An exploration of midwives’ views of the current system of maternity care in England

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Summary

Objective: to explore, in-depth, the views of midwives working in maternity services about birth setting, models of care and philosophy of care.

Design: an Appreciative Inquiry approach was adopted utilising focus group interviews as the method of data collection.

Setting: 15 focus group interviews were conducted at 14 sites in England.

Participants: a purposive sample of 120 midwives and six student midwives who were serving women in different birth settings (home, free-standing maternity units, midwife-led units, and traditional obstetric units) participated, in 2001/2002.

Findings: the main themes generated by the midwives were: cultural changes; midwifery leadership; appropriate role models; training in normality; appropriate responsibility of care divisions; choice for women; equity of care provision between women considered to be at high or low risk; and staff morale.

Key conclusions and implications for practice: this study highlighted the consistency of views amongst midwives working in different settings. Midwives wanted support to practice autonomously in an environment that facilitated equity of care for women and job satisfaction for midwives. Suggestions were put forward by midwives on how to improve maternity services. A unified approach is required to develop these suggestions into strategies, that will remove the identified barriers and promote normality.

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Introduction

Midwives play a major role in providing high-quality maternity services to mothers and their babies, despite having been subjected to many changes in working patterns over the last decade. The retention and recruitment of motivated midwives is essential to maintain and improve care and to fulfil the vision of a modernised health service as outlined by the UK Government (\textit{Department of Health, 1999, 2000}). Midwife shortages are significantly linked to higher intervention rates (\textit{Thomas and Paranjothy, 2001}) and as such can

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have an impact on the care of individual women as well as the organisation as a whole. It is therefore imperative and timely to investigate what is important to midwives. However, there is only limited and methodologically variable research into what is important to midwives in their work. Much of the current literature (Hundley et al., 1995; Turnbull et al., 1995; Sandall et al., 2001; Stevens and McCourt, 2001) has focused upon one particular model of maternity care or compared specific models. These studies have failed to provide an overview of the diversity and commonality of views across the UK.

A number of different midwifery models of care were initiated, and subsequently evaluated, following the recommendations of the Government report Changing Childbirth (Department of Health, 1993). Some of the new schemes advocated require varying degrees of flexibility from midwives, but flexible and longer working hours are associated with greater emotional exhaustion (Sandall, 1998). Yet autonomy and higher levels of responsibility are associated with lower levels of emotional exhaustion. Sandall (1998) also showed that continuity of care and the opportunity to build relationships with women was as important to midwives as it was to their clients.

Earlier work which explored 220 midwives’ views when evaluating three different patterns of care (Garcia, 1997), found several advantages of working in teams, particularly in terms of utilising existing midwifery skills, professional development and general job satisfaction. Furthermore, team midwives were more likely to say that they had autonomy in decision making than non-team midwives did. However, disadvantages were expressed as the inability to gain new skills and working in isolation. Team midwives were also more likely to say that their post affected the care of their dependents and their social life.

UK midwives have gone through many role changes over the last decade, yet it appears that they remain receptive to change if it means providing a consistent seamless service (Lavender et al., 2002). They are concerned, however that their fundamental role of supporting women through pregnancy and childbirth, is sometimes devalued. A regional survey exploring midwives’ views of redefining midwifery (Lavender et al., 2001, 2002) suggested that midwives are beginning to acknowledge a dichotomy of midwifery roles of equal status. Midwives suggested the need to value midwives at each end of the childbirth continuum. Therefore, midwives who wish to support women with a straightforward pregnancy and childbirth should be given the same status as those who care for women with childbirth complications.

Previous research in this area has been limited in that it has concentrated on the views of midwives working in a specific geographical area and within a particular model of care. This current research explores, in depth, the views of midwives working in different birth settings, models and philosophies of care. This work is part of a programme of work commissioned by the Department of Health, which comprised site visits and an exploration of women’s views, the results of which have been fed directly into the Children’s National Service Framework (NSF). This Framework for England, which is due to be published by the Department of Health in 2004, will provide new national standards across the National Health Service and Social Services for Children. The framework will consist of seven modules, of which maternity is one (Department of Health, 2003).

