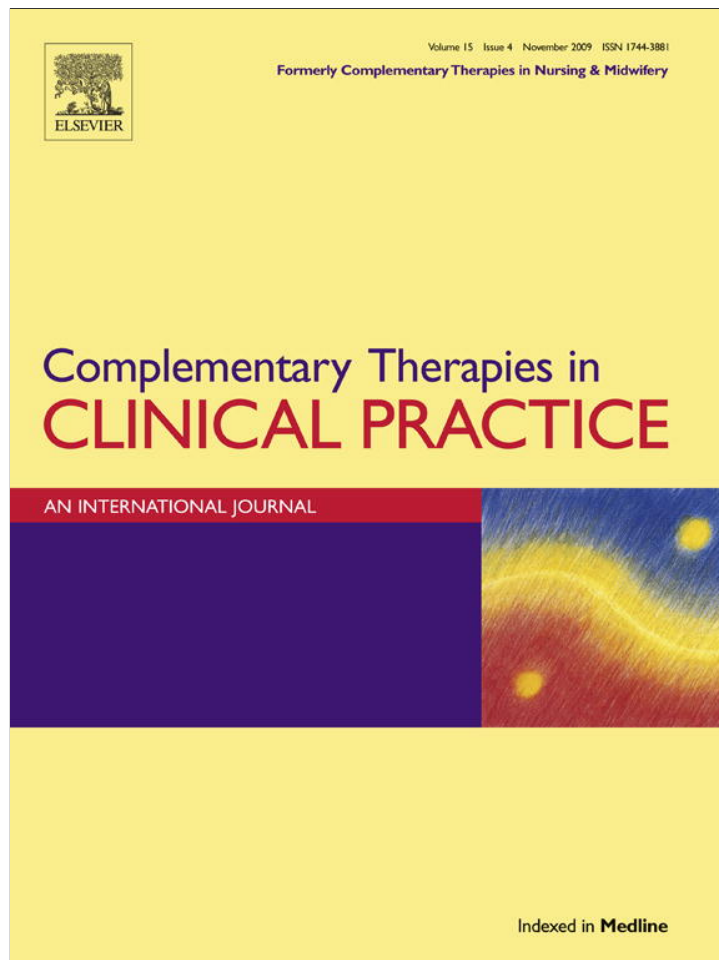


Provided for non-commercial research and education use.  
Not for reproduction, distribution or commercial use.



This article appeared in a journal published by Elsevier. The attached copy is furnished to the author for internal non-commercial research and education use, including for instruction at the authors institution and sharing with colleagues.

Other uses, including reproduction and distribution, or selling or licensing copies, or posting to personal, institutional or third party websites are prohibited.

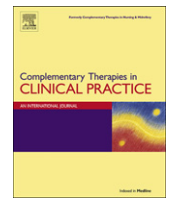
In most cases authors are permitted to post their version of the article (e.g. in Word or Tex form) to their personal website or institutional repository. Authors requiring further information regarding Elsevier's archiving and manuscript policies are encouraged to visit:

<http://www.elsevier.com/copyright>



Contents lists available at ScienceDirect

# Complementary Therapies in Clinical Practice

journal homepage: [www.elsevier.com/locate/ctnm](http://www.elsevier.com/locate/ctnm)

Guest Editorial

## Challenging current trends in maternity complementary therapies

I am delighted to have been invited to act as Guest Editor for this special edition on complementary therapies in maternity care. Having been involved in this specialist field for 25 years, I have seen many changes in attitudes towards the use of complementary therapies and natural remedies for pregnancy and childbirth, from outright scepticism and rejection in the early 1980s, to endorsement at a strategic level in the late 2000s. Since those early days, increasing numbers of midwives are using a range of complementary therapies in their practice and, in some areas, the use of aromatherapy, reflexology and acupuncture has become almost commonplace.

