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Where's the midwifery in midwife-led care?

What makes midwife-led care different? How do you know if you are doing it?

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THE PURPOSE OF THIS ARTICLE is to share some of our insights and thoughts about midwife-led care (MLC) which have arisen whilst engaged in an action research project recently.

As a result of a new hospital being built locally where all current in-patient services would be centralised, many concerns were expressed over the future of the midwife-led unit (Deery et al, 1999). This was accommodated in separate facilities to the obstetric-led unit and enjoyed a good reputation and increasing use by local women and midwives. Part of the reconfiguration of services locally meant that this unit would, from 2001, share the same geographical location with the obstetric-led unit.

Following the expression of various concerns about this, we are in the process of undertaking an action research project with a local NHS Trust looking at MLC and ways to develop this further when the midwife-led unit (MLU) moved into shared facilities with the obstetric-led unit in 2001. When we started out on this research project, we assumed that we knew what MLC was and that it clearly differed from obstetric-led care in its nature.

Initially we thought that issues the project would examine were:

- The current autonomy of the midwives giving MLC and what happens to that autonomy in an altered environment
- The territorial demarcations and power relationships that exist within midwifery and how these impact on MLC
- Whether and how technology infiltrates MLC
- How and why midwives act in the way they do when giving (or sabotaging) MLC.

However, not long after starting the project we began to realise that many of our assumptions were inaccurate.

Some limitations of the literature

Whilst our literature search is ongoing, the considerable amount we have already collected and read begins to indicate some of the problems we have encountered in our own project. There are many papers which describe policies and protocols, booking and exclusion criteria for various MLUs (Walsh, 1995; Campbell et al, 1999; Jones, 1997). There is also a considerable amount of audit or quantitative research looking at outcomes in terms of neonatal and maternal morbidity and satisfaction (Campbell et al, 1999; Shields et al, 1998; Young et al, 1997). There is, however, a complete dearth of articles describing how these two are linked. In other words, it is difficult to find any work describing the processes (what midwives actually do in MLC) that connects the structural characteristics with the outcome data. The papers we have read present the outcome data (e.g. Apgar scores, vaginal birth rates, episiotomy rates) as though it is solely linked to the booking criteria and transfer policies in place, rather than to the care actually received (Woodcock & Baston, 1996; Tucker et al, 1996; Law & Lamb, 1999).

Recognising the lack of definition of midwife-led care, Walsh and Crompton (1997) discuss the operational variations that exist and call for a more standard operational definition of MLC. Whilst they are primarily concerned with structural issues (e.g. booking criteria lists), the lack of a clear definition of midwife-led care also applies to process issues like communication and support practices (Walsh & Crompton, 1997).

The invisibility of the processes of midwife-led care

There is little or no idea from the literature of what MLC actually consists of or how it qualitatively differs from midwifery care given under the auspices of an obstetric-led unit. If the success of midwife-led care is solely to do with structural issues (e.g. booking criteria and policies), it suggests that midwife-led care is mainly concerned with the interpretation and implementation of these rather than the interpersonal qualities and skills the midwife herself may contribute to the process of care. The essence of mid-

wifery seems to be missing from most published work on MLC, together with any insights as to how midwifery care itself can facilitate positive outcomes.

There is a little descriptive work, which begins to touch on what midwife-led care consists of and how that care may actually contribute to the various differences in outcome independently to the booking criteria/transfer policies in force in any MLU. Walsh (1995) in outlining the Wistow midwifery project, attempts to articulate some of the factors essential to MLC. These are, he considers, a personal relationship between midwife and woman and continuity of carer. It is also possible to deduce from some of the quantitative studies certain elements of MLC, such as greater continuity of advice and continuity of carer for women having MLC (Turnbull et al, 1999). Campbell and Macfarlane (undated) report that women giving birth in the MLU they studied had a higher incidence of intact perineums than women in the obstetric-led unit. However, there is no comment on the midwifery care or actions that may have contributed to their intact perineums. In a rare qualitative study on the experience of labour of women having MLC, Walker et al (1995) describe constant support during labour, midwifery confidence, help with breathing and relaxation, lack of intrusiveness, respect for individual autonomy, feeling informed, being given choices and being able to make decisions, being given a feeling of personal control, friendliness, and a relaxed atmosphere as central to MLC. Whilst we are still unclear as to the processes of midwifery care whereby these were achieved (e.g. how the midwives created a relaxed atmosphere, how they helped the women retain personal control), they nonetheless begin to point us to the midwifery skills and qualities that may underpin MLC.

Walker (1996) also includes some descriptions of the nature of midwifery care in the MLC she studied. She reported midwives enabled women to make their own decisions, were unobtrusive yet always available, were continuously present when wanted, involved women's partners and left couples alone with their babies after birth. Again, we do not know how midwives involved women's partners nor how they facilitated

MLC appeared weak because there was no consistent or coherent ideology differentiating it from the midwifery care offered on the obstetric-led unit



women's decision making. We need to identify these skills and we need to be able to develop and propagate them if MLC is to expand successfully.

Shields et al (1997) looked at the impact of MLC on psycho-social outcomes postnatally. Women who had MLC felt prepared for parenthood, had better support and advice regarding infant feeding and had less postnatal depression. Given that this was a randomised controlled trial it must be concluded that it was what the midwives giving MLC actually did that was different to what their colleagues working under obstetric led care did, that made the difference. What that was is not stated (Shields et al, 1997). If the successes of MLC are to do with altered patterns in midwifery behaviour, skill development and ethos, then these need to be taken into account when setting up MLUs. The only preparation that midwives received prior to the setting up of one MLU was a talk by a consultant anaesthetist on intravenous cannulation and another by a consultant paediatrician on neonatal resuscitation and intubation (Atkins, 1997). This unfortunately reinforces the notion that the only valuable and effective midwifery skills relate to their mastering (sic) of medical technologies.

Putting the midwifery back into midwife-led care

This takes us back to the MLC project that we are currently engaged in. We undertook some observational data collection to identify what the threats were to MLC in accordance with the aims listed above. However, what emerged from these observation episodes was that threats to MLC were less external (e.g. the imperialism of doctors, the infiltration of technology) than we had assumed. MLC appeared weak because there was no consistent or coherent ideology or sets of practices differentiating it from the mid-

wifery care offered on the obstetric-led unit. MLC was defined by its booking criteria, its geographical location, the midwives carrying it out and an absence of certain technologies, namely epidurals, intravenous infusions and cardiotocograph machines. Outside of this list we could observe very little that made MLC qualitatively different from midwifery care in an obstetric unit. The rooms in and the policies governing the MLU were the same as in the obstetric unit.

In our opinion MLC should be grounded in an ideology of normal physiological childbirth and skills, attitudes, education and facilities should all centre on this. We would be very interested to hear whether other midwives feel that there must be an essential quality that defines MLC as different to obstetric-led care, and what the nature of that quality might be. We would like to see the skills described more fully so that these can be passed on. If you are a midwife working on MLU we would really like to know how your practice is different from when you worked on an obstetric unit.

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