A day in the life of...

A specialist perineal midwife

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OCCUPATION: Specialist perineal midwife
LIVES: London

This role was introduced in our hospital over three years ago. At the time, women with childbirth-related perineal problems were seen by the uro-gynaecology team. The aim of the new midwife-led, specialist service was to focus on the specific needs of these women and to offer them better continuity of care. The problems include obstetric anal sphincter injury (OASI), female genital mutilation (FGM), bladder and bowel incontinence, voiding dysfunction, perineal healing problems, history of perineal injury, dyspareunia and psychological problems related to perineal health or childbirth trauma. I work across the maternity and uro-gynaecology units; and teach and advise staff, as well as conduct research and audits.

A typical day

9.00 am My clinic runs at the same time as the uro-gynae clinic, so I can consult the doctors for a second opinion or prescription. Today, I see ten women – three of them are attending for routine follow-up after sustaining OASI. They ask questions about the injury and possible consequences. I enquire about any perineal – vaginal, bladder or bowel – symptoms, and perform a physical examination. Women often ask about sexual activity or enquire about contraception. I see them again in six months and one year postnatally. At a follow-up, I give women with OASI their results of endoanal investigations, so the safest mode of delivery in future pregnancies can be established.

Other patients today were a typical mix of those for postnatal follow-ups, and two pregnant women – one with a history of OASI and traumatic forceps delivery, terrified of the forthcoming birth; and a primip with type 3 FGM for whom I made an urgent referral for de-infibulation. There was a new patient eight months postnatal, unable to achieve full penetration during intercourse. The other new referral was for faecal incontinence at three months after forceps delivery. There was an add-on patient who has weekly check-ups for episiotomy dehiscence. We are waiting for the wound to heal, before deciding if she will need reconstructive surgery. Many of the women attending today need psychological reassurance and support. I wish the appointments were longer than the scheduled 15 to 20 minutes. I am also hoping to do the prescribers' course to become more self-sufficient and save time.

12.30 pm Administrative tasks, done over lunch. Recording letters to GPs about each patient seen in today's clinic. Processing referrals, checking answerphone, chasing results.

1.30 Visiting postnatal ward. Finding out from midwives if there are any women with continence problems, voiding difficulty or severe perineal trauma. I see and advise each of these women. Most of them will need referral to the perineal clinic. They are given information leaflets and my contact number, and are encouraged to contact me if they experience problems while awaiting their first visit to the clinic.

2.30 Learning to do perineal injections, which at present are done by the doctors. Women are referred, usually by me, for localised pain in the perineum and dyspareunia. Although very effective, the procedure is unpleasant. Once I learn how to do it, the continuity will be great, and women should find the experience less stressful.

3.30 Collecting and entering audit data. The uro-gynae team is research active, and we are planning to submit abstracts to conferences in the UK and abroad.

4.30 'Birth talk clinic'. Some women I see are traumatised about their birth experience and want to ask further questions and discuss their feelings. I offer these women an hour long appointment.

5.30 More paperwork – and home. A day in a life of a specialist perineal midwife is intense and exhausting, but I always leave with a sense of achievement and well-fulfilled duty.