Indeed, the growing concern over escalating intervention rates, such as induction of labour and Caesarean sections, together with women's general dissatisfaction with the maternity services<sup>4,6</sup> has led to various initiatives attempting to promote the normality of childbirth and to combat the "medicalisation" which has been a feature for so long. The Royal College of Midwives' Campaign for Normal Birth promotes care which facilitates women's abilities to birth their babies naturally, and a Global Policy on normal birth has been devised.<sup>8</sup> The National Service Framework for maternity care advocates the inclusion of "non-pharmacological" choices for pain relief<sup>2</sup> and the Maternity Services Working Party suggests that strategies such as massage, aromatherapy and other natural therapies should be made available to childbearing women.<sup>3</sup>

Conversely, the growing trend for post-registration specialism within independent complementary therapy practice has resulted in the development of areas of practice with a specific clinical focus, including that of maternity care and women's health, particularly in response to recommendations in core educational curriculae that all students explore issues pertinent to reproductive health.<sup>7</sup> In addition, the increase in the popularity of doulas (lay birth supporters) has facilitated the establishment of a new role for those therapists wishing to specialize in treating pregnancy, labouring or newly-born mothers. It is, however, essential that practitioners have a thorough working knowledge of pregnancy and labour physiology and an appreciation of the conventional maternity services. In the UK it is illegal for anyone other than a midwife or doctor to take sole responsibility for a childbearing women, except in an emergency, but it is also fundamental to good practice that therapists are expert in their own therapy and can apply the principles of that therapy to the specific clinical field.

This increase in interest, use and practice of complementary therapies in maternity care presents us with new challenges. Expectant mothers have always wanted to explore the use of natural remedies and it is estimated that almost half of pregnant

women self-administer natural remedies such as herbal, homeopathic or Bach flower remedies and aromatherapy essential oils.<sup>5</sup> As more maternity units sanction the use of complementary therapies, more women will consider these options as the norm, perhaps viewing integration within the NHS as tacit approval for *all* therapies without recognizing the wide diversity of mechanisms of action, philosophical bases and, most particularly, the inherent precautions and contraindications of each individual therapy. This demands that professionals involved in using complementary therapies for pregnant and childbearing women – whether conventional midwives and obstetricians, or therapists specializing in treating maternity clients – work within the accepted parameters of their personal clinical practice, and that care is – as always – based on safety, professional accountability and evidence-based knowledge.

I was saddened recently to read that a midwife in Wales has been removed from the Nursing and Midwifery Council's (NMC) professional Register because of an error involving aromatherapy oils (Daily Mail 7.8.09, BBC website 7.8.09). Whilst there appear to be other issues which contributed to her being "struck off" (drug and record keeping errors), the public media focused on the matter of aromatherapy. Apparently, the midwife had been refused permission by her trust to use aromatherapy during her NHS midwifery practice, although she had a diploma in aromatherapy. However, she proceeded to blend oils for a labouring mother with a headache, then left the blend with her, ostensibly for the mother to massage into her scalp, but allegedly without giving any instructions. When the husband returned to the room he urged the mother to drink the blend, obviously believing it was medicine.

There are several issues of concern here. First, the possession, by any midwife (or nurse), of a qualification in aromatherapy (or any other complementary therapy) does not infer that the "diploma" is of an adequate calibre for *clinical* practice. There are, of course, many courses of good academic and professional standard but national recommendations for training curricula are just that – recommendations, rather than statutory requirements. Secondly, possessing a complementary therapy qualification does not automatically mean that a midwife (or nurse) is able to apply generic therapy principles to the specific demands of using that therapy in NHS employment and within an institutional setting. Many training courses cover pregnancy and childbirth only superficially and rarely explore the pertinent issues of using the therapy in a maternity unit. Thirdly, the midwife had, apparently, been refused permission to use aromatherapy in her practice, thus by doing so she was automatically invalidating her right to vicarious liability insurance cover

within the trust, and personal insurance with the Royal Colleges of Midwives and of Nursing extends only to those midwives who have appropriate training and the permission of their employing authority to use the therapy in their practice. In addition, one must question the quality of the essential oils this midwife was using, her manner of storing them whilst at work, her lack of instruction to the mother and whether or not she recorded the administration of oils in the mother's labour notes. I would also query the appropriateness of using aromatherapy oils for a headache in labour without considering any differential diagnosis.

