Commentary

Individualised care for women with assisted conception pregnancies and midwifery practice implications: An analysis of the existing research and current practice

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A B S T R A C T

Objective: the aim is to explore the psychosocial needs of women who are pregnant after assisted conception, specifically in vitro Fertilisation and whether their needs are being addressed within the current maternity care service.

Design: critical review of the literature using a narrative approach.

Findings and key conclusions: 15 papers were identified. These included both qualitative and quantitative studies, literature reviews and surveys. The findings of this limited narrative review imply that women who undergo assistive reproductive techniques to achieve pregnancy have higher levels of anxiety in pregnancy and may have some difficulties in the transition to parenthood leading to perinatal morbidity. It appears that for this group of women it is important that their history in achieving pregnancy is known to the care providers, to enable the alleviation of some of the anxieties they face. Various aspects of antenatal care have been identified as possible areas which if addressed may reduce these levels of anxiety leading to a reduction in perinatal morbidity.

Implications for practice: currently, there is insufficient evidence to suggest that providing specialist midwifery care reduces morbidity in these women. However, maternity service providers should consider offering additional antenatal and postnatal services to meet the needs of this group in advance of further research in this area.

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Introduction

Women who are pregnant after assisted conception are believed to have specific psychological needs throughout the childbirth continuum which has implications for midwives and practice. Existing research has gone some way to identifying these needs yet the evidence remains insufficient especially from a midwifery perspective to pre-empt significant improvement to maternity staff knowledge and implementation in practice. Consequently, the aim of this paper was to undertake a narrative review to identify and summarise the relevant research observations about assisted conception upon the psychological well-being in pregnancy and early parenting outcomes. Additionally, literature surrounding theoretical concepts relating to emotion and reproduction were included. The objective was to formulate knowledge to improve maternity care staff’s understanding of the cumulative negative effect for this group of parents in a bid to provide patient centred care. It is hoped that this paper will broaden the midwife’s understanding of the specific issues of pregnancy after assisted conception. This will in turn lead to individualised, woman-centred midwifery care provision and a reduction in perinatal morbidity.

Method of review

The following inclusion criteria for literature were applied. Papers were required to be published in English or to have had direct author communication in English to verify the accuracy of the literature. These papers were authored in countries with
broadly comparable systems in terms of obstetric care provision, following assisted conception. Papers from Holland, Australia, Scandinavia, UK were included and the years of publication were restricted to between 1989 and 2013. The time span applied was 24 years prior to writing this paper and was chosen because this period covers the rigorous research methods that have used valid and reliable measuring tools. Books and chapters within books were included as an initial source of providing an overview about the area under discussion. Participants under consideration were women who had undergone assisted conception, specifically in vitro Fertilisation to achieve pregnancy. Due to the dearth of current research, the author wished to include both quantitative and qualitative methods, therefore a strict hierarchy of evidence was not applied. The rationale underpinning this decision was to capture the widest variety of relevant literature available. The narrative review was undertaken consistent with the approach suggested by Baumeister and Leary (1997). This approach allows inclusion of a spectrum of research types which is both comprehensive and directly relevant to the review area (Dixon-Woods et al., 2005).

A narrative review of the literature was undertaken between February and June 2013. The following electronic databases were searched:

- Medline
- Cinahl
- Midirs
- Cochrane Database of Systematic Reviews
- Cochrane CENTRAL Register of Controlled Trials.

Given the narrative review approach implicit to the methodology, a general internet search using the standard search engine was performed. Retrieved reference lists were hand searched for additional papers including an appraisal of secondary references from retrieved papers. Lastly, a combined thesaurus and free-text approach was adopted to identify relevant papers for inclusion in the review. The following keywords and search terms were used:

- Assisted conception
- Anxiety
- Parenthood
- Psychological issues
- Pregnancy

Findings

Grouping of the retrieved papers in order of relevance took place following the collection of the main body of papers and articles, summarising the main strengths and limitations of each. This provided background information about anxiety and psychological issues in pregnancy and early parenthood encountered by woman who achieved pregnancy via assisted conception. Taken as a whole, the overarching theme than began to emerge from these papers was that this group of women have specific issues which affect their psychological well-being throughout the childbirth continuum.

