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Welcome to the ninth issue of Midwifery Research Review.

The economic costs of intrapartum care in east London were explored and reveal that freestanding birth centres are a safe and cost-effective option for women. Following on we investigate the experiences of women seeking a vaginal breech birth (VBB) and discover that generally women found the whole experience extremely challenging, as many of the clinicians they encountered were very unsupportive of their choice to have a planned VBB. Among the other studies included in this review, we investigate fetal movement during pregnancy and prenatal attachment, mothers and midwives perceptions of birthing position and perineal trauma, the emotional wellbeing of New Zealand midwives, and Australian attitudes to commercial surrogacy.

We hope you enjoy reading this review and look forward to your comments and feedback.

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The economic costs of intrapartum care in Tower Hamlets: A comparison between the cost of birth in a freestanding midwifery unit and hospital for women at low risk of obstetric complications

Authors: Schroeder L et al.

Summary: This study compared the economic costs of intrapartum maternity care in an inner city area for ‘low risk’ women opting to give birth in a freestanding midwifery unit (Barkantine Birth Centre; n = 167) compared with those who chose to birth in hospital (Royal London Hospital’s consultant-led obstetric unit; n = 166) between 2007 and 2010; both units were run by the former Barts and the London NHS Trust in Tower Hamlets, a deprived inner city borough in East London, England. Compared with women who planned their care in the hospital, those who planned their care at the birth centre experienced continuous intrapartum midwifery care, greater use of a birth pool, lower rates of epidural use, higher rates of spontaneous vaginal delivery, higher rates of established breastfeeding and a longer postnatal stay. The average cost for care per mother-baby dyad was approximately £850 per patient less for those who had started their care at the birth centre (total cost £1296.23) than for those who received all their care at the Royal London Hospital.

Comment (KB): UK policy set out in Maternity Matters over a decade ago reset the scene for women to re-enforce their choice about place of birth, be that at home, in a maternity unit, or in a hospital. However, regardless of such recommendations, evidence would seem to suggest in the main, a women’s choice around place of birth in the UK continues to be restricted. In response, the Birthplace in England Research Programme was commissioned. The results from this particular study, although conducted independently from the Birthplace study, complemented and collaborated with the Birthplace Programme. The overall findings supported similar outcomes as those found in the Birthplace study in that freestanding birth centres emerge as a safe and cost-effective option. For instance the average cost of per mother and baby dyad for care in the birth centre was approximately £850.00 less than a hospital stay. In addition, women who planned their birth at the birth centre experienced higher rates of spontaneous labour and birth, lower rates of epidurals, experienced less medical intervention and higher rates of established breastfeeding. However, there were identified socioeconomic differences between the two settings, for instance only 20% of women who booked for the Birth Centre were of South Asian ethnicity compared to 80% who booked for the hospital. 92.8% of women booked for the birth centre spoke English compared with 46.7% booked to give birth at the hospital, which could suggest that the two birth settings were providing care for two very different socioeconomic groups. This difference in socioeconomic groups may be due to the opportunity that currently permits women from outside Tower Hamlets (who may have a higher socio-economic status) to self-refer to the birth centre. Therefore, the challenge is not to continue to provide more evidence that birth centres can and do provide safe and effective midwifery care, but to think about how do we encourage women from lower socioeconomic groups to utilise birth centres. Midwives working within a primary care model providing care for all groups of women and utilising the community birth centre would widen the access for all women.

Reference: Midwifery 2017;45:28-35

Abstract
‘Stress, anger, fear and injustice’: An international qualitative survey of women’s experiences planning a vaginal breech birth

Authors: Petrovska K et al.

Summary: The experiences of women who sought a vaginal breech birth (VBB) were explored via an electronic survey distributed online via social media in order to increase understanding as to how to care for women seeking a VBB birth option. A total of 246 women from 17 countries answered qualitative and quantitative questions, with the qualitative data being the focus of this paper. Responses to the open-ended questions were categorized into seven themes: Seeking the chance to try for a VBB; Encountering coercion and fear; Putting the birth before the baby?; Dealing with emotional wounds; Searching for information questions were categorized into seven themes: Seeking the chance to try for a VBB; Encountering coercion and fear; Putting the birth before the baby?; Dealing with emotional wounds; Searching for information

