EDITORIAL

Midwife-centered versus woman-centered care: A developmental phase?

As three of the early leaders and researchers in the field of midwifery continuity of care in Australia, we have been instrumental in addressing reforms to the fragmented model of maternity service delivery. These services have seen each childbearing woman in our public health system enduring up to 20 different care providers in one pregnancy experience.1

The last 20 years of research has included randomised controlled trials, case control studies and large population based epidemiological investigations. These studies have convincingly shown that midwifery continuity of care, provided in any location, is highly satisfying for women, leads to reduced interventions and is no less safe in terms of maternal and perinatal mortality when compared to the fragmented models that emerged last century.2 Many health services have now changed their models of care-delivery to incorporate new systems that are focused on improving the experience for each woman by enabling continuity of care from a known midwife. The key characteristic of these new models is that they have a specific focus on woman-centered or relationship-based care.

We have come a long way in the last 20 years. A considerable amount of work and effort has gone into this journey — one which many of you have been part of. We must continue to maintain the focus on the fundamental aspect of what makes midwifery continuity of care effective — that is, the midwife—woman relationship.

It is well documented that midwifery continuity of care has the greatest potential for health gain in the most marginalised groups of women — those women who, 10 or 20 years ago would not have sought out midwifery care in any form. These are women who are socially isolated, marginalised or vulnerable for a variety of social and psychological reasons. While these women may require additional time and effort, it is here where the public health benefit lies.3

A decade ago we were challenged in a public forum, with a claim that midwifery models were the ‘health food shop’ option in maternity care — being “really only for the well informed and educated; only for those women who really wanted a normal birth without analgesia”. At the time, we refuted the challenge and have spent the last decade continuing to refute such claims. Midwifery continuity of care has benefits for all women, regardless of the choices or options in care they might have or choose to make. Taking a stance on normal birth or choice of analgesia is unhelpful. Midwifery continuity of care can turn these things around, on the woman’s terms, but cannot be based on the ideology or preference of the midwife.

Recently, we have become concerned that this effort to change the way maternity care is delivered in Australia is being jeopardised and challenged. Our concerns come from personal experiences as well as colleagues’ reports of midwives working in ‘midwife-led’ models of care who state that they are not willing to provide care for particular groups of women. These groups include women who have not ‘chosen’ this model of care (eg. were allocated by virtue of geographic location) and who therefore may not be as ‘committed’ to a non-interventionist birth; or women who are not motivated to labour without analgesia or anaesthetic assistance to manage their pain. This list has also included women who come from disadvantaged sectors of society or who may be non-English speaking; have mental health challenges or perhaps are simply having their first baby. The rationale for such pronouncements is that some midwives are not prepared to expend the additional time and energy on women who are not committed to what the midwives want and see as important (normal birth without intervention). An additional factor may be that the women may take longer to care for and need much more assistance if they have complicated life stories. Is this midwifery approach being woman centred or midwife centric?

Other concerns revolve around the way midwives work and their perception of a work-life balance. Some midwives working in continuity of care models have started to object to being on call for women, regarding being ‘on-call’ as not ‘midwife-friendly’. Some midwives employed to provide continuity of care and be on-call 24/7 have simply stopped doing it, arranging instead for women to be shared amongst their colleagues in a fragmented way with limited possibility for ‘continuity of carer’ for the woman. When called to account for these changes to their agreed contractual arrangements midwives assert that women will receive better care if their midwife’s needs are met first.

Should we be concerned at the emergence of what sounds like a model of ‘midwife centred’ care? Are the midwives
right in regarding continuity of carer as unfriendly to midwives? Who is the health system set up to serve? Is a midwife centred approach a growing trend or a transitional process through which midwives will pass as they adapt and settle into their new role?

We feel that a midwife-centered approach to midwifery continuity of care where relational continuity is not valued or achieved is a developmental phase that skilled midwives will soon move through. This is a necessary phase of adaptation to the new autonomous and professional role that will bring Australian midwives into line with midwives internationally. It is likely that the development process will help midwives understand that the key to successful and satisfying professional practice is a relationship built on trust. Relationships with colleagues and co-workers that are truly respectful and honour the individual contributions each person makes to maternity care whilst recognising the autonomy of the midwife will mean that the pendulum will swing back to woman centred care. Over time, relationships with women that may require time and authentic focussed attention to develop will be seen as the most valuable and significant.

Part of this development will see that being fulfilled at work means the relationships with our own family and support network that are essential to health and wellbeing, can also flourish rather than take back stage.

Providing midwifery care in this radical new way is potentially stressful and we see the issues outlined above as examples of midwives dealing with their stress in perhaps the only way they know. Experience has shown us the reality of how difficult it is sometimes to sustain new models and how much creativity, energy and strategic thinking is required. In this editorial we explore the questions we have posed with a focus on relationship-based care and the issue of trust.