The evidence

The World Health Organization (WHO) (2013, p. 7), defines infertility as ‘a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse’. They suggest that infertility is viewed globally by couples as ‘a tragedy which carries social, economic and psychological consequences’. Boivin et al. (2007) suggest that a substantial proportion of couples experience involuntary childlessness with statistics reporting that infertility affects one in six couples, which translates into 3.5 million people in the UK (Department of Health, 2013).

To enable parenthood, this phenomenon has been overcome by assisted reproductive technologies which have been developed over the past 35 years and since the birth of Louise Brown in 1978, are being increasingly used in developed countries (Adamson et al., 2006; Paulson, 2007). The most prominent and commonly used method is in vitro Fertilisation (IVF), a method in which the ovum is fertilised by sperm in vitro, outside the woman’s body and the subsequent embryo is replaced into the woman’s uterus. IVF is neither an easy option, nor a lifestyle choice and for most couples is the only route to achieve conception (Lerol, 2006). The process demands an intense and often painful regime of self-administering medication orally, enterally, parenterally, mucosally and/or percutaneously. As a surgical procedure, the egg retrieval process carries its own risk (Kennedy, 2005). In addition to the above, constant monitoring of hormone levels and intrusive procedures which include the transfer of embryos after fertilisation into the uterus is mentally and physically taxing to both partners and the social ‘stigma’ of infertility makes it extremely burdensome (Kaliarnta et al., 2011). This social stigma is discussed by Allan (2007) and parallels may be drawn with Bolton’s (2007) argument that much of gynaecological nursing and midwifery concerns caring for women who are ‘other’, in that their care involves ‘dirty work’. This refers to the fact that it deals with the innately private, women’s reproductive health domain. In addition to this, infertility she claims, is considered to be socially difficult and consequently receives minimal public recognition due to its association with the ‘catastrophic disintegration’ of women’s sexual body. In this context this group of women exemplifies the hidden dimensions of midwifery due to their heightened emotional needs resulting from the above.

According to the UK’s independent regulatory body for fertility treatment, the Human Fertilisation & Embryology Authority (HFEA) (2013), 2% of all UK births result from IVF and the number is rising year on year. In 2011, IVF resulted in 13,703 pregnancies in the UK alone. The social context for the increase in IVF is multifactorial. Lifestyle factors include weight issues, stress, smoking and importantly the increasing trend for many women who elect to start families after pursuing a career, thereby leading to an increase in women of advanced maternal age requiring assisted conception due to a reduction in fertility. Additionally the number of same-sex female couples receiving IVF treatment has increased by over a third in the last year. These figures are recorded in the HFEA’s third report on fertility trends (HFEA, 2014). It appears somewhat surprising therefore, that little research into the experiences of these women, following successful treatment has been undertaken. Allan and Finnerty (2009) suggest that these are ‘forgotten women’ who upon achieving a successful pregnancy, their journey in their quest to conception is overlooked. Consequently, there is insubstantial evidence and practise midwives are unaware of this group of women’s specific needs during pregnancy, birth and motherhood.

The recently updated National Institute for Health and Clinical Excellence (2013) guidelines for the treatment of infertility acknowledges new knowledge and developments in this field, making corresponding recommendations to meet these. The new guidelines received developmental input from a service user, who herself required IVF in order to conceive. She publicly acknowledges that the path from diagnosis to fertility treatments can be a long and emotional process, yet the needs of women who have achieved conception resulting in a live birth following IVF are not
addressed. In early pregnancy, the risks of spontaneous miscarriage and ectopic pregnancy are higher than in spontaneously conceived pregnancies, with an almost doubled risk of ectopic pregnancy (Kennedy, 2005; Paulson, 2007). In later pregnancy, associated risks with assisted conception include placenta praevia, abruptio, gestational diabetes (Paulson, 2007), hypertension and pre-eclampsia (Wang et al., 2002) and caesarean section (Van Voorhis, 2006). The possibility of an increased risk of major malformations in children conceived via assisted conception has been widely discussed (Hanson et al., 2005; Ludwig, 2005; Van Voorhis, 2006; Paulson, 2007), with particular concern around the Intracytoplasmic sperm injection (ICSI) procedure (Sutcliffe, 2002). Sutcliffe and Ludwig (2007) estimate this increased risk to be about 30%. The increased anxiety caused by all of the above has been shown to continue into pregnancy with a fear for the well-being of the unborn child yet it may be assuaged with ongoing support and reassurance throughout pregnancy (McMahon et al., 1997). The above recommendation notwithstanding, it would seem obvious that this heightened emotional state and anxiety from a long, arduous and uncertain journey remains with the couple, certainly in the early stages of pregnancy and for some in the later stages, even after reaching the final destination, that of parenthood. This theory has been demonstrated repeatedly by historical qualitative and quantitative studies including Reading et al. (1989), Bernstein et al. (1994), Van Balen et al. (1996) and Eguster and Vingerhoets (1999) whose major review of the research into psychological reactions of women throughout the IVF continuum demonstrated that IVF parents experience more stress during pregnancy than non-IVF parents. The systematic evidence that continues to emerge lends qualified support to these theories. The absence of a national policy regarding antenatal booking visits following assisted conception, claims Allan and Finnerty (2007), has created a practice gap in the care of women following successful infertility treatment. In their article which aims to highlight the gap between existing research evidence and midwifery practice, they suggest that midwifery staff appear to be unaware of the specific needs of infertile women during pregnancy, birth and early motherhood.