Methods

Perspective

An appreciative inquiry, as opposed to a problem-solving approach, was adopted. This was believed necessary in preventing individual midwives from feeling vulnerable. Appreciative inquiry (Cooperrider and Srivastva, 1987) is an Organisation Development process, which grows out of social constructionist thought and has been applied in multiple settings. The purpose of Appreciative Inquiry is to encourage individuals to consider the strengths of their organisation and suggest innovative ways to strive for improvements (Mantel and Ludema, 2000). Appreciative Inquiry differs from other approaches in that it recognises the power of positive language (Astley, 1985; Gergen, 1994) and purposefully uses conversation to discover what gives ‘life’ to a system when it is at its best—socially, economically and environmentally. The intention, therefore, is to create an upward, as opposed to downward spiral. The potential impact of such an approach can be illustrated through the work of World Vision, a private volunteer organisation working in over 100 countries to provide relief from war, famine and natural disasters whilst assisting communities to develop agriculture, education and health (Mantel and Ludema, 2000). For example, positive conversations initiated by Appreciative Inquiry positively influenced the Romanian orphan situation.

There are four main stages within Appreciative Inquiry; discovery, dream, design and destiny (Barrett, 1995):
Discovery involves determining what gives life to an organisation, asking questions about the best of what is. With this in mind, midwives were asked what was good about their maternity unit.

Dream calls for imagining an ideal future, creating a positive vision of what might be. Midwives were asked to consider what they would aim for if they had no organisational barriers and a blank cheque-book.

Design demands deciding on ways to make the vision become a reality. Midwives were encouraged to consider workable strategies to assist them to realise their vision.

Destiny involves implementing actions to strive for the ideal. Once midwives had made decisions regarding appropriate actions, it was hoped that implementation of them, within their organisations, would be achieved.

Selection of participants

This study took place between Autumn 2001 and Summer 2002. The sampling strategy and subsequent size were determined by the duration of the study. As there are currently more than 200 obstetric units and over 60 smaller community units in England a purposive sampling strategy was adopted. This strategy is defined by Bowling (2002) as ‘a deliberate non-random method of sampling, which aims to sample a group of people, or setting, with a particular characteristic’ (p. 380). In this current study, it was important to ensure that the sample contained midwives working in birth settings that serve women from various socio-economic/ethnic backgrounds, from different areas of England. The units were chosen to provide information on various models of maternity care, namely, home births, free-standing midwifery-led units (MLUs), MLUs on the hospital site (different building and same building), integrated midwifery-led care (same birthing centre), and midwifery care within obstetric, consultant-led units.

For logistical reasons, midwives were nominated by the head of midwifery or volunteered to attend themselves. Midwives represented units supporting 50 births per annum to those with 6000 births per annum. The geographical spread of the units was from the South West coast of England up to the England/Scotland border.

Procedure

Focus group interviews were conducted with midwives at each of the study sites, in a place of their choosing. Focus groups were believed more appropriate than one-to-one interviews having the advantage of generating discussion around the topic area and identifying diversity and difference within ‘everyday arguments’ (Lunt and Livingstone, 1996, p. 96). The focus group schedule gained content validity as it was developed through previous focus group work, literature and multi-professional discussions. Furthermore, the focus group was piloted with midwifery colleagues prior to commencing the evaluation. Accessing the views of clinical midwives and managers prior to and following the focus groups increased the reliability of the information presented and placed the responses in the context of the individual unit.

A deliberate decision was made not to tape-record the focus groups, as midwives may have felt more vulnerable, given that they would be discussing their organisation. This means that complete verbatim transcripts were not obtained; however, notes were made prospectively and verbatim quotes of frequently occurring issues were documented throughout the process. Focus groups lasted between 60 and 260 min, utilising an in-depth interactive style, which facilitated the emergence of in-depth data, contextualised in the organisational environment. The questions were open ended, directed only by three main questions. The questions were ‘What do you believe to be good about your unit?’ (Discovery stage); what do you want to achieve in your unit?” (Dream stage); and ‘What actions are needed to make your vision a reality?’ (Design stage). To determine the level of agreement between responders, participants were requested to make a gesture following each response, such as nodding or shaking of head.

