Working for Health

'Changing Childbirth'

Presenter
In the early 1990s, the 'Changing Childbirth' policy was introduced as Government policy in an attempt to highlight issues that were of concern to women, their families and to healthcare professionals – issues of choice, control and continuity of care. Andrew Prentice, consultant obstetrician at the Rosie maternity hospital in Cambridge.

Andrew Prentice
I think changing childbirth offered a number of opportunities to change the pattern of care that was offered. I feel that one of the major advantages would have been removing a large number of normal pregnancies from obstetric care. However, I believe that that hasn't happened to the extent it should have happened, and I think the reason that hasn't happened is that many women are not being given the choice.

And changing childbirth won't work until women are given the choice. And for that failure GPs have to carry the can because they're the ones that are deciding at the moment which pattern of care women slot into.

Presenter
Gaynor Hayde, Senior Support Midwife at the Rosie Maternity Hospital.

Gaynor Hayde
I'm not convinced either that many first time mums actually know that they have a choice. This is probably the first time in their life they may even have been to their GP, they're really excited, pregnant, the GP presents them with a model of care and they accept that as normal. So I think there's a whole education package there still to be undertaken.

Presenter
In the light of Changing Childbirth, professionals have continued to reappraise their respective roles

Andrew Prentice
It's important that we keep reminding ourselves that the patient is at the centre and we should decide between ourselves what is best for this patient, and if it means that the doctor shouldn't be involved, then the doctor should step back. If it means that the midwife should adopt a nursing role rather than a midwifery role, then so be it. But that means flexibility from individuals, at all times, and constantly reappraising what each patient needs.

Presenter
What are the barriers to this more flexible approach to care in practice?

Andrew Prentice
People jealously guard their own ground. GPs want to keep patients, midwifes want to look after patients, obstetricians want to retain control over patients who come through hospitals. And the person that loses out in that situation is unfortunately the patient

Gaynor Hayde
Midwifery training has now changed and student midwives are now based mainly and certainly start their training out in the community. So it isn't a medical model that we're training them into and yet the day they qualify and apply for a post in a unit, they seem to sit

themselves comfortably into a medical model. So why is it they then come into a unit and four walls seem to change the approach that they have to the pregnant woman?
Presenter
Jen Ferry, Maternity Services Manager at the Rosie Hospital.

Jen Ferry
We're employing them into a hospital setting and they are being disempowered almost straight away by the midwives who have lived in a medical model of care and the culture that they've grown up in is where they are subservient to the doctors.

And whilst everything is in place and the doctors are signed up, we haven't actually managed to change that culture and so we need to address those issues of change in perceptions, change in cultures and change in the way midwives view their own role in the structure of providing care to mother and babies.

Andrew Prentice
In the sixties and seventies everybody tried to medicalise pregnancy. It's an altered state of physiological well being rather than an illness.
In a low risk pregnancy, I would see that the role should be mainly with the midwife. That conflicts with the traditional view that a GP looks after the patient from birth through death, through all aspects of their life and health. This perhaps is the thin end of the wedge of medicalising pregnancy, and it would be a radical change, and perhaps a desirable change for the whole of umm pregnancy for low risk women to be undertaken by midwives.

Presenter
This is precisely the approach taken by the Edgware Birth Centre - an NHS initiative that was set up to provide a safe, woman-centred, more natural alternative to routine hospital birth.

Debbie
You walk in and it is so friendly, they make you feel like you're a first time mum all the time even if you're not. They make you feel that you're the only person that counts, and the care is just wonderful that you receive.

Sarah
You feel very much part of the sort of the set up here, you know and you sort of have a cup of tea and a cup of coffee and meet the other mothers and it's so informal and so relaxed

Miriam
It just seemed so right and different to last time, just more easy going, and totally supporting our views about natural child birth. It was just to do with being in the right place, and feeling comfortable, and trusting the midwife so much
So I didn't have that worry, all I needed to do was concentrate on the pain and getting the baby out and that was pain relief in itself

Presenter
The Edgware Birth Centre is a midwifery-led unit with no medical staff on site. It was set up in 1997 as a demonstration project funded by the Department of Health. Jean Chapple, consultant in Public Health Medicine at the North Thames Perinatal Public Health Unit, leads a mulitidisciplinary team that is evaluating the project.