Research by Hjelmstedt et al. (2003a, 2003b), McMahon et al. (2003) and Hjelmstedt et al. (2004) has contributed significantly to understanding how the complexities resulting from infertility treatments affect pregnancy, birth and parenthood. Whilst their findings point towards further research, two main issues come to the fore. One directly impacts the provision of individualised woman-centred maternity care, the other indirectly, yet they are interlinked. Firstly, the ongoing psychological needs which differ greatly from those of a woman with a spontaneous conception. Secondly, the social identity and stigma attached to infertility which is not easily divested upon conception. Allan and Finnerty’s (2007) literature review highlighted the gap in research evidence and subsequent midwifery practice following successful infertility treatments. They note that midwives were not asking critical questions regarding consequences of assisted conception. Evidence can only be provided if these questions are asked thereby closing the practice gap by enabling professional training for midwifery staff with the potential for the provision of evidence-based care for this group of women. The standardised approach may be inappropriate for these women whose psychosocial needs may be vastly different.

Hjelmstedt et al.’s (2003a, 2003b) longitudinal comparative study conducted via IVF clinics and antenatal clinics, aimed to compare couples who had conceived via IVF with couples who conceived spontaneously, regarding personality factors and emotional responses to pregnancy. Although the relatively small sample size could deem the study flawed, within the constraints of the above clinical settings this would be more realistically achievable. The results demonstrated that although the IVF group responded more positively to the pregnancy with less concern regarding the child’s gender and the loss of independence, they had more muscular tension and were more anxious about losing the pregnancy than the control group. The IVF women with high infertility distress were less ambivalent than the women with lower distress. Interestingly, the IVF men had more somatic anxiety, indirect aggression, guilt and were more detached and more anxious about losing the pregnancy and less ambivalent than the control group. Additionally, the IVF men with high infertility distress were more anxious about the baby having an abnormality than the men with lower infertility distress. This demonstrates that the increased anxiety was noted equally in both partners, a stark reminder to midwives that the holistic care we provide includes the father and the importance of early recognition and treatment of anxiety in the antenatal period. Later that year Hjelmstedt et al. (2003a, 2003b) conducted a comparative study, the aim being to compare between IVF couples and a control group, the patterns of emotional response to different stages of pregnancy amongst other factors. The findings demonstrated once again that it was both the mother and father in the IVF group who experienced greater anxiety throughout the pregnancy continuum about losing the pregnancy than the control group. Additionally, the IVF men were also anxious about the baby suffering a birth injury. An exploratory study by Darwiche et al. (2013) examined via means of questionnaire and interview, the transition from fertility to obstetric care of women who conceived through IVF. The findings shed light on the crux of the issue in the common theme which runs through all the studies and something which most midwives lack the training and skills to understand (Allan and Finnerty, 2007). For women who conceived via IVF the course of the pregnancy is still very uncertain and a positive outcome cannot be guaranteed as the live birth rate is approximately 20% per embryo transfer. Therefore, not only does the increased anxiety stem from the arduous journey in achieving a clinical pregnancy, but the additional and ongoing fear for the continuation of the pregnancy exacerbates the anxiety. These women worry more about miscarriage and the survival and health of their baby. These findings underscore the importance of taking into account, not only the standard pre and postnatal variable, but also factors related to the care experience when evaluating the transition to motherhood of women who conceived via IVF. The implications for practice are obvious, antenatal care providers, in the UK, the midwives, should have a greater understanding and increased sensitivity to women’s needs in terms of antenatal and postnatal support due to the specificity of the experience of conceiving with medical assistance.