However the implications of this case go far beyond the individual midwife and the unit in which she worked: it concerns *all* midwives, managers, supervisors and educators, as well as practitioners in other clinical fields, both in conventional and in complementary healthcare. In my work running accredited courses on maternity aromatherapy and other complementary therapies, I travel around the country and meet many enthusiastic and interested midwives who are keen to work within accepted parameters and criteria laid down by the various NMC regulations and guidelines. Unfortunately, I also hear many anecdotes which fill me with alarm. Although the practice of aromatherapy cannot normally be done covertly because the aromas can be noticed by colleagues, I have heard of many midwives who just quietly "tweak" reflexology points on the feet to accelerate contractions or expedite placental separation and others who use reiki with mothers in their care, without approval to do so, and in the absence of unit policies and guidelines. I have lost count of the numbers of midwives who presume to offer incomplete, inaccurate and sometimes dangerous advice on remedies such as raspberry leaf, homeopathic arnica and Bach flower Rescue remedy without adequate knowledge and employer permission. I also know of at least one UK maternity unit with an established intrapartum aromatherapy service where the aromas are so strong that staff, mothers and visitors are often affected by headaches and nausea, yet no one appears to have audited the aromatherapy practice of the midwives involved. More recently, I have had reports from midwives in three different units, in which the liberal use of clary sage oil may possibly have contributed to the development of fetal distress in labour, including one case in which the baby was stillborn, and I frequently have communications with mothers enquiring about using clary sage at home to "get themselves into labour" to avoid

induction. This is alarming given that those who are trying to establish aromatherapy within their midwife-led units often use clary sage very effectively for pain relief and to enhance contractions in labour, a fact which is borne out by research.<sup>1</sup>

I am not surprised about the events leading to the removal of the midwife from the NMC Register. We have, as yet, had no known legal cases involving complementary therapies but increased use and popularity could well lead to negligent practice in the not too distant future. Without further monitoring, education and managerial and supervisory audit it is merely an accident waiting to happen. I believe there remains a complacency amongst midwives (and nurses) about the safety of complementary therapies such as aromatherapy, reflexology and herbal remedies. These incidents emphasise the need to treat all complementary therapies with respect. If they have the potential for a positive therapeutic action when used correctly, they also have the power to cause harm if abused or misused.

## References

1. Burns EE, Blamey C, Ersser SJ, Barnetson L, Lloyd AJ. The use of aromatherapy in intrapartum midwifery practice: an observational study. *Complement Ther Nurs Midwifery* 2000;**6**(1):33–44.
2. Dept of Health. National Service Framework for children, young people and maternity services. Last viewed online 31.3.09 at, [www.maternityevidence.bham.ac.uk/docs/DH\\_MaternityNSF.pdf](http://www.maternityevidence.bham.ac.uk/docs/DH_MaternityNSF.pdf); 2004.
3. Dept of Health. *Maternity matters: choice, access and continuity of care in a safe service*. London: DoH; 2007.
4. Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. *Cochrane Database Syst Rev* 2007;(3). CD003766.
5. Holst L, Wright D, Haavik S, Nordeng H. The use and the user of herbal remedies during pregnancy. *J Altern Complement Med* 2009;**15**(7):787–92.
6. King's Fund. *Safe births everybody's business. An independent enquiry into the safety of maternity services in England*. London: King's Fund; 2008.
7. O'Hara C, editor. *Core curriculum for reflexology in the United Kingdom*. London: Douglas Barry Publications; 2006.
8. RCM 2008 Evidence-based guidelines for midwife-led care in labour.

Denise Tiran, MSc RM RGN ADM PGCEA, Director  
 Expectancy Ltd, The Beeches, 4 Beechwood Drive, Culverstone,  
 Meopham, Kent DA13 0TX, London, UK  
 E-mail address: [info@expectancy.co.uk](mailto:info@expectancy.co.uk),  
 URL address: <http://www.expectancy.co.uk>