For logistical reasons the majority of focus groups (n = 11) were facilitated by one single researcher (TL) and the remainder by two researchers. However, to minimise interpreter bias, a summary of the key findings were relayed to the participants at the end of each focus group. Furthermore, focus groups were analysed by two members of the project team. Discussions then took place to ensure that a consensus was reached. Summaries of the focus groups were returned to members of the focus groups to enhance the authenticity of the interpretation. Three groups requested changes to their summaries. One group wanted minor changes to factual data; one group wanted their responses contextualised further given that their unit was currently reconfiguring; and the final group wanted the positive aspects of their unit highlighted further. Minor changes were made as suggested by the groups and returned for approval prior to wider dissemination. No changes were made to the direct quotes.
Baseline details of participating midwives were obtained. This included place of work, model of care within which they worked, number of years qualified and professional grade.

Ethical issues

Appropriate Trust approval was sought and gained prior to conducting any focus groups. This study was commenced prior to the new Governance arrangements for research ethics committees, which stipulates approval must be sought for ‘NHS staff recruited as research participants by virtue of their professional role’ (Department of Health, 2001, p. 7), therefore ethical approval was not sought. However, ethical principles were fully adhered to. Midwives were informed that participation in the study was entirely voluntary and that confidentiality would be maintained. It was made clear that they could refuse to answer any questions and leave the group at any time they wished. Pseudonyms are used in the Findings section to preserve anonymity.

Analysis

The focus groups’ records were read several times in an attempt to obtain an initial overall impression of the data. Identification of common characteristics was then carried out, and, for ease of interpretation put under category headings. The categories were identified from comments made by the midwives themselves rather than created by the researchers on speculative grounds.

In the next stage, a method of analysis proposed by Norris (1981) was used, whereby the data were systematically indexed to facilitate the development of themes and conceptual frameworks from the most frequently recurring topics. In keeping with this approach the numerical value obtained from counting occurrences was unimportant in its own right. What was important was to be able to categorise the occurrence of midwives’ words and phrases in order to analyse and compare the various meanings produced within each category.

The two researchers, who independently generated categories from the responses, viewed the data. Using more than one analyst provided an opportunity to assess the reliability of the coding with respect to major themes and issues. The categories were then collated and individually discussed until a consensus was reached.

The findings have been presented to midwives at various professional forums, which has elicited consistent claims of strong resonance.

Findings

Fifteen focus groups were conducted with 126 participants of various midwifery grades as shown in Table 1. The median number of participants in each group was eight (range, 5–14). One focus group was held at each site with the exception of one unit where it was more convenient for the organisation to conduct two focus groups in different areas of the hospital. The place of work and model of care within which the midwives were working can be seen in Table 2. The median number of years qualified was 18 (range, 0–32 yrs). Although student midwives were not actively encouraged to attend, their contribution to the area under discussion was valuable given their involvement in the organisation as a whole. The views of the students appeared consistent with those of the midwives therefore their responses are included in the analysis.

Themes

In keeping with the Appreciative Inquiry approach, the themes reflected what the midwives believed to be good about their unit (Discovery stage), what they wanted to achieve (Dream stage), and what actions were needed to make their vision a reality (Design stage). The main themes were cultural changes; midwifery leadership; appropriate role

<table>
<thead>
<tr>
<th>Student</th>
<th>E grade</th>
<th>F grade</th>
<th>G grade</th>
<th>H grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Group 2</td>
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<td>Group 15</td>
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<td>4</td>
</tr>
</tbody>
</table>

Grade E = newly qualified/less experienced midwives.
Grade F = experienced midwives.
Grade G = experienced midwives usually with leadership role (e.g. shift leader, team leader).
Grade H = experienced midwives usually with managerial and/or specialist role.
models; training in normality; appropriate responsibility of care divisions; choice for women; equity of care provision for women considered to be at high or low obstetric risk; and staff moral.

