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Building confident ways of working together around higher-risk birth choices


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Mariamni is a qualitative midwife researcher with a special interest in women's experiences of childbirth and midwifery attitudes around 'high-risk' or unconventional birth choices. Other research interests include the spirituality of birth, birth art, creativity in midwifery practice, and hermeneutic phenomenology. She currently divides her time between research projects based in the UK and graduate study in the USA where she is a PhD student at Marquette University exploring the meaning of 'trust' in midwifery relationships. She also runs 'The Nativity Studio' making birth art with families and birth workers, and blogs at midwifemariamni.wordpress.com.


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Shawn is a midwifery lecturer at City University London who provides clinical support to other health professionals at planned breech births. She developed the Heads Up Clinic model at the James Paget University Hospital in Norfolk, where she worked as a Breech Specialist Midwife. Most recently with Imperial College Healthcare, she has provided consultancy, education and proactive risk management for hospitals attempting to reinstate support for planned breech births in a safe and sustainable way. She is writing her PhD on '*Upright breech birth competence and expertise*', and blogs at breechbirth.org.uk.

'Self-preservation is a full time occupation'

DiFranco A (1990). *Talk to me now*. Buffalo, NY: Righteous Babe Records.

Midwives and higher-risk birth choices

Women who want to make choices about their births which are different from standard care practices or fall outside guidelines, especially when their pregnancies are categorized as 'higher risk', may often feel that midwives are more aligned with the hospital system which employs them than with the women who receive their care (Kirkham 2010). Midwives who seek to support women and provide a care pathway which is tailored to the woman's unique circumstances, often find themselves bullied and reprimanded and their practice subjected to intense scrutiny (RCM 1996, Gillen *et al* 2008). A risk-averse hospital culture, where standardised pathways aimed at risk reduction are the driving factors behind guidelines and protocols, provides a conflicted environment for the midwife aiming to deliver authentically woman-centred care which bears any resemblance to the government policy rhetoric of informed choice as set out in documents such as *Maternity matters* (DH 2007).

It is in this setting that midwives suffer 'burn out', become worn down by systematic pressures of working within the hospital care system, and develop defensive coping mechanisms (Kirkham *et al* 2006). Shallow describes many midwives '*being torn between their loyalty to women and their duty to the organisation, leaving them feeling vulnerable and caught between the familiar rock and hard place*' (Shallow 2013). In a context of professional conflict (both horizontally within the midwifery workforce and in a hierarchical structure with obstetric colleagues) it is difficult for the midwife to voice doubts and concerns about a clinical situation both to her peers and to the family, particularly if she alone is holding the space for the woman's birth plan when it is contested by midwifery and obstetric colleagues. This dysfunctional and hostile environment, with suboptimal communication, diminishes safety and can easily erode the trusting relationship between midwife and mother, which may leave the midwife feeling isolated through lack of support from her peers (Stevens 2003, RCOG 2008, Schmid & Downe 2010). Where there is isolation, a lack of mutual support, pressure to conform and an ingrained sense of helplessness, midwives themselves feel unsupported and it becomes extremely difficult for them to extend their support to women (Kirkham 2010).

We need to reconceptualise ways for midwifery autonomy to function within institutions, and create sustainable and healthy ways of supporting midwives so that they are not reduced to defensive and all-consuming self-preservatory coping mechanisms and behaviours, enabling them to be wholly present for the women in their care. Many women are increasingly asking for low-intervention care regardless of their risk status, which requires midwives to have the skills to normalise unusual labours (Schmid & Downe 2010, Welsh & Symon 2014). In this way the midwife moves beyond classic dichotomous models of care to become '*a postmodern midwife who can seamlessly traverse between social and technocratic models*' (Walsh 2010:4). This type of midwife does not operate in isolation but is engaged in 'active consultation' and develops collaborative and co-operative relationships with the multidisciplinary team and the family (McCourt 2010).

Building confidence out of fear

Defensive practice has become commonplace in the delivery of maternity care in general, with midwives needing to demonstrate, often repeatedly, that they have appropriately counselled women on the 'risk' of certain procedures or choices (Birthrights 2013). It has been well documented in midwifery research literature that this type of defensive and 'self-preservatory' mindset has contributed towards manipulative behaviours in which midwives both overtly and subtly 'direct' women towards making the 'right' choice (Edwards 2005, Kirkham 2010, Birthrights 2013). This culture of coercion and compliance leaves midwives who advocate for and support women who make higher-risk choices extremely vulnerable and can make them feel isolated from their peers, perceived as 'trouble' by their managers and feel that they are taking on a high level of personal risk. One way forward in providing normal midwifery care for high-risk women is by providing support systems for midwives through strong leadership and fostering a midwifery team approach to complex care provision with the focus on normality. Changing the culture of care provision to enable women to make real choices, rather than be managed towards making the 'right' choices, requires midwifery and obstetric creativity and innovation.

Consultant midwives can play an important role in facilitating this type of change; however as Shallow notes, changing set processes such as Trust guideline ratification procedures can present insurmountable obstacles. In her case, attempting to develop a guideline for women opting for low-intervention active vaginal birth after caesarean section (VBAC) proved difficult. Unable to get their guideline ratified, they instead called it a framework and it has now been in use for seven years (Shallow 2013). The existence of their documented framework has supported both women who desire

a low-intervention model of care and the midwives who care for those women.

