Women in the driving seat: birth centre insights



Ruth Deery, Pat Jones and **Mari Phillips** present the results of a study suggesting that a social model of birth taking place within a local birth centre is one of the ways forward for midwifery

Birth centres seek to promote physiological childbirth by recognising, respecting and safeguarding normal birth processes. This philosophy enables women and their families to experience a positive start to parenthood (Kirkham 2003a). Midwives are also able to practise 'real midwifery' (Kirkham 2003b: 14). Indeed, when there is no risk to mother or baby, the mother should be the person who decides where her birth will take place (DoH 2004). A structured review of birth centres carried out by Walsh and Downe (2004) found that five studies reported benefits to women choosing to birth their babies in freestanding birth centres. There is also well-documented evidence that home births and midwife-led care are safe options for women (Tew 1998, Walsh 2000, van der Hulst et al 2004).

The local context

This article reports some of the findings from a small exploratory study commissioned by the Birth Centre Project Board. Funding was provided by the Centre for Health and Social Care at the University of Huddersfield; the overall aim was to evaluate the implementation of a new stand-alone birth centre. Maternity services in the Trust in which the research was undertaken provide for a socially, culturally and ethnically diverse community, and support 3,600 births per year.

Following reconfiguration in February 2002, including the relocation of hospital maternity services, the Trust decided to implement some of the Department of Health's Action Plan (DoH 2000) and open a stand-alone birth centre in the city centre. This was widely seen by midwives and members of the public as a poor substitute for the obstetric unit that was being merged with another maternity unit some nine miles away (Shallow 2003). The challenges experienced by the midwife seconded to help set up this birth-centre facility are reported elsewhere (Shallow 2003). Disappointingly, the majority of these difficulties have persisted, and there continues to be some resistance to this social model of birth. Further funded research to explore the underlying reasons behind these difficulties is about to begin.

Methods

This was a small qualitative pilot study that was undertaken in three consecutive phases over a period of one year (September 2002-2003). Focus groups with midwives were undertaken in November 2002 and May/June 2003. Due to the limited numbers of midwives (n=9) working in the birth centre, all were invited to participate in the study. All women who had used the birth centre were offered the opportunity to participate, and 15 women were recruited to the study. These women took part in an individual interview during January-June 2003. Exclusion criteria in both cases (midwives and women) were declining to participate; and also, in the case of the midwives, if a midwife was no longer working in the birth centre. These criteria were also approved by the local NHS Research Ethics Committee.

Phase one

Focus groups were conducted with the midwives approximately two months after the opening of the birth centre. The researchers hoped this would create a safe environment in which the midwives could share their ideas and views. Indeed, the synergy that the focus groups brought to this research was particularly useful as it provided an opportunity for the midwives to talk freely about their thoughts and ideas and resulted in a range of different opinions being expressed.

There are reported benefits to women choosing to birth their babies in freestanding birth centres. There is also well-documented evidence that home births and midwife-led care are safe options for women

This is supported by Morgan and Krueger (1993) who point out that having the security of being among others who share many of the same feelings and experiences provides research participants with a secure base from which they can share their views. The midwives were asked their opinions about the birth centre, skill development, what they were hoping to achieve and the impact their achievements might have on care provision.

Phase two

During phase two, individual interviews were undertaken with 15 women who had used the birth centre. These interviews were undertaken in the women's homes and at their convenience. Women were initially approached by the midwives from the birth centre who provided them with an information leaflet from the researchers. The women were asked to complete a tear-off slip on the information sheet (with their name, address, contact number and baby's date of birth) if they wished to be involved in the research. This slip was then posted, by the women, to the researchers in a pre-paid envelope. The researchers were then able to contact the women to provide more information, and to determine whether they still wished to participate in the study. Informed consent was obtained from the women prior to the interviews. They were asked about their initial decision to use the birth centre, their overall impression of the service and the process of care-giving within the birth centre. ►

Phase three

A second round of focus groups was conducted with the midwives, approximately nine months later, to help determine whether their views had shifted over time. They were asked whether working in the birth centre had met their expectations, whether their practice had changed, what future developments they would like to see, whether they had come across any unforeseen obstacles while working there, and how they saw the birth centre impacting on care provision in the area.

Since the first round of focus groups there had been some movement of the midwives working in the birth centre, with a newly appointed midwife taking up post shortly before the second round. This midwife did take part in a focus group. Also, the senior midwife co-ordinator at the birth centre resigned three months after the centre opened.

Ethical issues

Ethical advice was sought through the School Research Ethics Panel at the university, and ethical approval was granted by the local NHS Research Ethics Committee and the Trust's Research and Development Department. Confidentiality and anonymity were identified as important factors by the researchers, and permission to publish anonymised data was obtained from the participants. The midwives and women were guaranteed anonymity in that no one would be able to trace information back to them individually.