Darwiche et al.’s (2004) study into the impact of social identity on the pregnancy hypothesised that a link exists between the emotional integration of the history of infertility and the adjustment to pregnancy and psychological status. The result of their in-depth qualitative, observational interviews and questionnaires concluded that couples who integrated their history of infertility were able to improve psychological status in pregnancy. Continuing this theme, Cox et al.’s (2006) prospective study’s aim to establish the relationship among self-esteem, anxiety during pregnancy and parenting self-efficacy demonstrated that self-esteem increased as pregnancy progressed. Self-esteem was negatively correlated with anxiety during pregnancy, as the self-esteem increased, anxiety decreased. Recommendations included the provision of coaching and mentoring through antenatal clinics in the early stages of pregnancy, individually tailored to incorporate advice regarding self-esteem in addition to management of pregnancy and psychological well-being.

Fisher et al. (2005) aimed to identify the association of assisted conception as a risk factor for postnatal mood disturbance and
early parenting difficulties. They found that there was little systematic evidence about post partum psychological functioning after assisted conception. However they suggest that assisted conception appears to be associated with a significantly increased rate of early parenting difficulties. It could be argued that this phenomenon is due to the highly anticipated and desired nature of the child, therefore these women may feel less inclined to complain or seek help which may lead to insufficient preparation for the social isolation, loss of autonomy and potentially challenging nature of neonatal care. A compounding factor to this is the increased likelihood of both multiple birth and operative childbirth, commonly associated with IVF pregnancy, which appears to amplify the difficulty in forming a healthy maternal identity. In their systematic review of 28 studies, Hammarberg et al. (2008) took the above subject even further by exploring the psychological and social aspects of pregnancy, childbirth and early parenting after assisted conception. Their aim was to assess psychological and social consequences of pregnancy, childbirth and early parenting after assisted conception. Their findings concluded that there was a potential cumulative negative effect on antenatal psychological functioning and post partum adjustment. The recommendations were that health care professionals involved in the care of patients during pregnancy and after birth should observe and monitor their women for potential signs of the previously mentioned cumulative negative effect to prevent perinatal morbidity. Clearly, the evidence base serves not only to bring recency to the more historical pieces but adds gravitas to the momentum of neonatal care. A compounding factor to this is the highly anticipated and desired nature of neonatal morbidity. Clearly, the evidence base serves not only to bring recency to the more historical pieces but adds gravitas to the argument, demonstrating the importance of recognising the correlation between assisted conception and psychosocial difficulties in the transition to parenthood with the aim of addressing them early in pregnancy to negate negative consequences later.

Policy and guidelines

Although this group of women is not specifically addressed at policy level there is a plethora of professional standards and political guidance to support these women. The National Service Framework (NSF) (Department of Health/Department for Education and Skills, 2004), for children, young people and maternity services for England, sets out in standard 11 a requirement that women have access to high quality and supportive maternity services designed around their individual needs and those of their infants, yet currently there is no national midwifery guideline for the management of pregnancy resulting from successful treatment. The Nursing and Midwifery Council (NMC) Code (2008) states that midwives must treat people as individuals, with kindness and consideration, advocating for them to access the relevant information and support. In its midwifery summary for the Centre for Maternal and Child Enquiries’ (CMACE) report into saving mothers’ lives, Garrod et al. (2011) make eight recommendations for midwifery practice. One of the recommendations is for the provision of continuity of care to vulnerable women; another is the early referral for psychiatric services for women with pre-existing psychiatric disorders. Although, this group of women is not specifically mentioned in this category, the growing body of evidence clearly demonstrates that this group which includes high proportions of older and primiparous mothers are vulnerable and have specific psychological issues which increase the risk factors. Ethically and morally therefore, the same provision should be made, in a bid to provide individualised care and prevent morbidity and its ramifications.