Often, low-intervention models of care for higher-risk women have a midwife as the lead professional at birth rather than an obstetric lead; the pressures on this midwife to both deliver care and simultaneously document have a negative impact on her ability to provide high-quality midwifery care at birth and during labour. The provision of high-quality care, or what is sometimes described as 'presence', is often a crucial component of facilitating a good outcome (Pembroke & Pembroke 2008, Kennedy *et al* 2010). An obstetrician taking the lead at a breech birth, for example, would have dedicated team support, while a midwife lead might be expected to multi-task to a far greater extent than is feasible, resulting in some aspect of care being suboptimal. A culture of blame for bad outcomes has led to an increasingly fearful climate, especially in higher-risk cases, where '*in order to protect themselves midwives felt compelled to produce very thorough documentation at the expense of providing high quality midwifery care* (Birthrights 2013:19). Whilst supervision can be one means of addressing a blame culture that can lead to horizontal bullying for individual midwives, there needs to be a paradigm shift to make women-centred midwifery care possible, sustainable and fearless, through support rather than blame (Wilkins & Hawkins 2005).

What does 'support' look like?

Alongside written guidelines, frameworks, and pathways, managers and colleagues need to support midwives to deliver higher quality midwifery care while maintaining standards of documentation and safe practice. The question is, what does 'support' look like and how can it be implemented to enhance midwifery care? Midwifery 'pairing' as practised at home births could be remodelled within the hospital environment, with a clear definition of roles, for example one person to focus on the woman and another to act as record keeper. A high level of mutual trust, rapport, and attunement between midwives is necessary in this type of situation. The record keeper needs an in-depth understanding of the clinical decision making process which may unfold during the care episode, and a robust knowledge of the manoeuvres involved in supporting complications when using new ways of working in non-lithotomy positions (such as upright breech birth). Rather than being a second midwife in the room in a clinical sense, the second midwife's role is to 'midwife the midwife', to be her scribe, her interlocutor, and to 'cover her back' because the demands placed on a midwife in this type of situation may extend beyond the physical capabilities of a single midwife. While staff shortages may impede this type of support being implemented, in the longer term this approach may have a significant impact on the long-term retention of midwifery staff.

Real practical support also means building relationships within the workforce to combat the perception and isolation of midwives who facilitate choice as 'deviant' or 'maverick'. This requires brave and forward-thinking leadership and managerial support, which is followed through on the floor and does not consist of empty promises or support rhetoric. It also involves time and commitment to building dynamic cohesive teams which can respond appropriately to complex clinical scenarios such as upright breech birth. This situation requires a flexible, normality-focused approach with continuity of care, good communication, eye contact between the care team members, and a thorough understanding of the appropriate time to intervene with manoeuvres. This is challenging in a system which is geared towards a clearly defined team approach to standardised obstetric scenarios (usually classified as emergencies) where a uniform approach is adopted and follows an established drill. A new approach could be both uncomfortable and destabilising — we suggest that such midwifery-led teams are currently in a 'liminal stage', standing at the threshold of new ways of working, and in the process of identifying different strategies to ensure effective teamwork around the time of birth.

Developing reflexive adaptable teamwork

Upright breech birth is a good example of where a more flexible team approach may be needed, and where a lead midwife will need to be well supported to deliver the safest possible care, moving beyond the dichotomous tensions between obstetric and midwifery approaches to a collaborative vision of care (Plested 2013). Supporting a woman's choice for a planned active upright breech birth needs teams which evolve with experience, who take time out to reflect and observe themselves, and make a plan to become a stronger, tighter team (Walker 2014). Providing a planned breech birth service necessitates a reflective remodelling of the workforce and cannot lie on the shoulders of a single specialist midwife. Where women opt for a 'midwife-led' higher-risk birth we cannot continue to put them in conflict-ridden scenarios where an obstetric team is headed by a token midwife; even in situations where there is no open conflict, there is often a tendency for team members to become 'enthralled' by the unusual event unfolding, not focussed on what their role is. We need to find novel and innovative ways of building midwifery-led teams that incorporate obstetric expertise appropriately and develop a mutually respectful skill-sharing exchange (and reskilling if necessary), such as a specialised midwifery-led breech birth service with continuity and integrated obstetric and midwifery expertise.

Teamwork is fundamental to the safety of breech births, but as skills around breech birth are nurtured the team must also have flexible, evolving, ongoing development. Proactive, rather than reactive risk management is crucial to this process. Michael West has written extensively about the characteristics of 'real teams,' as opposed to 'pseudo teams.' Real teams have clear, shared team objectives, role interdependence and role clarity, and they meet regularly to review and improve performance (West & Lyubovnikova 2013). Supporting women with individualised care in high-risk situations is essentially a constant innovation.

Key points:

- For a midwife to provide quality care and 'presence' at higher-risk births she needs designated support, particularly with documentation and novel clinical skills.
- Normalising complex births requires innovative team formation and openness to learning and sharing new skills.
- Unique care plans require dynamic teams with flexible, evolving, ongoing development strategies.
- Proactive, rather than reactive, risk management is crucial to cultural change which is maximally safe for mothers, babies and health professionals.

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