A thematic content analysis approach was used in data analysis (Burnard 1991) where emergent themes were coded and then clustered into categories and sub-categories until all the data were exhausted.

Findings

A summary of some of the key findings is presented below. These represent some of the dominant themes that emerged from talking with midwives and women about the birth centre.

Women

Satisfaction levels

The women who birthed their babies in the birth centre were satisfied with the continuity of care that a social model of childbirth brought. The booking criteria at the time meant that participating women had to have given birth at least once before. This meant that the participants were able to compare birthing experiences. The women's words suggested that higher levels of satisfaction in relation to their well-being and confidence were experienced. Also, their accounts suggest that individual needs were met during care-giving in the birth centre:

> *I could do whatever I wanted…*
>
> (Mother, 29.04.03)

The environment was described as relaxing and comfortable, and relationships with midwives were experienced as non-hierarchical:

> *It's more relaxed; it seemed to be more relaxed than in hospital where they're all running round and you see so many people at once…*
>
> (Mother, 29.04.03)

Two recent surveys conducted by the National Childbirth Trust (NCT 2004) found that 75 per cent of women would consider giving birth in a birth centre and that they would give preference to these centres rather than hospital settings. The women's words above accord with an overall sense within the maternity services that midwives and women want to participate in a range of services, especially those that are midwife-led (Davies 2004: 143-156, Hundley et al 1995, Kirkham 2003a).

Relationships: continuity and trust

Phase two revealed that the social model of care within the birth centre, rather than continuity of carer, was more important for the women. Their accounts reflected the positive aspects of being able to progress in labour at their own pace without intervention and being able to exert choice and control at all stages of their childbearing experience:

> *…we were able to discuss it [labour] at length with the midwives…*
>
> (Mother, 28.04.03)

Increased social support during labour has been shown to be effective in reducing maternal anxiety (McCourt et al 1998). The women participating in the study stated that being able to include family members and close friends in the birthing experience was beneficial to them during labour:

> *…it was just 'do whatever you want' and you can have as many people here and bring your mum… he [woman's partner] stayed overnight… I thought it was the nicest thing. You're very emotional afterwards and you need somebody there with you that you know.*
>
> (Mother, 29.04.03)

Individualised and family-centred maternity care, with an emphasis on skilled, sensitive and respectful midwifery care, are therefore important for women. This approach provides a relaxed and informal environment in which women are encouraged to labour at their own pace. This is in contrast to the constraining and unfriendly atmosphere that some women have described in hospital settings (Wilkins 2000: 28-54). Promoting physiological childbirth by recognising, respecting and safeguarding normal birth processes enables women and their families to experience a positive start to parenthood (Kirkham 2003a).

A cultural shift in the maternity services

Prior to this research being undertaken, the participating women had located previous birthing experiences within a medical model of childbirth where birth was only deemed normal in retrospect:

> *When you're in hospital, they seem to take everything out of your hands… there's no discussion on what you want…*
>
> (Mother, 28.04.03)

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They were also unaware that they could give birth in a different environment:

...I just felt a lot happier. I was really excited... I think it's the completely different environment. I actually enjoyed my labour... last time it was so horrible.

(Mother, 29.4.03)

The birth centre provided a different context in which to experience birth, enabling the women to dispel previous negative experiences of childbirth:

I was so calm, and I was just back to my normal self... I was such an emotional wreck last time, and I didn't feel myself at all.

(Mother, 29.04.03)

...I wanted to do it differently and I wanted to do it properly on my terms and what I wanted rather than what the medical staff wanted.

(Mother, 28.04.03)

Furthermore, they expressed a desire to encourage other women to use the birth centre, and were readily passing information to friends and family about the new service. This is an important finding because Kirkham (2003a) has pointed out that women who use birth centres are usually a special group who know what they want and are self-confident:

We've been made to feel so special... it's such a fantastic place... I'd certainly recommend it [birth centre] to anybody.

(Mother, 03.06.03)

The women's words suggest a growing confidence around birth, indicating that the birth centre was becoming an accepted and integrated part of the community.

Midwives

The midwives participating in this research came from a variety of midwifery backgrounds and had different types of experience. Each had worked on a labour ward in a hospital setting.

Becoming a 'good midwife again'

Being a 'good' midwife was seen by the midwives as being able to practise 'normal' midwifery, using their midwifery skills without medical interventions or the use of technology:

...we choose to really use the skills that a lot of midwives have lost.

(Focus group (FG), 26.06.03)

...we trust their [the women's] bodies and we instil that trust in them.

(FG, 29.05.03)

The midwives reported that they had become more critical in their approach to midwifery, and that their skills were developing further. Previous midwifery practices that did not always reflect the needs of women and their families were beginning to be questioned:

...we're not jumping in there and rupturing their membranes at 3cm or 'whapping' drips up.

