

Empowerment: Challenges during pregnancy

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Article points

1. Women with diabetes continue to carry a high risk of adverse outcomes with regard to pregnancy despite the St Vincent Declaration, as highlighted by the 2007 Confidential Enquiry into Maternal and Child Health.
2. Multidisciplinary team support is viewed as vital for helping to secure a successful outcome.
3. The provision of preconception advice and educational support will help to empower women towards behavioural change.
4. The diabetes specialist midwife has a unique role in creating partnerships with women and helping to normalise the situation.

Key words

- Pregnancy
- Midwife
- Support
- Education

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Diabetes is recognised as the most common pre-existing medical condition to complicate pregnancy in the UK (Mitchell, 2000). It is predicted that the number of women with diabetes in the UK may increase by 48 % by 2023 (Newnham et al, 2002). In 1993, the St Vincent Joint Task Force produced a global recommendation proposing that within 5 years, women with diabetes should be able to anticipate an outcome to their pregnancy similar to women without diabetes. Despite these recommendations, women with diabetes continue to have a higher risk of adverse pregnancy outcomes (CEMACH, 2007).

In recent years, there has been a marked improvement in choice for women in maternity care. This has been achieved through the implementation of the recommendations of *Changing Childbirth* (DoH, 1993). Prior to this, childbirth had become medicalised as a result of the development of the National Health Service in 1948 that saw the emergence of centralised obstetric care and a shift of responsibility of care from midwives to obstetricians (Harcombe, 1999). This reduced the power and control by women over their own birth experiences (Levy, 1999). The ethos of *Changing Childbirth* focuses on equal partnerships and the empowering of clients (Harcombe, 1999). *Changing Childbirth* (1993) recommended that women should participate in the planning of their care and that they should have a right to choose of the type of maternity care received.

For women with diabetes, choice in maternity care is affected by the need for intensive monitoring to achieve a successful outcome to their pregnancy. Studies such as the DCCT (1996) have provided substantial evidence to

suggest that there is a direct correlation between blood glucose levels and the risk of complications. It is now clearly recommended that antenatal care should be provided in a specialist diabetes antenatal clinic by a specialist multidisciplinary team (Scottish Intercollegiate Guidelines Network, 1996; Clinical Resource Efficiency Support Team [CREST], 2001; CEMACH, 2007).

CREST also recommend a minimum of 18 hospital visits during the pregnancy for optimum control. The intensity of this recommended regimen highlights the importance of empowering the woman with diabetes to be participant in the management of her pregnancy. However, this issue also creates debate as to the possibility of achieving empowerment in such a medicalised environment.

Reflecting on the recommendations of *Changing Childbirth* (1993), it could be construed that women with diabetes are losing an element of choice and control as the option of attending their GP or community midwife is removed. Under this recommendation, the risk of adopting

a shared care philosophy involving GPs and other healthcare professionals would result in fragmentation of care. This could mean that the mother is not receiving an optimum standard of care (Hadden, 1999). Heller (2000) suggests that it is the strength of the relationship that develops between the mother and the DSN or midwife that is more important in ensuring successful outcomes than the principles of management during pregnancy. From the author's personal experience, the development of the role of the diabetes specialist midwife minimises the risk of fragmentation of care through close multidisciplinary liaison and partnership working, which will be discussed in more depth.

Empowerment philosophy recognises that the individual is the expert in their own life and that they have both the

right and the responsibility to make choices regarding their own health (Parkin, 2001). If individuals are given this freedom of choice, they are more likely to make and maintain behavioural change (Parkin, 2001). Identifying the professionals' role as experts in clinical aspects of diabetes, while recognising that the individual is an expert in their own life, may combine to provide an effective coalition to facilitate self care (Rubin, 1998). Alleviating the powerlessness often felt with chronic illness should be a crucial nursing role. If left unaddressed, physical and psychological detrimental effects such as anxiety, depression and hopelessness may develop. When one factors pregnancy into the equation, the duty to make a woman feel empowered may indeed be a very important one.

Pregnancy challenges

In early pregnancy, it is vital that glycaemic control is tightened as quickly as possible. The hormones of pregnancy affect the body's sensitivity to insulin, often causing hypoglycaemia in the first trimester (Mitchell, 2000). It can be a frightening experience for a woman with well-controlled diabetes to experience hypoglycaemic episodes while simultaneously being informed of a need to keep blood glucose levels generally lower than normal. The consequences of hypoglycaemia can impact significantly on her lifestyle in terms of her ability to drive or care for young children. These women must be given back control psychologically in order to adjust to the physical challenges pregnancy will bring. Sharpe (1999) suggests that people with diabetes often keep blood glucose levels

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1. Equipping women with knowledge and understanding of their condition and an understanding of why hypoglycaemia may occur in early pregnancy will help them to set realistic care goals.
2. Increased social support can reduce stress that may be causing a barrier to adherence to treatment and subsequently improve glycaemic control.
3. Taking a detailed assessment of each individual's personal aims and goals helps them to make informed choices regarding the management of their diabetes.
4. To create an empowering situation there must be a trusting relationship between the individuals concerned.
5. Healthcare professionals and women may be coming from two different goal perspectives as the professional may view success in terms of maternal and perinatal outcomes, while the woman may expect good outcomes in addition to a satisfying birth experience.

higher than normal as they fear loss of control, regardless of the cost to their health.