Midwifery 2020 (2010, p. 5) reinforces the above as key messages for midwifery practice in an ever evolving maternity health care environment. They state: ‘Women and their partners want a safe transition to parenthood and they want the experience to be positive and life enhancing’ and ‘Each woman and her partner need a midwife they know and trust to coordinate their physical and emotional care through pregnancy and until the end of the postnatal period’. Additionally, the NMC Midwives Rules and Standards (NMC, 2012, p. 15) stipulate in rule 5, section 2: ‘You must make sure the needs of the woman and her baby are the primary focus of your practice and you should work in partnership with the woman and her family providing safe, responsive, compassionate care in an appropriate environment to facilitate her physical and emotional care throughout childbirth’. NICE’s clinical guideline 45, antenatal and postnatal mental health (National Institute for Health and Clinical Excellence, 2007) includes in its principles of care the prediction, detection and management of a possible mental health disorder. It includes symptoms of anxiety and makes recommendations based on diagnostic criteria. The NHS 6Cs (Department of Health, 2012) vision and strategy for compassionate caring oblige midwives to offer a level of care provision which includes all of the following elements: care, compassion, commitment, courage, communication and competency. It could be argued that this is an ideal to aspire to in a service where staffing levels are woefully inadequate. In 2012, using a widely recognised benchmark of 29.5 births per midwife per year, there was a shortfall of 2300 midwives (National Audit Office, 2013). In their report on the state of maternity services provision in England, the NAO acknowledge that demands on NHS maternity services is at its highest level in 40 years due to an increasing birth rate. Additionally the proportion of complex births requiring greater clinical involvement due to numerous factors including multiple births and advanced maternal age over 40, both common phenomena amongst women undergoing assisted conception has increased. Notwithstanding the above, these core elements form the centre point of the compassion in practice strategy unveiled by the NHS commissioning board chief nursing officer and DOH director of nursing and it remains the duty of every midwife to embrace and implement these principles at a local level, ensuring that every woman receives this level of care.

The implications for midwives and practice

The implications for midwives and practice are manifold and worthy of exploration. Using the diagnosis of pregnancy as a starting point, the differences are already apparent. Confirmation of pregnancy is made earlier in an assisted conception cycle than a spontaneous conception due to the intensely monitored nature of the treatment. Upon confirmation of pregnancy, an early ultrasound scan is performed between six and eight weeks’ gestation (Sidebotham, 1997). The reasons are twofold, firstly to ensure that the pregnancy is intrauterine and not ectopic, secondly as a legal requirement of the HFEA (2013) to maintain a register of the outcomes of treatment cycles resulting in pregnancy. Their definition of a clinical pregnancy is the presence of a fetal heart on scan. Once diagnosis and confirmation is made, the couple are subsequently referred to local maternity services.

Morgan (2008) suggests that this transfer of care to a health professional who has no concept of the history and stressful journey taken to reach this point can lead to a sense of abandonment. These couples will be acutely aware of the risk of pregnancy loss and in a system which routinely addresses the success of pregnancy, may feel unable to voice their doubts and fears to the midwife. Koudstaal et al. (2000), suggest that women with IVF pregnancies have more antenatal hospital admissions, in part due to increased anxiety. Only a midwife sufficiently knowledgeable about the psychological aspects of infertility can competently and compassionately impart information to the couple, whilst enabling
them to discuss their fears and concerns. This would enable the midwife to offer the reassurance that most couples experience some fear, irrespective of conceptual origin, which can help the parents divest a little of their ‘abnormal’ status. In order to reduce the afore mentioned anxiety, it may be necessary to offer the couple more support via additional appointments if the standard appointments do not afford the luxury of extra time. This could be provided by their community midwife if s/he feels suitably equipped, a specialist mental health midwife or if this does not address the needs of the couple they could be signposted to specialist perinatal mental health services. Confidentiality may be an issue for the couple and they may choose to disclose information whilst requesting that it not be recorded in the notes. In accordance with the NMC Code (2008), confidentiality must be respected where there is no concern for well-being, thereby the midwife would be obliged to respect their request. This would have ramifications for the couple if they were to be seen by multiple midwives. However, we know from Kirkham (2010), that the basis of the midwife–mother relationship is grounded in mutual trust and respect, which can be achieved via continuity of care provider. In this continuous, safe and understanding environment, with time the couple may be able to cultivate a closer link which in turn could lead to a more open relationship. In a utopia, women and their partners would be assured of continuity of carer and afforded as much time as necessary to allow the above relationship to develop enabling the above benefits, however current midwifery service provision does not allow for individualisation of services. This stark reality is demonstrated in the Royal College of Midwives’ (2012) second annual report on the state of UK maternity services. They relate that the ‘baby boom’ has continued its upward trend in England and the projections indicate that this rise will continue. Of relevance to this paper is the claim that in 2012, 40% of women had seen a different midwife during their recent pregnancy and one fifth of women did not feel supported by the NHS during their pregnancy and birth, a sad indictment. Another cited factor highly relevant to this paper is a change in the profile of pregnant women with a rise in pregnancies to women over the age of 40. Advanced maternal age is a recognised feature of women who undergo assisted conception due to the advances in reproductive technology but may also be the harbinger of additional challenges.