Cultural changes
Midwives in all units believed that there was a fundamental problem with the culture and ethos of maternity care in England:

The culture and philosophy of a unit is the most important thing. If you get that right you’re laughing and everything else slots into place. Unfortunately the social model is less dominant in hospitals in England and units are hard to change. (Midwife 1: Community—free-standing)

Although midwives from some units ($n = 6$) talked about a ‘normal philosophy’ in their own units, others stated that the ‘medical model of care’ appeared to dominate ($n = 8$). Furthermore, in some units ($n = 6$) it was believed that some senior midwives and to a lesser extent, obstetricians were sustaining this model:

Some of the older midwives trained in the times of technological advancements and have forgotten that childbirth is normal. (Midwife 101: Hospital—low risk)

Another said:

We used to blame the obstetricians but if you think about it the shift leaders are the main barriers to normality. (Midwife 60: Hospital/Community rotation)

Midwives from one of the consultant-led units believed that their high caesarean section rate was because the unit’s philosophy failed to promote normality. The philosophy of the unit was ‘everything abnormal until proved normal’. This philosophy was ‘transferred to the women’, and the midwives stated that the unit was ‘very accommodating to women’s wishes with regard to induction and caesarean section’.

In one unit, the maternity department was established before the rest of the hospital, which prevented a medical model being introduced. In four units, midwives commented that they were ‘tired of fighting for normality’ and suggested that there was a ‘constant battle with obstetricians and paediatricians’. In some units, the midwives felt undermined by the anaesthetists. For example, in one unit anaesthetists would accompany doctors on ward rounds and say ‘I’ll be back later to put your epidural in’, despite no epidural request from the woman. Midwives felt that their colleagues had lost confidence in their abilities as midwives:

We all want the same thing but it is really hard sometimes. Some midwives are fighting for normality but eventually your confidence is beaten out of you.... (Midwife 12: Team—high/low risk)

Midwives in the consultant-led units felt that they were always ‘working against the clock’ and the culture of the delivery suite was one in which midwives were encouraged to have ‘everything done and dusted within an hour following the birth’. Midwives believed this prevented them from completing appropriate care such as ‘skin-to-skin’ contact. Many comments were made which supported the view that ‘it takes a very brave midwife to practice normal midwifery care’. Peer pressure to intervene and work within a time frame was often difficult to resist. Midwives believed that supporting a woman in labour, for example, was given lower status than putting up a Syntocinon infusion.

<table>
<thead>
<tr>
<th>Place of work</th>
<th>Model</th>
<th>$N = 120$</th>
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</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Low-risk care only</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>High-risk care only</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Rotation—high-/low-risk care</td>
<td>38</td>
</tr>
<tr>
<td>Community</td>
<td>Freestanding unit—low-risk care</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Traditional community care (antenatal and postnatal care with some home births)</td>
<td>24</td>
</tr>
<tr>
<td>Hospital/community</td>
<td>Teams—high-/low-risk care</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Teams—low-risk care</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Teams—high-risk care</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Teams—specialist care (teenagers)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Teams—specialist care (underprivileged area)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Caseload care</td>
<td></td>
</tr>
</tbody>
</table>

The six participating students have been omitted from the table as they were being exposed to various models.
Action (Design) suggested by midwives:

- National programme required to raise the profile of birth as a normal life event;
- Re-education of women, midwives and obstetricians in the needs of low-risk women;
- Low-risk care to be seen as the default in maternity care;
- Rotation of midwives between 'low-' and 'high-' risk units should be considered;
- Use of appropriate triage systems to refer and defer women appropriately;
- Obstetricians to be involved in low-risk care only as requested or needed.

Strong leadership

Some midwives ($n = 38$) believed that they had very strong midwifery leaders who they wanted to 'do their best for' as they had a 'mutual respect for each others' roles'. Midwives expressed the need for someone with status who could 'fight our corner'. In some units, the midwife manager was seen as someone with status but who was also considered a 'team player'. Midwives believed strongly that their midwifery manager could 'make or break a unit':

Our mangers are just part of the team. They have clinical respect but are respected by the Trust, obstetricians, anaesthetists and all the midwives. I don't know what we would do if our Head left... (Midwife 13: Team—high/low risk)

In some of the units ($n = 3$), the midwives suggested that the manager was a 'lap dog for the obstetricians'. They believed that this created a barrier to change in terms of promoting normality. In two units, the lack of strong midwifery leadership was believed to be leading to practice based on consultant preference as opposed to evidence base, e.g. CTG monitoring. Midwives said 'we are tired of fighting now and just accept it'.