Empowerment through education

One key to helping achieve confidence must be through the provision of knowledge through education (Cavan, 2001). Equipping women with knowledge and understanding of their condition and an understanding of why hypoglycaemia may occur in early pregnancy will help them to set realistic care goals. This will then enable them to implement the behavioural changes needed to reach those goals (Anderson et al, 1991). It is suggested that intensive patient, family and midwife involvement in care can reduce the burden of high levels of medical intervention. Furthermore, increased social support can reduce stress that may be causing a barrier to adherence to treatment and subsequently improve glycaemic control (York et al, 1996).

Sharpe (1999) has suggested that healthcare professionals sometimes educate people with diabetes at inappropriate times, such as when physiological and emotional needs related to the condition have been met. In this state, education may never be effective. It would seem that in order to be effective, education must be individualised and active. Some of the key features of education should include a multi-faceted approach incorporating opportunities for individualisation and feedback using resources and skills to facilitate behavioural change (Parkin, 2001).

Rubin (1998) suggests that a people with diabetes' emotional and physical wellbeing is most enhanced through the use of problem-solving skills. He recommends that a number of strategies are undertaken, such as targeting the areas the individual finds most troublesome and dealing with them on an individual basis. Taking a detailed assessment of each individual's personal aims and goals helps them to make informed choices regarding the management of their diabetes (Parkin, 2001). Rubin goes on to recommend that people with diabetes can benefit from a multidisciplinary team approach as this allows them to be educated in all aspects of their care and helps to minimise some of the barriers to self-care.

Creating an empowering relationship

It is suggested that to create an empowering situation there must be a trusting relationship between the individuals concerned (Levy, 1999). It is important to remember that the literal meaning of midwife is 'with woman'; suggesting equal partnership (Robertson, 1997). The International Code of Ethics for Midwives (International Confederation of Midwives, 1999) dictates: 'Midwives work with women, supporting their right to participate actively in decisions about their care, and empowering women to speak for themselves on issues affecting the health of women and their families in their culture/society'.

The development of a specialist midwife role within the multidisciplinary team allows for a trusting relationship to build where the midwife is able to recognise both the anxieties and concerns that pregnancy presents, combined with specialist understanding of the challenges of diabetes.

Harcombe (1999) suggests that while midwives are keen to form equal partnerships with women as suggested in papers such as *Changing Childbirth*, they may also use this as an opportunity to enhance their own professional status and power in the face of medicalisation. This could represent a conflict of interests. Kopp (2001) proposes that power interplay may be complex owing to the fact that both sides are potentially powerful. From experience, while it is possible to identify how midwives may recognise the power of their position, there is a clear opportunity to use the role of both advocate and educator to help women to feel participant and active in their care, which, due to the need for intensive monitoring during pregnancy, provides a real opportunity for close liaisons and development of a rapport.

Access to the media and the amount of information now widely available has made women increasingly vocal in their views regarding childbirth. Healthcare professionals and women may be coming from two different goal perspectives as the professional may view success in terms of maternal and perinatal outcomes, while the woman may expect good outcomes in addition to a satisfying birth experience (Kopp, 2001). Paterson (2001) has suggested that practitioners adopt the language of empowerment

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1. The educator should not dominate the process of assisting the person to make decisions about pursuing care goals, but instead should facilitate the process.
2. When developing an empowerment approach to education, an important factor is ensuring that the information given is correct and consistent.
3. Despite talk of empowerment, in practice, professionals often resort to traditional medical models.
4. It is important to note that not all women will necessarily wish to take an empowering role.

while behaving in a way that implies professional dominance. The challenge for midwives must be to re-examine their power position and learn to work alongside women (Harcombe, 1999).

There is much written about how education should be carried out in an empowering way. Rubin (1998) suggests the need for a coalition of care that helps the client to assume a role that is initiating rather than defensive. He also suggests that educators need not necessarily solve problems, but should learn to listen, recognise and accept emotions expressed by the person with diabetes. The educator should not dominate the process of assisting the person to make decisions about pursuing care goals, but instead should facilitate the process (Anderson et al, 1991). A true aim of education is to provide the individual with knowledge to make informed choices in care. Hicks (1999) recommends that diabetes education should not exist on its own, but should be enveloped into a total management plan that will reflect on the totality of that person's life.

Primarily, when developing an empowerment approach to education, an important factor is ensuring that the information given is correct and consistent (Hicks, 1999). The basis of a successful consultation should include frequent follow up; reinforcement of information; longer sessions; and the provision of feedback – which gives an opportunity for individualisation (Parkin, 2001). This also underlines the client as the focus of control by recognising that 98% of diabetes care is carried out by the person with diabetes. Rubin (1999) suggests that people with diabetes are more likely to achieve and maintain goals if they see that their needs are the professionals' primary concern. In pregnancy, women visit the multidisciplinary team within the hospital on a fortnightly basis – this provides the diabetes specialist midwife with excellent opportunities to provide support and develop a clear pathway of individualised care.