Comment (KB): Despite clear evidence, that a VBB is a safe option for some women that choose to birth this way, VBB continues to be restricted with a caesarean birth being the promoted default position. This study using surveys distributed via social media sought to explore the experiences of some women who tried to navigate the system in their attempt to achieve a planned VBB. The findings identified seven main themes that described the women’s journey. In the main, women found the whole experience extremely challenging, as many of the clinicians they encountered where very unsupportive of their choice to have a planned VBB. Indeed, some of the women also faced disapproval from within their own social circles. The women no longer felt at the centre of their pregnancy—decisions about their mode of birth were being made over and around them led by the perception of risk that surrounds a VBB. This resulted in the women feeling stressed and anxious as they tried to circumnavigate the system. Whereas the women who reported a sense of autonomy through shared decision-making between themselves and the care provider reported feeling much more positive about their experience, regardless of the subsequent mode of birth. The results of this survey suggest that women want to be acknowledged and involved in the decisions around their own birth, they want shared decision making between themselves and their care provider, their views to be acknowledged and valued, and their preferences prioritised over the preferences of the system and clinician. Women will continue to choose a VBB over a caesarean birth. Therefore hospitals and maternity services need to move away from a system centred care approach towards a patient centred approach. A VBB should be considered as a valuable and legitimate option for birth for women and therefore hospitals have an obligation to ensure they have skilled practitioners who are able to provide support for any woman who elects to have a VBB.

Reference: Midwifery 2017;44:41-7

Abstract

Prenatal attachment and its association with foetal movement during pregnancy - A population based survey

Authors: Malm MC et al.

Summary: This Swedish study investigated the association between the magnitude of fetal movements and level of prenatal attachment within a 24-hour period among 456 low-risk pregnant women from 34 to 42 weeks gestation (296 multiparous and 157 primiparous) using a revised Prenatal Attachment Inventory (PAI-R) and assessment of the perception of fetal movements. Among 31% who completed the questionnaire, the majority (96%) felt their baby move mostly in the evening. While 55% stated that they perceived frequent fetal movement on two occasions during a 24-hour period, almost a fifth (18%) noticed frequent fetal movement during the whole period. Perceived frequent movement at least three times during a 24-hour period was reported by over a quarter (26%) of respondents and this was associated with higher scores of prenatal attachment in all the three subscales.

Comment (KB): This is a very interesting study from Sweden, which explored the relationship between fetal movements and prenatal attachment. Previous studies focusing on the relationship between fetal movements and prenatal attachment have been incongruous, with one study suggesting a woman’s awareness of fetal movements accelerated a woman’s psychological attachment to her unborn baby. Whilst another study revealed that counting fetal movements in the third semester did not motivate or increase prenatal attachment. Therefore this study is timely and necessary. A total of 426 women completed the questionnaire, which used PAI-R to measure from a woman’s perspective, the affectionate connection that develops between a woman and her unborn baby. Findings from the PAI-R survey highlighted that women who perceived frequent fetal movements on several occasions within a 24-hour period had significantly higher scores of attachment, therefore suggesting that women who experience several episodes of fetal movements develop a greater sense of attachment. It is suggested that the movements remind women of their baby’s existence and actuality. This group of women also scored a higher level of anticipation when compared to women who experienced fewer episodes of fetal movements. The findings from this study certainly highlight the role that a midwife can play when engaging with women during the antenatal period. For instance by asking women about the movements of her baby or listening to the fetal heart. Even the midwife describing to the woman what she/he is feeling when they perform an abdominal palpation may also aid the woman’s sense of connection and attachment with her baby. Another interesting finding from this particular study is that women over the age of 35 years scored a lower level of attachment, however, when seeking a possible explanation for this, it could simply be that older women are more likely to be a multipara and be influenced by external factors such as children, work as well as a busy home life leaving them with less time to focus or concentrate on fetal movements than perhaps a primipara.


Abstract

Mothers and midwives perceptions of birthing position and perineal trauma: An exploratory study

Authors: Diorgu FC et al.

Summary: The prevalence of different birthing position and episiotomy and the differences in perspectives of mothers who had vaginal birth/perineal injury and midwives who attended births that resulted in perineal injuries were explored in this study involving 110 mothers and 110 midwives at two hospitals in Nigeria. High rates of lithotomy position for birth were reported by both the mothers (65%) and the midwives (98%), but 57% of mothers perceived the lithotomy position as not being helpful for birth (in contrast 59% of midwives did consider it helpful). A high majority of mothers (90%) and midwives (85%) reported that they would be willing to use alternative positions. While the majority (73%) of mothers underwent an episiotomy, 69% reported that they did not give their consent for the procedure and 53% reported that they were not given local anaesthesia, 27% of midwives confirmed they performed an episiotomy without local anaesthesia.