Action (Design) suggested by midwives:

- Midwifery managers to receive leadership training and continuing development programmes such as learning sets;
- Care needs to be taken within Trusts not to marginalise midwifery because of larger number of nurses (This may include having a midwife on the Trust board.);
- Leaders must command clinical respect and be visible showing clinical skills;
- Leader must provide support for midwives to practice normal midwifery.

Role models

Midwives recognised the importance of role models within their unit and many midwives contributed the names and/or role of those they believed could make a difference in maternity care. Most midwives believed that ‘Supervisors are good role models’. But in other units midwives suggested that ‘Supervisors could do more to improve clinical care’. Some midwives ($n = 22$) shared the view that ‘some supervisors have been in post for years and have forgotten what normal midwifery is’.

Most midwives felt that consultant midwives in particular were thought of as good role models having 'status and clinical credibility'. However, it was generally felt that more consultant midwives were needed:

Our consultant is great but she’s on her own... we need more of the same to really make a difference to women. (Midwife 49: Hospital—high risk)

There were, however, a large number of comments at all sites regarding the lack of role models in the clinical areas. Midwives generally felt that junior staff had minimal exposure to autonomous midwives.

Action (Design) suggested by midwives:

- Need for 'old style clinical tutor' (who has respect and status within trust);
- Rotations between high- and low-risk areas should be considered;
- The employment/promotion of leaders with vision;
- Need for more consultant midwives.

Training in normality

Training of midwives and students was perceived to be inadequate. Midwives believed that 'although the theory provided in training is excellent it does not always reflect practice'. Student midwives suggested that it was 'often difficult to follow the gold standard due to pressure from qualified midwives'.

Midwives from all units thought that midwives needed retraining in the care of low-risk women. Midwives in the low-risk and free-standing units were encouraged to work in a consultant unit for 'in-service training' but it was rarely suggested that a midwife from a consultant unit worked in a 'low-risk area'. In one unit, the midwives from a free-standing unit said they felt insulted because during 'in-service training' they were 'allocated a woman and told — take her you will get a nice normal delivery'. Units with two-way rotations believed they had good working relationships with...
their colleagues. Midwives felt that exposure to home births and low-risk care was essential for all midwives to prevent losing skills. However, others disagreed saying that ‘it is not training which needs altering but midwives’ attitudes’. Updating of midwives in ‘low-risk’ care was, however, a recurrent issue. In obstetric units, midwives were often allocated to ‘high risk’ care first which midwives felt ‘prevents them from adopting a philosophy of normality’. Similarly, free-standing units and midwife-led units tend to appoint ‘experienced staff only’. Many midwives felt that ‘midwives are trained for normality’ and therefore should be encouraged to work in areas, which facilitated this. In one unit, senior student midwives were encouraged to carry a small caseload. The midwives questioned saw this as very positive. But some midwives expressed their lack of confidence in working in a low-risk unit saying that they felt ‘isolated’. In two units, the midwives said that ‘the MLU does not get used, as midwives are too scared to work there’.

Midwives in the free-standing units believed that they had excellent in-service training, particularly in obstetric emergencies and neonatal resuscitation. Similarly, many of the obstetric units believed that mandatory training and external study was usually facilitated.

Action (Design) suggested by midwives:

- Student midwives to be exposed early to low-risk care;
- Newly qualified midwives to start allocation in low-risk area (and home births);
- Re-training and development of qualified staff to increase confidence/competence in low-risk care.