One of the ways to explore the notion of relationship-based care is to consider what continuity of care really means. Three types of continuity of care have been identified as management, informational and relational continuity. Management continuity concerns the communication of facts and judgements between the team, institution and professionals and patients. Informational continuity concerns the timely availability of relevant patient related information. Relational continuity concerns the establishment of relationships based on reciprocity and trust of the service user with one or more health professionals over time. It is relationship continuity that is the focus of these new models of maternity care, since relationship continuity has been found to have the greatest impact on experiences and outcomes of healthcare.

Within our health system, we have been practising management continuity for years. For example, policies and procedures have been developed and are followed to some degree, depending on the setting and the individuals. We have also been practising informational continuity with lots of emphasis on records and notes. There has been much less emphasis on relational continuity – few woman receiving public maternity care have had the opportunity to actually have relationships with individual care providers. This is what midwifery continuity of carer has been trying to achieve. Caseload and group practice models are ways that this can be achieved but only if the relationship is allowed to develop. Obviously, it is much easier to develop a relationship with one person than with a number of people who have limited opportunity to establish a trusting relationship.

The imperative for midwives to be supported through the implementation of midwifery continuity of care is reinforced in the work of Ruth Deery and Mavis Kirkham in the UK. Midwives cannot work in models such as caseload practice in public maternity services without explicit support systems in place. In our experience, this support needs to come from the service leader or manager, who requires many of the personal skills and attributes outlined in the Box 1 below.

While the strategies outlined in the Box 1 are primarily focused on managers, they equally apply to midwives who work alongside or within midwifery continuity of care. We all need to support one another in building and sustaining a better system for women.

Providing midwifery continuity of care is not without its challenges. We have been working in challenging health systems for long enough to know that there are times when it does seem to be too hard and not worth the effort. But the evidence for midwifery continuity of care is strong and we must remember that there are considerable benefits for women if we work in this way.

We have heard of stories from midwives who, while they embrace the ideology of continuity of care, at times struggle with the reality, especially if they are also tired. It is essential to have time away from work. This is necessary to balance work, life and family responsibilities. Deciding to work in a

### Box 1. Supporting midwifery continuity of care: qualities of a manager

- Commitment to the value and importance of midwifery continuity of care, including the benefits for women, midwives and the organization.
- Understanding of the need to step back and let midwives ‘self-manage’.
- Accessibility and availability for trouble shooting.
- Effective communication skills.
- Willingness and ability to give advice and direction.
- Ability to resolve conflict.
- Encouragement of reflective practice.
- Willingness to put structures into place to enable midwives to meet regularly (for example, every week) and to provide feedback about practice issues.
- Understanding of the stress and workload issues for the midwives and the need to help them identify ways to manage these.
- Ability to help the midwives identify and meet their professional development needs.
- Advocacy for the model and willingness to deal with philosophical and organisational disputes.
model of care where periods of on call are needed is a decision that should be made while considering all the factors that are important to the individual midwife. We recognise that ‘time off’ or ‘time out’ is essential and that midwives should not feel guilty or selfish about taking care of themselves. Developing strategies to have time off while maintaining a commitment to relational continuity is the key. No one model or approach will work for everyone. You need to work out your own approach in consultation with your midwife partners and with the woman remaining a focus.

In our experience, we have found that most women understand and support their midwives to have adequate rest and time out. This is particularly so where there is an ongoing relationship. Communication is key here. Women are unlikely to call their midwife during ‘unsociable’ hours unless there is a good reason, especially if this has been previously discussed. There will of course always be instances where this is not the case and this needs to be identified and addressed. We have heard of stories where midwives say they felt some women took advantage of their availability. Midwives taking on a continuity relationship need to recognise from the outset the importance of creating professional boundaries to keep themselves safe and that creating dependencies is unhelpful to both themselves and the women. Talking with women about these matters at the outset is essential. We must remember that ‘we cannot be all things, to all people, all of the time’. But we can provide a level of continuity if our support systems and back-ups are in place.

We recognise that most midwives are women and we have been challenged on this - maybe woman centred care and midwife centred care can co-exist? Certainly there are exemplars of this in Australia. We know that retention of midwives is a critical issue and keeping midwives happy and satisfied is also important. In our experience, and on reading the body of literature, we know that midwives will be satisfied and happy if they are supported at work and at home to work in flexible ways, which enable the development of meaningful and mutually satisfying relationships with women.

We believe that midwifery continuity of care is an essential way of providing maternity care. Making it ‘work’ for women, midwives and managers is challenging and we need to steer a careful course to ensure sustainability and effectiveness. As midwives we must hold true to our fundamental philosophy of being ‘with woman’ — always putting the woman at the centre. We need midwifery continuity of care for the future that ensures these models are the mainstream option for all women, especially those who are hard to reach, hard to access, vulnerable, scared or uncertain about what they want or what they could have. Midwifery must not be the health food shop option — it must be the option that makes a real difference to women’s lives, that is, for all women, all of the time.

References


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