Adherence versus empowerment

Anderson et al (1991) carried out a small study with diabetes educators comparing an adherence-based approach to diabetes education and an empowerment-based model similar to some of the strategies mentioned above. Adherence-

based care assumes that the professionals should be the primary decision makers owing to their expertise and that the person with diabetes will obey the treatment recommendations suggested. This type of care has almost no advantages to the individual who becomes a passive recipient to advice. The client may fear upsetting the healthcare professional and sustain little right to reply (Walker, 1998). Anderson and colleagues concluded that although educators agreed with the philosophies of the empowerment model, some of the behaviour changes that this approach required were difficult to achieve owing to ingrained behaviour.

A small, qualitative study was carried out by Paterson in 2001. In it, people with type 1 diabetes who were deemed experts at self care were interviewed. The results suggest that over time practitioners often discount experiential knowledge of their patients. Despite talk of empowerment, in practice, professionals often resort to traditional medical models. Rubin (1998) identifies that empowering people with diabetes may be frustrating for educators, particularly when an individual is refusing to follow advice. They must therefore learn to recognise the limits of their ability to effect change. This can be particularly challenging when caring for pregnant women with diabetes, owing to the potential impact on the fetus. There is currently recognition that the provision and uptake of preconception advice by healthcare professionals is poor (CEMACH, 2007), which highlights an important area for consideration to educate women in helping to care for themselves and motivate them towards potential behaviour change.

When considering adherence versus empowerment models of care, it is important to note that not all women will necessarily wish to take an empowering role. Harcombe (1999) suggests that some women prefer a paternalistic approach to care. Paterson's (2001) research identified that even when practitioners promote active participation in care, the outcome can be a 'deligitimisation of a patient's ability to participate as an active partner in decisions about care'.

Hicks (1999) suggests that the degree to which an individual participates in their care depends on the amount of confidence they have

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1. Tightening glycaemic control for pregnancy may represent substantial behaviour changes for some women and this may be a difficult barrier.
2. Successful education programmes need to be flexible enough to deal with the issues identified with the person with diabetes.
3. Research has identified that although women's glycaemic control can improve significantly during pregnancy, prolonged improvement in HbA_{1c} patterns are not sustained.
4. The provision of care ideally needs to commence before conception, through preconception care and advice that both diabetes specialist midwives and nurses should provide.
5. Enhancing a women with diabetes' self-esteem will help to promote self-care with the aim of achieving a successful outcome to the pregnancy for both the mother and the practitioner.

regarding their condition. When one considers the heightened stress and anxiety experienced by pregnant women, the concept that some women will prefer a paternalistic approach to care may be understandable. The challenge for midwives must be to help overcome this through support and open and transparent provision of information.

Tightening glycaemic control for pregnancy may represent substantial behaviour changes for some women and this may be a difficult barrier. Rubin (1998) suggests that empowerment could be achieved in small steps for those with poor control, as once they see evidence of success they may be more likely to take a more active role in self management. Successful education programmes need to be flexible enough to deal with the issues identified with the person with diabetes (Cavan, 2001). Research has identified that although women's glycaemic control can improve significantly during pregnancy, prolonged improvement in HbA_{1c} patterns are not sustained. This may be due to loss of contact with the diabetes team or discontinuation of frequent self monitoring of blood glucose (Feig et al, 2006).

The evolving changes in maternity care mean that the ideology of women's empowerment is becoming valued and accepted (Harcombe, 1999). There is definitely a more positive climate for change. Empowerment is still an evolving concept and evidence exists that practitioners still cling to professional dominance and will need to be taught how to enact empowering behaviours and practices (Paterson, 2001). Multidisciplinary team working and the development of trust between mother and midwife will aid transition and accelerate change.

Mitchell (2000) suggests that although the current care practices for diabetic pregnancy are highly medicalised, the midwife has a unique role in 'normalising' the experience for pregnant mothers. Education and management should not just be optimised during pregnancy, but should aim for long-term behaviour change. This is where the diabetes specialist midwife has a unique role to play. Possessing the skills of both an expert in pregnancy combined with specialist diabetes knowledge, she can become the ideal educator and partner in a woman's care. The provision of care ideally needs to commence before conception,

through preconception care and advice that both diabetes specialist midwives and nurses should provide – the challenge is finding a sustainable and approachable portal that will target women and encourage early behavioural change.

All maternity units providing specialist support to women with diabetes have the responsibility to develop the role of a diabetes specialist midwife who can ultimately become a key professional within the woman's journey through pregnancy: not only providing invaluable support to the mother-to-be, but also working in close liaison with DSNs to provide a seamless link between primary and tertiary care services. Enhancing a women with diabetes' self-esteem will help to promote self-care with the aim of achieving a successful outcome to the pregnancy for both the mother and the practitioner. ■

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