health care in the UK is the emphasis placed on the autonomy and choice of the mother. As such, care and treatment of postpartal moms takes place primarily in her home. Furthermore, if the antepartal expectant mom elects to deliver her baby in her own home, *even if she is considered high-risk by the National Health Service (NHS)*, a community midwife will still attend her birth. (Unfortunately for us, we did not get to see any home births, though we hoped with all our might!)

At any rate, the community midwife attempts to see the new mom at 3, 7 and 10 days post-delivery, and if all is well on day 10, the midwife will 'discharge' the new mom from their care, which simply means the mother is no longer an active patient with those community midwives. The new mothers still have access to the healthcare available through the NHS, and the interdisciplinary nature of postpartum care also involves visits from a health visitor (who provide family health services through the mom's pregnancy and up to the child's 5^{th} birthday.)

We visited three new mothers in their homes, and each visit was as unique as the mother herself. In one home we encountered a space the size of a large bedroom, in which the new family of three lived. The bathroom was in the hall and shared with another flat. It was clean, organized and tiny.

Another new family of three lived in a larger, but less tidy flat that smelled strongly of body odor, and made me wonder if the conditions were ideal for a newborn. However, assessment of this baby yielded a thriving 11-day old, whose mother was successfully breastfeeding, and father was highly involved in his new son's care.

The third home we visited was a flat in a newer apartment building, and was exceptionally clean and "homey." The mother in that apartment had just had her second baby, and was the youngest of the three new moms. I found these home visits to be highly informative and felt the U.S. system of medicine could benefit from such a model.

New mothers in America are assessed upon their return to their OBGYNs for follow-up care post-delivery most commonly at 6 weeks, and some complications as postpartum depression or other concerns might be missed, unless the mom recognizes the symptoms and seeks assistance. I enjoyed spending time with the families in their homes, chatting with the new moms and assessing her and her baby. It was effective and therapeutic.

Our antenatal checks were performed out in the community, at a medical office building. The expectant mothers would arrive at a scheduled time and have their blood pressure and urine screened, after which the midwife checked the fetal heart with a Doppler. It was the first time I had seen a tape measure used to measure fundal height, and the interaction between expectant mother and midwife seemed a bit more intimate to me, than what I have witnessed between expectant mothers and OBGYNs in the U.S.

Overall, I gleaned a great deal of information from my day in the Eastbourne community with Lynn, community nurse midwife, and I intend to implement some of the practices I witnessed someday myself, when I obtain my certified nurse midwifery degree.

Journal 2
By Lindsey Hand

During our second week in Eastbourne, England, we had the opportunity to visit both a maternity unit in a hospital, as well as a midwifery-led birthing center. We also attended classes regarding breech presentation and management at the University of Brighton. Throughout this week (and our entire time in the UK) I was continually re-evaluating my preconceived opinions and ideas regarding maternity care in Great Britain. Before I traveled to England, I was fully convinced that midwifery under the National Health Service (NHS) was far superior to the U.S. system of maternity care, and that the U.S. would be better off following this model. After spending some time observing the midwives and the various mechanisms of care delivery, I recognized there are ways in which U.S. maternity care surpasses that of the UK, and ways in which the U.S. could indeed benefit from adopting some of the practices from over the pond.

Hospitals in the UK have either medically-staffed midwifery units, or midwifery-led birthing centers. In the birthing centers, expectant mothers may deliver their babies under the care and supervision of a trained midwife, an expert in normal birth. However, these units do not have access to some of the methods of pain relief (e.g. epidurals) available in the hospital units, nor do they have ability to do surgical interventions. Mothers who deliver in the birthing centers are low-risk women who wish to have a natural delivery.

When we visited the birthing center in Crowborough, I encountered the kind of attitude and mindset toward birth that I had (rather foolishly) ascribed to all British midwives. Here we saw midwives who were advocates of low-intervention (sometimes no intervention) natural deliveries, and who were not only willing to deliver babies in the water, but encouraged expectant mothers to labor and deliver in the tub. These midwives were unafraid of breech presentation, and one even described a home birth at which she had assisted a primiparous, thirtysomething who, at first, would not allow the midwife even to touch her, as she wanted her birth to be entirely natural. This midwife recalled having to chart “appears mother is contracting by the sounds heard through the ceiling”

as, at times, she was banned from the birthing room. I could only extrapolate the way such a mother would be treated in the U.S., but this midwife described her continued support and assistance of this woman, citing her main thought throughout the entire process was "this expectant mother wants a midwife to be present – *I can work with that*."

At the other end of the spectrum was the labor unit at the Conquest Hospital in Hastings. This was the unit where high-risk mothers were encouraged to deliver their babies (OB physicians in the UK can only make suggestions to pregnant women; at the end of the day, the decision of where/how to deliver is still up to the mother.) Here in this unit I had the opportunity of observing a Cesarean delivery of a young mother with pre-eclampsia. I was fascinated by the differences in healthcare delivery (in a unit more comparable to a L&D floor in a U.S. hospital). The mere differences in equipment, procedures and standard precautions made me recognize the incredibly high value the U.S. healthcare system places on safety. I observed a *true* surgical time-out prior to the section, which was a great learning experience.

Finally, at the university, I attended lectures demonstrating that breech presentation is a *normal* position, and more often than not we ought to treat it that way. If an unborn baby is found to be in breech position in the U.S. (my experience thus far has taught me that) that baby will be delivered via Cesarean section. This saddens me, as the research conducted in the UK demonstrates that outcomes are no worse for breech babies delivered vaginally, and indeed, when one considers the co-morbidities of a major surgical operation for the mother, it is not hard to see why vaginal delivery might even be preferable.

Overall, my experience in the UK taught me never to assume, to keep an open mind, and that things are not always as dire in one's corner of the world as one may imagine. I was struck by some of the unique ways in which babies are brought into the world in the UK, and recognized the ways in which the U.S. could benefit by observing a few of these models. Ultimately, I saw firsthand the universality of the joy of birth, regardless of one's country of origin.