Comment (KB): An exploratory study using a survey explored the differences between the mothers and midwives perspectives about birthing positions and perineal trauma. The results from this exploratory study from Port Harcourt, Nigeria, confirmed that the vast majority of women in the hospital gave birth in lithotomy, a position that in the main appeared to have been chosen by the midwife and not the woman herself. Indeed it would appear the women had very little influence in regards to adopting a birth position of their choice. Although aware of alternative birthing positions available to women, the majority of midwives placed women in the lithotomy position for birth without any discussion or instruction from the women. Overall, the vast majority of women felt too disempowered to request labouring or birthing in alternative positions, with only a minority of women using an upright position. Additionally, most of the mothers in this study had a routine episiotomy performed. Only 40% of the women reported that they were informed about the procedure or provided with an explanation why it was necessary to perform the procedure, thereby suggesting that maternal consent was not obtained prior to the procedure. Furthermore, 53.3% of mothers reported that local anaesthesia was not administered before an episiotomy was performed. The results from this study seem to suggest that the women were no more than passive and inactive participants in their labour and birth, with informed consent for any procedure viewed by the midwives as not necessary or required. One positive outcome from this study was the willingness of the midwives to embrace education, change their practice and to consider alternative birthing positions.
The emotional wellbeing of New Zealand midwives: Comparing responses for midwives in caseloading and shift work settings

Authors: Dixon L et al.

Summary: This online survey explored the emotional wellbeing of 1073 midwives in New Zealand, comparing demographic and work-related factors in midwives who were self-employed (n = 473), organisationally employed (n = 452) or both (n = 148), and exploring factors associated with burnout. Organisational employed midwives worked less hours (median 32 hours vs hours 40 and 36 hours) but had higher levels of work and personal-related burnout (Copenhagen Burnout Inventory) and anxiety (Depression, Anxiety and Stress Scale, DASS-21). Organisational employed midwives also had lower levels of autonomy, empowerment and professional recognition (Perceptions of Empowerment in Midwifery Scale; PEMS). Factors associated with burnout included inadequacy of resources, and lack of management support, professional recognition and development opportunities.

Comment (KB): There is a growing awareness internationally of the need to generate strategies to promote the emotional wellbeing of midwives. The New Zealand College of Midwives commissioned this ground-breaking research to generate understanding around the factors that contribute to the emotional wellbeing of the New Zealand midwifery workforce. Most readers will know that New Zealand is one of the few countries in the world where caseload midwifery is the norm for most women, so a strength of this paper is the sample size of midwives within each group, enabling comparison and robust statistical analysis across caseload, shift based working or a combination of the two. The results of this study add weight to the emerging evidence confirming that working in a continuity of care model is associated with less risk of burnout than working in a traditional shift based system. Furthermore, midwives working in continuity of care have better overall emotional health, a greater sense of empowerment and greater overall satisfaction with their work experience.

The results generated by this study have global significance and should be used by policy makers, educationalists, and maternity service providers to support the widespread implementation of caseload midwifery in line with the evidence, as the findings firmly refute the concern cited by service planners that working in caseload midwifery is associated with burnout. Despite the positive findings regarding factors that can reduce the overall risk of burnout, it is important to note the overall rates of stress, anxiety, depression and burnout across the total population of midwives, and strive to find ways to support all midwives and ensure they are able to enjoy optimal emotional health.

Reference: NZ College of Midwives Journal 2017;53:5-14

Abstract

The relationship between midwife-led group-based versus conventional antenatal care and mode of birth: a matched cohort study

Authors: Kearney L et al.

Summary: In this retrospective matched cohort study from Queensland, mode of birth (vaginal vs instrumental birth) was compared between pregnant women attending midwife-led group antenatal care (n = 110) and conventional individual antenatal care (n = 330). There was no difference in the number of caesarean births between care models; the largest increase in odds of caesarean birth was associated with previous caesarean birth (p < 0.001) and no previous birth (vs previous vaginal birth; p < 0.003). Breastfeeding rates and infant birth weight did not differ between groups.