Jean Chapple
The main aim of the evaluation is to try and work out the extent to which the Edgware Birth Centre can deliver a safe woman's centred type of childbirth, and the comparative cost of doing that. We're also trying to look at the operation of the unit and how it works in management terms, whether people like working there, whether doctors and midwives like referring women there, to see how it fits into the local profile of health care

Presenter
Developing an atmosphere of mutual trust between staff and the women in their care is at the heart of the project's philosophy. Jane Walker, Project Leader at the Centre.

Jane Walker
We have worked very hard at creating what we consider to be a shared ethos. It is about trust and it's about confidence and it's about control. And it's a shared philosophy, a shared approach to care..and that's what enables the woman to feel safe, and to feel that they can trust whoever is looking after them when it comes to it.

Presenter
Midwifery assistants like Jo Brain work closely with the midwives to achieve this sense of continuity of care.

Jo Brain
The most important part of the job is being a support to the women, being a contact and a face that they know, and they get used to seeing me around the place coffee mornings workshops on the telephone they phone up for advice so that if they come in labour if they haven't managed to meet that particular midwife who's on duty, there's a good chance that they will have met the midwifery assistants and I like that part of my job the best.

Presenter
Olive Jones, Supervisor of Midwives, was one of the team whose vision pioneered the project.

Olive Jones
What we feel has evolved is not so much woman-centred care as family-centred care. The woman's whole family, and that doesn't mean just her partner, it means the grandparents if they wish to be involved, the children if they wish to be involved. They're all involved in information sharing .Clearly the decision is down to the woman in the end, but I think she appreciates the support of her family in this.

Presenter
Photos on the walls of the Centre provide testimony to one of the delivery options available for women during labour.

Jo Brain
They're quite vivid images of a water birth, you can see the midwife using a torch and mirror to see the baby's head, not needing to touch the baby at all or touch the lady, she looks very relaxed there and happy. Her son's in the room with her seeing what's going on having a look at his new sister be born that's a sister it was a little girl, her husband's there with her, and they're just a lovely set of photographs and they're a good advert for a water birth I think.

Miriam
The moment I got in it was like oh wow, even though I was about to have a contraction it was just such an incredible feeling just the warmth like around my body. I could feel the head basically doing every it was supposed to do because of course I had no drugs so there was nothing to stop me feeling anything and she came out on the second contraction.

Olive Jones
We don't promote giving birth in water but we do promote the use of water for pain relief and then if the woman feels that she wants to stay in the pool to birth, then that's fine we support her and, all the midwives have been trained to do that. We now have about seventy percent of our women using water, during labour, and I think about sixty percent of those actually birth in water

Jane Walker
It is very very important in terms of the issue of safety, in relation to water, that everything in the labour is progressing normally, that the foetal heart is fine. If there's a problem, you get the woman out of the water. If it's a real problem, just as the baby's coming out, you stand her up, so that the baby is born into air.

Jean Chapple

We're trying to look at the safety of the unit by looking at clinical outcomes and comparing the women who go to the birth centre with those with a similar background and obstetric record who go to the the three local maternity units which are on a traditional site with obstetricians. The birth centre actually chooses the women it looks after and they should be low risk. So one of the things we want to do is to make sure are they choosing correctly, because we wouldn't be expecting them to look after women who were likely to have problems. And we also need to know how many women are transferred in labour because that's obviously a more dangerous approach to care if a woman is at one place and then has to be put in an ambulance and taken several miles away to a consultant unit.

Jane Walker
It's fine for those women who end up having nice normal births, and it's everything they wanted, and it's exactly the way they wanted it. But what about those women who end up being transferred as emergencies : do they still feel okay about the fact that they made that choice ?

Presenter
One woman shared her experience of being transferred during labour.

