



# Complementary therapies and the NMC

Midwives frequently meet mothers wishing to use complementary therapies (CTs) and natural remedies (NRs), but many answer queries without adequate knowledge. My concerns about CTs in pregnancy are extensively documented elsewhere, but the popularity of NRs highlights an urgent need to raise midwives' awareness of relevant accountability issues. This article offers a personal interpretation of sections from the Nursing & Midwifery Council (NMC) website of relevance to midwives, using raspberry leaf tea (RLT) to illustrate concepts related to professional accountability.

## Understand research

RLT is a popular over-the-counter herbal (ie, pharmacological) remedy thought to tone the myometrium in preparation for labour, although research is inconclusive (Parsons et al 1999, Simpson et al 2001). Studies reveal that the vasodilatory effects of some constituents may decrease contraction of tonic tissues (McFarlin et al 1999, Mullen et al 2002) which appears to be dose-dependent (Rojas-Vera et al 2002), possibly lengthening pregnancy, with potential adverse fetal effects (Johnson et al 2009). This uncertainty calls into question the ethics of advising expectant mothers to take RLT routinely (Holst et al 2009a).

The *Code of Standards, Performance and Ethics* (NMC 2008a) requires midwives to act as advocates for women wishing to use NRs, but is this at the expense of working "within the limits of (their) competence"? Many fail to apply the Code's principles adequately to NRs, despite the statement that the use of CTs must be "in the (clients') best interests". Numerous midwives fail to record their conversations about RLT with mothers, yet the Code requires "clear and accurate records of the discussions" they have. Furthermore, midwives are personally accountable for "actions and omissions", yet inadequate knowledge means they are unable to assess whether a mother's history precludes her from taking RLT. This is important because, although sceptical midwives may decline to offer information, all practitioners should be sufficiently well informed to identify contraindications and precautions.

## Conflicting advice

Midwives must "justify (their) decisions" based on "best available evidence or best practice", but conflicting findings from the minimal research on RLT further call into question their ability to advise women from an evidence-based perspective. Conversely, rationalising advice based on "best practice" suggests that midwives should acknowledge contemporary practice and defer to appropriately trained authorities.

## Taking responsibility

The *Standards for Medicines Management* (NMC 2008b) requirement to have "undertaken training and be competent to practise" CTs (standard 23) may not apply directly since the midwife does not administer RLT. However, standard 9 states that midwives "are responsible for the initial and continued assessment of (women) who are self-administering and have continuing responsibility for recognising and acting upon changes in (their) condition". Consequently, midwives must take responsibility for ensuring that women understand dosages of RLT, to avoid side-effects such as excessive Braxton Hicks contractions. Many midwives advise not starting RLT until 37 weeks' gestation, in a misplaced attempt to avoid preterm labour, yet fail to check if mothers with a

history of preterm labour are aware of the need to avoid it completely. However, the active constituents have an accumulative effect, so it is recommended that RLT is started at about 30-32 weeks' gestation.

The *Standards for Pre-registration Midwifery Education* (NMC 2009a) emphasise the need for all midwives to respond to "the changing nature and context of midwifery practice", to remain continually updated and to apply

contemporary evidence to support practice. The new *Essential Skills Cluster* on medicines management in the education *Standards* highlights the need for midwives to be "aware of the danger of giving advice on CTs when not qualified", specifically identifying "raspberry leaf and (other) over-the-counter herbal products". They are advised to refer to "a registered complementary therapist", but given the lack of comprehensive coverage of pregnancy within the majority of therapy training courses, this is not particularly helpful. Perhaps, too, the NMC does not go far enough in matching the need to "respond to the changing nature" of maternity care to the requirements for midwives to provide "accurate, evidence-based information" by incorporating subjects such as popular NRs into the curriculum for training.

## The NMC's role

The NMC cannot take responsibility for training and practice of CTs except when it relates to midwifery (and nursing). The NMC's advice sheet on *Complementary Alternative Therapies and Homeopathy* (NMC 2009b) reinforces the right of individuals to use NRs, requires midwives to "ensure that any .... herbal remedies are not contraindicated with ... prescribed medications ... and (to) advise (the woman) accordingly". However, despite the peculiar differentiation of "homeopathy" from "CTs" in the title of this advice sheet, it fails to differentiate between herbal and homeopathic medicines. Indeed, reference to potential interactions of homeopathy with prescribed medications indicates

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Failure to recognise the fact that complementary medicine is as much a specialism as ultrasound scanning or care of high-risk women poses possible risks for mothers and babies

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### ACTION MEDICAL RESEARCH TREK FOR TINY LIVES

A huge thank you to the people who have sponsored me for November's trek; I've still got a long way to go to reach my target of £2,750! If you can find the smallest amount to sponsor me at [www.action.org.uk/sponsor/laurayeatestrek2010](http://www.action.org.uk/sponsor/laurayeatestrek2010) you will be helping premature babies and their families cope with a life that poses challenges which midwives and health professionals understand so well. *Laura Yeates Managing Editor*

a complete lack of understanding of the mechanism of action of homeopathic medicines that do not potentiate nor inhibit pharmacological agents, unlike herbal remedies.

It is worrying that a statutory regulator of healthcare professions can make such a fundamental error – albeit in relation to a discipline outside its sphere of control. Furthermore, the current NMC requirements in relation to CTs do not take account of the fact that pregnant women are among the most common users (Holst 2009b) and that CTs and NRs have become an established component of contemporary approaches to pregnancy and childbirth. Failure to be more prescriptive regarding education and practice of midwives, and to recognise the fact that complementary medicine is as much a specialism within midwifery as ultrasound scanning or care of high-risk women, poses possible risks for mothers and babies. The NMC should, at the very least, consider re-wording of its advice sheet to reflect current practice, to rectify errors and misunderstandings and to emphasise more cogently the professional accountability issues at stake when midwives are working with women using CTs or NRs. While this article has considered RLT in relation to the NMC's documents, the same principles apply to all other therapies, including self-administered NRs and manual and other therapies that midwives may wish to incorporate into their practice. **TPM**

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