Appropriate responsibility of care

Midwives, in the main, wanted to be the professional responsible for the care of ‘low-risk’ women accessing maternity services and in some units this was the case:

We are the lead professional for low-risk women and only refer to the obstetrician when needed. It is ludicrous for doctors to see all women. Why would they want to? I can’t understand midwives who would allow this to happen. (Midwife 19: Case load)

However, midwives strongly believed that a re-organisation of roles needs to be considered. Many midwives suggested that a major problem was the fact that the first health professional women see is their General Practitioner (GP). It was thought that this ‘started the medical ball rolling’. In one unit, however, the first contact has been changed to a midwife and this has resulted in an increase in the number of women attending the MLU.

In some units (n = 4), the midwife would write the referral letter but the GP would sign it. The midwives thought this to be unnecessary. Midwives were also angry that GPs claimed for maternity work, which was carried out by midwives. Midwives did acknowledge, however, that ‘some women seem upset that they haven’t seen a doctor throughout pregnancy’ and that they ‘see midwives as less than nurses’. An important observation made by some of the midwives in the rural areas was that it is often easier for a woman to see a GP to confirm the pregnancy without other local people knowing the reason for you attending.

A further problem identified was that many GPs would only refer to a consultant obstetrician. Midwives believed that for ‘low-risk women’ direct referral should be made to a midwife who would then be responsible for the care. One unit has achieved a system, whereby 95% of women are seen directly by a midwife and the responsibility rests with a midwife unless a problem should arise. Other units felt that ‘because the consultant’s name is on the notes he/she feels responsible and therefore gets involved unnecessarily’.

Concerns were raised as to whether midwives were expanding their roles too much instead of ‘concentrating on the basics’:

There are so many specialist roles now that there isn’t anyone left to do hands on midwifery. (Midwife 76: Community—free-standing)

But others thought that specialist midwives were necessary to ensure that women with special needs received appropriate care. For example, midwives in one unit, have initiated two separate schemes using a caseload approach to serve two distinct groups of women, one for teenagers and the other for women living in a Sure Start Area. Midwives also felt strongly that those wanting to work in the high-risk areas should be supported to do so.

Midwives working with advanced neonatal nurse practitioners believed this role to be a positive one. They said they were ‘more experienced than junior doctors’ and that ‘you are more able to trust them because there is a mutual respect’.

Action (Design) suggested by midwives:

- Women should be given the option of confirming their pregnancy with a midwife or a GP;
- Care should be undertaken by a midwife unless a problem or query warrants the woman being referred to an obstetrician;
• GPs and midwives should stop duplicating each other’s work;
• The lead professional should be appropriate to the care required.

Choice for women
Midwives in some units \( (n = 6) \) were very proud of their ability to offer women choices about the care they receive and the birth setting:

We are really lucky and have a number of options in our unit depending on what the women want. (Midwife 4: Hospital—high/low risk)

Other midwives suggested that they do not always give women an informed choice of available options because of the resource implications. During the site visits, for example, three of the midwife-led units were closed, yet eligible women were in the central delivery suite. Midwives explained:

When staffing levels are low the midwife-led unit is always the first place to close. Women then don’t have any choice of where to labour. (Midwife 17: Hospital—low risk)

Some units \( (n = 4) \) also suggested that because the shift leader often covered the high and low areas ‘she usually wanted all women in the one area to keep an eye on them’. This did not happen when the midwife-led unit was managed independently. Interestingly, midwives believed that their personal philosophy of care altered according to birth setting as there was a lot of peer pressure to ‘conform’.

Two units in this study were able to sustain a home birth-rate of more than 9%, despite difficulties with staffing levels. However, some midwives felt that the on-call demands prevented them from wanting to increase the number of home births:

We don’t always offer home births as they deplete the service of resources as two midwives have to be present. (Midwife 31: Traditional community)

One spoke on behalf of others when she said:

We hope consultants say ‘no’ to home births because we can’t cope. (Midwife 112: Teams—low-risk care)

Action (Design) suggested by midwives:
• Units should ensure equity of care regardless of risk;
• All women should receive the same options regarding postnatal care;
• Rotation of midwives between free-standing units and obstetric units should be considered.

Equity of care provision between women considered to be at high or low risk
Midwives were generally concerned that within one unit, which offers different models of care, women were not always given equity in terms of quality of care or continuity. Furthermore, in some units the intrapartum rooms for low-risk women were often decorated and furnished to a higher standard than the ‘high-risk rooms’. One unit has overcome these problems by formulating a system, which promotes midwife-led care for all women regardless of risk. All women in this unit are cared for in similar rooms.