Linda
The midwife who'd stayed with me for the last stage at the birth centre actually stayed because I was scared of the hospital experience. I was rushed into the delivery room. So I was put on to the bed and I was hooked up into the stirrups immediately and then suddenly lots of people came in the room. The consultant was a female, was lovely : and treated me as a person. A paediatrician had to be present as it was an extraction baby it wasn't a natural born baby. He came into the room, I didn't realise who he was, and he was still eating his sandwich. I just felt that the environment wasn't as much what I wanted, although I understood that the baby was under distress my privacy wasn't respected.

Presenter
These events emphasize the challenge of maintaining a sense of continuity when problems during labour require that women are transferred from one process of care to another. Clearly a change in environment should not preclude safeguarding a woman's dignity – even in emergency situations. However, the rigorous entry criteria for low risk women to the Birth Centre has helped to ensure that the transfer rates of women from the centre are low.

Jane Walker
We anticipated that antenatally up to thirty percent of women would be transferring for their care because that's what the literature led us to believe. We had about a seventeen percent transfer of care antenatally, Then, when it comes to labour, eighty eight percent of the women came here in labour. Eight percent transferred during labour, and again the stats led us to believe anything up to a sixteen percent transfer rate in labour.

Presenter
Quite apart from its impact on patients, what effect does working at the Birth centre have on its staff?

Jane Walker
As midwives working in a in a busy acute unit, you learn to practice defensively and when you come to a unit like this where you are actually encouraged to expose your vulnerability, maybe where the gaps in your knowledge are, maybe where the gaps in your experience are, that is very difficult to do. But it has been such an opportunity for personal growth and development.

Presenter
Part of the shared philosophy of the centre is to have regular opportunities for group guided reflection – where staff at the centre exchange ideas about their work.

Olive Jones
I've sat and observed the midwives and I tell you I feel so proud of them. They have absolutely blossomed and they are so brave now. They have confidence to sit there and present their cases and the self-analysis, I mean it's just phenomenal.

Jean Chapple
One of the issues is going to be how much it actually costs to have a baby at the birth centre. It may be cheaper to run the birth centre with a lot more women delivering there, but then you might lose some of the the feel of it being small and homely with everybody getting known.

Jane Walker
One of the successful components of a unit like this, is its intimacy, as soon as you start expanding the numbers game, you'll lose some of the quality of care, and the quality of the environment. And so, our motto is, there should be one in every health district and it's more rather than bigger.

Presenter
What do units like the Edgware Birth Centre suggest for future models of maternity care throughout the NHS?

Jean Chapple
It would make quite good sense to have a birth centre midwifery led centre, and an obstetric consultant led centre very near each other because they're symbiotic they need to work together, but how could we make that happen and how can we stop takeovers by the doctors ?

Olive Jones
From the feedback we've had from the midwives, the way they need to practice in a stand alone unit, is different in terms of decision making than when they're practising in the consultant unit As they gain confidence in their decision making and in their own ability they become empowered as practitioners. The empowered midwife is then in the position to empower the women in their care.

Andrew Prentice
In certain parts of the country it may be desirable to have a local midwifery unit because it's 60, 70 miles to the local consultant unit. There in that situation there's no doubt that you have to have a separate unit. If you have a situation where geographically the patients travel no further to the midwifery unit than they would travel to the consultant unit then ideally they should be on the same site and ideally they should be on the same floor and what we should strive to have in these integrated units is that when people move from one type of care to another type of care, that transition as far as the patient is concerned should be seamless.

Presenter
Andrew Prentice, consultant obstetrician at the Rosie Maternity Hospital in Cambridge. His colleague, Jen Ferry, Maternity Services Manager, favours an integrated model.

Jen Ferry
Inherently childbirth is unpredictable. If the integrated unit is structured appropriately then women can go through on a totally low risk track with no medical intervention whatsoever. However, if and when problems do arise, either in pregnancy or in labour, the midwives have the support of the consultant team alongside. It enables swift effective transfer from midwifery-led care to consultant-led care. It also enables the midwives to have a greater range of skills and when they deal with the abnormal as well as the normal cases, they are usually quicker to identify problems.