In her theory on time and midwifery practice, Stevens (2009), acknowledges that in the current service provision, relationships are intensified only to be temporally limited as appointments, while offering the privacy necessary to disclose, are hindered by being of fixed duration. Failure to observe these limits leads to an intrusion on schedules, both the midwife’s and the additional women awaiting their appointment. These tightly defined boundaries create a task orientated model which forces midwives to be reactive rather than proactive, a barrier to individualised care. Other gaps have been identified in providing this individualised service. In an age of austerity, scarcity of resources has remained an ongoing issue which has traversed the professional and political arena. Prior to his election as leader of the current government’s coalition, in his manifesto Mr. Cameron pledged to recruit 3000 more midwives into the NHS to address the rising birth rate. Sadly, once seated in office, this pledge was promptly dropped and never honoured, leading to inadequate staffing levels in maternity services (Dabrowski, 2012). Finally, it is suggested by Allan and Finnerty (2009), that there is a lack of professional skills and training methods for midwifery students and staff. They believe that providing the above, creates the potential for providing evidence-based care to infertile women and their families in pregnancy. All the above elements combined, prevent this group of women being provided with a service provision which addresses their specific needs.

Conclusion

This paper has explored the unique challenges faced by women and their partners who achieve pregnancy via assisted conception. The research clearly identifies that this group of women have increased levels of anxiety in pregnancy which stems from the long and difficult journey from diagnosis to pregnancy to parenthood, which is multidimensional and caused by the following: the social identity and stigma acquired throughout the years of infertility is not easily divested upon achieving pregnancy; the early confirmation of pregnancy and the fear of spontaneous miscarriage or ectopic pregnancy in an assisted cycle; the increased risk of numerous obstetric complications later in pregnancy; The significantly higher chance of a malformation in the child, related to the cause of infertility and the technique necessary to overcome it. Finally, the psychosocial difficulties which may be faced in the transition to parenthood and early parenting difficulties. All of the above have the potential to create a cumulative negative effect on antenatal psychological functioning and post partum adjustment which may lead to perinatal morbidity. Current national policy does not specifically address this group of women; however they are included in professional standards and political guidance which stipulates that all women should receive supportive maternity services designed around their individual needs. Suggestions for practice by the researchers which would address the above are hindered by obstacles. These come in the form of a lack of awareness of this group’s needs due to insufficient knowledge and training of midwifery staff in this specific area. Equally if not more significantly is the reality of current midwifery service provision. Unfortunately, during this time of austerity resources are extremely limited preventing individualisation of care, be it in sufficient and adequately trained manpower or through lack of a precious commodity, time.

Recommendations

Recommendations to overcome the above obstacles may include further quantitative research via data collection within maternity units regarding the number of women who present with assisted conception pregnancies and the number of admissions with anxiety related issues. This would prove beneficial in determining whether providing additional midwifery training and/or the development of a specialist midwife role would have a threefold benefit. Firstly, in providing these women and their partners with the individualised midwifery care they deserve. Secondly, in a bid to reduce perinatal morbidity and improve early parenting outcomes and finally, as a means of reducing costs to the Trusts from unnecessary admissions.

Conflict of interest

None declared.

References