In one hospital, the midwives believed that they gained a high level of job satisfaction and achieved as much continuity of care for women attending the high-risk antenatal clinics as the low-risk women. Similarly, those midwives offering an integrated service believed that ‘all women get an equal standard of care’ whilst they ‘maintained skills in all areas’.

Midwives from Trusts containing a free-standing unit and a consultant-led unit believed that women attending the free-standing unit received better care due to increased staffing levels. This they believed was at the expense of the other women. Midwives in the consultant-led units envied the fact that the free-standing units could offer more supportive postnatal care. Some free-standing units allowed women to recuperate there for ‘as long as required’, saying ‘we mother the mothers so that they can mother their babies’. In the consultant-led units, women were often ‘encouraged to return home because the beds were required’. To overcome this problem, some units offer the same access to community postnatal care regardless of place of birth. This means that women who give birth in the obstetric unit have the option of being transferred to a unit within their community for rest and support, for example, with breast feeding.

Midwives in the free-standing units believed they had a better relationship with women and their families:

In smaller units you can address women by their first name and you know the family. (Midwife 88: Community—free-standing)

This they believed gave them greater job satisfaction. However, the midwives from the larger units believed this could be achieved with adequate staffing and an appropriate model of care. Midwives working in ‘specialist teams’, e.g. Sure start and those carrying a caseload, believed they were more likely to build a relationship with women than those who rotated throughout a unit.
Action (Design) suggested by midwives:

- Improved channels of communication between units;
- Explore the need to rotate midwives between units;
- Encourage multi-disciplinary working.

Staff morale
Midwives who said that they had high morale were working in units which stated that they had a culture of birth as a normal physiological process; pride in a low caesarean section rate; a commitment to one-to-one care during labour; strong team leadership; multi-disciplinary working and a strong commitment to evidence-based practice. Interestingly, these factors were identified by Hodnett (2000), when she explored criteria of hospitals in Ontario that appeared to be related to low caesarean section rates.

Those midwives who felt valued (by women, managers and peers) expressed that they had greater job satisfaction regardless of workload. Midwives who could 'work together, play together and cry together' believed they coped better during busy periods. The free-standing units were generally seen as more supportive environments. In one unit they described themselves as a 'holding unit' for staff who were stressed and midwifery students who were 'about to jack it in'. In another free-standing unit a midwife said she was 'working in Utopia'.

Midwives in the consultant-led units were more likely to say that they did not feel valued and commented that they were 'just a pair of hands' with 'lots of criticism and no praise'. One midwife said:

Give a lot of good will but get nothing back…….feel why should I bother? (Midwife 87: Hospital/community rotation)

A major issue was the poor communication within some of the larger units with information failing to be cascaded down. The working environment was thought to influence staff morale, with several midwives commenting on poor catering facilities and difficulties parking.

Action (Design) suggested by midwives:

- The facilitation of autonomy and innovation should be encouraged;
- Better parking provision for midwives;
- Flexible and innovative catering facilities for midwives working in all areas and particularly for night shifts.

Importantly in qualitative work, what is not said is as valuable as what is. When some midwives were asked what changes they would make in their organisation some said none at all. These midwives were working in free-standing units. Interestingly, very few midwives requested more midwives.

Discussion
This exploratory study is the first of its kind to explore, in depth, the views of midwives from different parts of England about their own views of maternity services. The Appreciative Inquiry approach placed midwives in control of the focus groups and allowed them time to reflect on their own organisation. However, at times, and perhaps due to lack of forums to vent their views, midwives used the focus groups to air their frustrations. However reassuringly, in all units midwives could identify good aspects of their organisation.

This study had limitations determined by its duration and available resource. Midwives who participated in the focus groups were either asked to attend by their manager or they volunteered. Midwives who were requested to attend by their managers may have done so because of the particular views that they held. However, this is unlikely given the negative comments made by some midwives. As this was not a random sample, one could suggest that the views may not be representative. However, informal conversations with midwives during the site visits, and formal presentation of findings at professional forums add validity to the findings.