Comment (MS): Using a retrospective matched cohort study this explored and compared the relationship between two different models of antenatal care and mode of birth. The models of care were (1) midwife-led group-based antenatal care and (2) conventional antenatal care. The primary outcome being measured was the proportion of caesarean births between the two different models. The Midwife led Group ’Expecting and Connecting Group Pregnancy Care Service (EGCPS) was a collaborative partnership between a regional health service and local university. Overall, the findings demonstrated that there was no difference between the two groups in relation to mode of birth, uptake and use of pain relief, birth weight or breastfeeding rates upon discharge. However, the highest risk factor for a repeat caesarean birth was found in the group receiving conventional antenatal care, demonstrating the need for a further research in this area as the current literature is mixed in regard to whether the mode of antenatal care has an effect on birth outcomes for women. Previous qualitative studies on group antenatal care have reported high maternal satisfaction, peer support and the value of shared experience associated with group antenatal care especially models that include continuity of care. We already know that throughout pregnancy, birth and postpartum, regardless of risk factors, continuity of care is the optimal model of care with a whole list of maternal and neonatal benefits including increased chance of a vaginal birth, a lower risk of instrumental birth, episiotomy or epidural. Therefore, this is the optimum model of care that all maternity services should be promoting and striving for.


Abstract

For love or money? Australian attitudes to financially compensated (commercial) surrogacy

Authors: Tremellen K and Everingham S et al.

Summary: An online survey of 500 Australians of reproductive age (18-49 years) elicited their views on gestational surrogacy and acceptable compensation levels in different social and medical scenarios. A majority supported surrogacy access for couples, irrespective of marital status or sexuality and only 9% believed surrogacy unjustifiable under any circumstances. Among those with views on compensated surrogacy, 58% believed the current ban was unjustified, while 62% also believed that Australians should be allowed to access overseas commercial surrogacy. Most believed that payment should be determined through negotiation between surrogate and commissioning parents, and supported additional payments for ‘hardship’ pregnancies. Half supported legalisation of professional surrogacy agencies, but 17% were totally opposed.

Comment (MS): I would urge midwives to read this paper carefully and use it to examine how our personal beliefs and attitudes may affect the way we view the world and subsequently provide care for women. There are many aspects of assisted reproduction that raise contentious debate and discussion and surrogacy is one of those topics that people may have polarised views on. This paper challenges current practices that deny access to commercial surrogacy in Australia and seeks to provide evidence to refute the current NHMRC ethical stance on the subject. It is interesting that the survey only sought the opinion of participants within an age bracket and group that may require the services of a surrogate as opposed to generating a wider population-based view on what is an ethical consideration for the whole of society to debate. Clearly we rely on the legislative processes to create an environment that respects choice but protects individuals from exploitation and harm. So I urge you to seek that balance when reading and considering the points raised in this paper. The most important thing to keep in mind is the discussion and debate is about the health and wellbeing of all women and babies. With that in mind, any formal discussions around the ethical principles governing the provision of assisted reproductive services should be transparent, inclusive and free from professional, personal or political influence.


Abstract
The Role of Sleep in Happy, Healthy Baby Development

Sleep has important cognitive, social, emotional and behavioral benefits

Sleep plays an important role in baby’s brain maturation, learning and memory, helping to retain existing memories and create new ones.1-4 Sleep also helps improve baby’s social, emotional and cognitive development.5-7 Babies who sleep better have been shown to be more approachable and adaptable.8 Improving babies sleep has been shown to improve maternal mood.

Sleep problems are universal

Sleep problems are common, especially in the first three years.7 Difficulty falling asleep and night wakings were found to be the most common sleep problems during infancy.7

There are a number of treatment strategies for bedtime behavior problems and night wakings in children, including behavioral management techniques, parent education, and medication. Studies have shown that use of behavioral (non-pharmacological) therapies for sleep problems are highly effective during infancy and toddlerhood.8

Routines help babies learn

The developing brain thrives on routines. Studies show daily routines in general lead to predictable and less stressful environments for young children and are related to greater parenting sense of competence and improved daytime behaviors.9,11

Why experts recommend a consistent before bed routine

The sleep-wake cycle is regulated by light and dark and these rhythms take time to develop, resulting in the irregular sleep schedules of newborns. The rhythms begin to develop at about six weeks, and by three to six months most infants have a regular sleep-wake cycle.10

Before bed routines help make sleep times and wake times different and distinguishable, supporting the child’s ability to self-regulate their sleep states.11 A consistent bedtime routine gives baby the opportunity to fall asleep in a relaxed, calm and secure state and get better sleep overall. The more frequent the routine, the better the sleep outcomes.12

Simple strategies to help parents at Bedtime

Recommended routines include a warm bath, a soothing massage, and quiet activities to wind down, such as a lullaby, or reading a book.13 In a clinical study, a 3-step bedtime routine was proven to help baby fall asleep faster and sleep longer.13

A routine that includes multisensorial stimulation through a warm bath followed by massage is a simple behavioral intervention for improved quality and quantity of sleep in babies.13 Better sleep outcomes are associated with a consistent bedtime routine. The earlier the routine is started the better.13

7. Mindell, Jodi A., et al. “Improved daytime behaviors associated with a consistent bedtime routine gives baby the opportunity to fall asleep in a relaxed, calm and secure state and get better sleep overall. The more frequent the routine, the better the sleep outcomes.” Sleep Medicine, 2015, 16:25-25.