(FG, 29.05.03)

Autonomy: 'owning' the birth centre

The midwives reported increased confidence in their own abilities, stating that where they would have once turned to the obstetrician or a 'machine' for reassurance, they were now able to assess the situation, discussing and planning care with their peers and the women:

yeah...they're [women] in the driving seat.

(FG, 26.11.02)

They described being able to 'break free' of previous working practices that restricted a woman-centred approach (DoH 1993):

I've never worked anywhere where I've just been able to give one person my undivided attention...where I worked before you'd have six or seven women...

(FG, 26.11.02)

The midwives' words suggested that a flexible, open-door service was the way forward:

...that's the other thing about being open 24 hours...they don't just have to come nine to five...we've got an open-door, drop-in type policy.

(Midwife, 25.01.02)

The midwives reported that they were able to engage with their peers in a non-threatening, non-hierarchical manner and that they never felt undermined. They also reported a sense of less scrutiny over their individual practice. The midwives were determined to work within a birth centre philosophy demonstrating ownership.

The promotion of physiological childbirth through recognising, respecting and safeguarding normal birth processes enables women and their families to experience a positive start to parenthood

'Working in a goldfish bowl'

However, the midwives reported an increased awareness that their birth centre was being scrutinised, and they reported feeling under increased pressure to 'prove' the birth centre's success:

I felt we were on show.

(FG, 26.11.02)

There will always be sort of Big Brother looking down on what we do and why we do it.

(FG, 26.06.03)

You're working in a goldfish bowl and everything you do will be scrutinised...every single thing...

(FG, 26.11.02)

The midwives reported feeling angry that, despite their efforts, the birth centre had received little in the way of promotion within the community and that there had not been a celebration of its opening:

...we didn't know what day we were opening.

(FG, 26.11.02)

They also reported constantly hearing rumours that the birth centre was going to close:

...especially when the rumours were not denied...we just felt undervalued...

(FG, 29.05.03) ►

They expressed a sense of continuous 'doom', and this had an impact on staff morale. Recognition of the work that was done in the birth centre was reported to be crucial if it was to continue succeeding. The midwives also articulated a need for more effective support:

> *...we don't feel that we have had adequate support from Board level...*
>
> (FG, 29.05.03)

Discussion

There is a clear message emerging from this evaluative study that a social model of birth taking place within a locally situated birth centre is one of the ways forward for midwifery. The implications of different ways of working need to be considered at the appropriate levels within the Trust, by midwifery management and by individual midwives. The appropriateness of the birth centre for realising the priorities for maternity care established in government policies has been clearly expressed by the participating women and midwives in this evaluation, especially the need for a flexible, open-door service.

Effective support has been shown to improve the childbearing experience for women and midwives (McCourt et al 1998, Flint et al 1989, Mander 2001). The women who participated in this study expressed a need for support from family and friends as well as midwives. There is a need for maternity services to offer a flexible, family-centred birthing experience for women. The participating midwives also expressed a need for mutual support from their peers but especially from all managers within the Trust. Effective support mechanisms that facilitate reflection and the growth of interpersonal skills need to be explored for use with midwives (Deery 2003, 2005). There is also a need for research that explores future education provision for midwives.

The culture and organisation of midwifery is a constant thread running through this research. Practising autonomously and having more control over their work enhanced job satisfaction for the participating midwives. They appreciated being able to use their midwifery skills as well as being able to exercise their decision-making responsibilities. Conflicting ideologies (Hunter 2002, 2004) or clashing personal philosophies (Deery 2003, 2005) about midwifery were found to be unhelpful in a birth-centre setting and detrimental to working relationships. Therefore, like-minded midwives need to be grouped together in order to facilitate successful working relationships that will help to enhance the birth experience for women and their families. Further research within the birth centre will address individual and collective working and clinical practices and how the midwives have organised care.

Limitations of the study

On reflection, the feasibility of focus groups with such a small sample could be questioned; the researchers would use individual interviews in the future. Shift patterns, days off and annual leave meant that it was never possible to get a large enough group of midwives together. There were also some difficulties encountered in recruiting women, in that the researchers relied on the women returning the tear-off slips from their invitations to participate. However, being busy coping with a new baby could have meant that the women forgot to return the slips.

In conclusion, there is now well-documented evidence that home births, birth centres and midwife-led care are safe options for women (Kirkham 2003a, Walsh and Downe 2004). Care in a birth-centre setting can empower women (Walsh 2000), and clinical outcomes could be improved. Research has also shown the clinical and cost-effectiveness of a midwifery model of care (Walsh and Downe 2004). In addition, midwives are able to practise 'real midwifery' in this setting, giving them increased job satisfaction. However, birth-centre philosophy is different from medical philosophy, and the perception of threat is ever present for doctors and midwives (Kirkham 2003a) and for managers (Shallow 2003). It is therefore important that further research is undertaken to address this situation. **TPM**

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