No attempt was made to validate any 'facts' that were stated in the focus groups—for example, 'we give as much continuity to high-risk women as low-risk women' or 'there are no opportunities for staff development'. The focus groups therefore reflect feelings and perceptions of the midwives present. Although obstetricians often volunteered their opinions during site visits, there was no formal evaluation of their views. The views of other professionals, such as obstetricians, paediatricians, anaesthetists and GPs may have offered alternative perspectives.
Although midwives had varying degrees of discovery, the dream was always the same. Midwives wanted support to practice autonomously in an environment, that facilitated the equity of care for all women and job satisfaction for midwives. Midwives acknowledged the fact that they do not always project an appropriate image to provide role models for student and junior midwives. Consultant midwives and Supervisors of midwives should be instrumental in the promotion of evidence-based practice with normality as a central focus. Ball et al. (2002) surveyed 1975 midwives who had not notified the UKCC of their intention to practice in 2000, despite doing so the previous year. This study found dissatisfaction with midwifery to be the main reason (29.9%) for midwives leaving. As in this current study, lack of effective management and clinical support, poor communication and feeling undervalued were key issues.

Some midwives openly talked about the lack of confidence to care for women with a straightforward pregnancy in a ‘home-like’ setting. This, they acknowledged, was having an effect on their own morale and subsequent care for women. The current drive to promote ‘normal’ childbirth by consumer representatives (Newburn, 2002), professional bodies (Royal College of Midwives, 1997, 2000) and individuals (Downe, 2001) is evident. However, to promote ‘normal’ childbirth, midwives must regain their confidence as autonomous practitioners, identify local barriers to ‘normality’ and publicise their role to the general public.

In the design stage, numerous action points were put forward in an attempt to strive for the ideal. This was encouraging, as midwives identified local problems and were actively seeking solutions. Until these actions are implemented the destiny will not be reached. Many of the action points suggested are relatively easily implemented. For example, midwives wanted additional support for administrative and practical work. These findings support the evaluation project by Garcia (1997) who found that 45% of midwives questioned believed that non-midwife carers could do more in the postnatal wards.

Although clearly defined themes are presented here, in reality they are interrelated. For example, in units with a traditional culture of normality and strong leadership the midwives were more likely to say that morale appeared higher. It is therefore important that organisations do not isolate individual aspects of their service but use a holistic strategic plan. Interestingly, some of the themes identified by the midwives were consistent with the 12 criteria identified by Hodnett (2000) as having a possible relationship with rates of caesarean section. This is an area that warrants further investigation as it may be that the more qualitative aspects of an organisation, such as leadership or morale may have a greater effect on maternal outcomes than we appreciate.

Midwives acknowledged the effect that multi-professional working relationships can have in a unit. Multi-professional boundaries have become less defined making it imperative that local strategies are developed to ensure that appropriate personnel care for women and duplication is prevented. These strategies should include clear channels of communication.

The duplication of work carried out by GPs and midwives was a particular area of concern for midwives. The guideline for allowing GPs to be recognised to provide maternity medical care (National Health Service, 1992) should be reviewed and consideration given as to whether it is still appropriate to pay GPs for referring women to consultant obstetric care. This review should include an exploration of the views of women. Interestingly, a study exploring the views of GPs (Young, 1995) found that only 14% believed that their own role was clear within midwifery group practices and 64% thought that communication with midwives was poor. However, encouragingly, over 80% believed that midwives had the skills to detect deviation from the normal. Whilst it is important not to waste resources by duplicating work, the importance of multi-professional working should not be ignored. The sensible solution appears to be that the midwife is acknowledged as the primary care giver for women with straightforward pregnancies, with the support, when necessary, from the GP and other members of the primary care team.

This work has provided stakeholders with some indication of how midwives are currently feeling about maternity services and importantly how current problems may be overcome. Much of what the midwives suggested have been fed into the forthcoming Children’s NSF. This framework, which to a large extent will determine our destiny, will support and encourage midwives to implement the local initiatives they suggested.

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