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Australian midwives’ experiences of their workplace culture

Authors: Cottling CJ et al.

Summary: This study used a qualitative descriptive design examined the midwifery workplace culture from the perspective of urban, rural and regional-based midwives in Australia. New and experienced midwives felt frustrated by organisational environments and attitudes, and themes were identified: Bullying and resilience. Fatigued and powerless midwives. Being hampered by the environment, and The importance of support for midwifery. Detailed discussion focused on workplace culture and care models, and supportive relationships from peers and managers.

Comment (MS): We have increasing reports of the factors that inhibit midwife’s satisfaction at work, and workplace culture has a major influence as identified by this paper. I am certain that midwives across Australia and indeed globally will read this paper and say “yes – I understand – that’s my experience too”. For too long now we have read descriptions of midwives working within divisive unsupportive environments, where they struggle to provide holistic care, and face risk of consure and bullying for trying. Again and again we read of marginalisation – and singling out between groups of workers within the workplace where hierarchical shift occurs resulting in division and discord further increasing the experience of lack of trust, support and sense of value. It is not surprising then that we see such high reports of emotional and psychological distress within the midwifery population. It is encouraging though to see midwives’ enjoyment of midwifery still shining through. Where the environment enables midwives to provide holistic relational care and interact with women in an environment where they are valued, trusted and supported they thrive, but sadlly while midwives enjoy midwifery they often really dislike the institution where they undertake that work. If we want to see real growth towards the implementation of woman-centred evidence-based care then we clearly need to stop the rot inherent in many institutions and stop reporting on the toxicity and start working towards resolution. It’s time to start addressing this issue proactively. The solution is simple – we need to be nicer to each other. We need to be individually accountable for our omissions and recognise the need to step up and address poor behaviour. We need to recognise the potential of collective like-minded action, stop standing by and instead stand up together to address the balance and change the culture to one that we want to be part of.


Explores women’s preferences for the mode of delivery in twin gestations: Results of the twin birth study

Authors: Murray-Davis B et al.

Summary: This analysis of data from the international, multicentre randomised controlled Twin Birth Study aimed to understand participants’ perspectives on study participation and mode of delivery preferences. A questionnaire was completed 3 months after giving birth by 91% of trial participants, in which the majority indicate they would participate in a similar study again. The main benefits of participation were identified as benefits to one and one’s babies, altruism, and receiving quality care. Mode of delivery randomisation was challenged to participants because of a desire to be involved in decision-making. Survey findings related to childbirth experience indicated a preference for vaginal birth and those who had given birth vaginally were more satisfied with their birth experience.

Comment (MS): Within the current medicalised risk orientated focus on maternity care provision where women’s choices are often restricted, studies like this that provide robust evidence in relation to women’s preferences for birth are important. This paper reports on a postnatal survey conducted with participants of the Twin Birth Study and confirms the important with twins would prefer a vaginal birth. This is an important finding when considering supporting women holistically and enabling their choices to be self-generated based on empirical evidence. The findings of this paper are also useful to inform the practice of designing randomised controlled trials to examine issues that we still do not have gold standard evidence for. What this examination of women’s views 3 months after birth shows is that women were satisfied with their experience of being in the trial, and would do the same if offered the opportunity again. They felt supported by their caregivers and enjoyed the contact with researchers (as opposed to seeing that as an intrusion). These findings were consistent regardless of the actual method of birthing experienced by the woman. While these findings do indicate that women’s experience was positive – especially in terms of the satisfaction experienced with the research team, I would still urge caution to be adopted by those responsible for designing, approving and conducting clinical trials to ensure that the findings generated within this study associated with altruism and wanting to do good for others, dependence on others to make difficult decisions on their behalf, the satisfaction of having a plan and knowing the plan, do not become the major factors governing choice to participate. One of the factors that hinders the design of randomised controlled trials is the “unwillingness” to be randomised when women have a strong preference up front. The important factor here was the ability as cited by one participant to pull out at any time – up to the birth regardless of randomisation providing the much needed safety around validity of consent in this case. This should be core to any future trial designs to prevent inadvertent coercion and ensure valid consent is achieved.


Reference: Midwifery 2016;Sep 28 [Epub ahead of print]

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