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Midwifery-led models of care

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Abstract

Pregnant women are faced with an overwhelming array of options for their pregnancy, birth and postnatal care. However, while there may be many options, how can a woman choose which one is appropriate for her? This essay presents an overview of the different models of care available to women and then focuses on two specific ones, caseload midwifery and homebirth. First, the models of care are briefly outlined and the midwifery-led models of care are highlighted. Then, caseload midwifery and homebirthing are critically analysed, including definitions of each, the effects of these models of care on women and the advantages and disadvantages of each for women and midwives according to midwifery research. There are many consequences of a woman's choice of model of care and it could be the subject of more midwifery research to discover why women choose a specific model of care and how they would evaluate the outcome of that decision. However, this assignment aims to give only a brief survey of the caseload midwifery and homebirth models of care.

Pregnant women are faced with an overwhelming array of options for their pregnancy, birth and postnatal care. However, while there may be many options, how can a woman choose which one is appropriate for her? This essay presents an overview of the different models of care available to women and then focuses on two specific ones, caseload midwifery and homebirth. First, the models of care are briefly outlined and the midwifery-led models of care are highlighted. Then, caseload midwifery and homebirthing are critically analysed, including definitions of each, the effects of these models of care on women and the advantages and disadvantages of each for women and midwives according to midwifery research. There are many consequences of a woman's choice of model of care and it could be the subject of more midwifery research to discover why women choose a specific model of care and how they would evaluate the outcome of that decision. However, this assignment aims to give only a brief survey of the caseload midwifery and homebirth models of care.

There are many models of care to choose from. The options vary between public and private care with a general practitioner (GP), obstetrician or midwife as the primary carer. At the Royal Hobart

Hospital (RHH), the options given to women on booking in are share care with a GP, the Know Your Midwife (KYM) scheme, the Birth Centre, the midwives clinic, and an obstetrician if there are complications with the pregnancy (RHH Maternity Unit 2006, p. 1). There are two distinct cultures in caring for women throughout pregnancy: the midwifery view that pregnancy and birth are low-risk natural events requiring guidance, support, counselling and medical intervention only as needed, and the obstetric view that birth is a potentially high-risk situation requiring technological back-up. Midwives operate under a wellness model while obstetricians under an illness model (Reibel 2004, p. 329). The World Health Organisation (WHO) states that midwives are the most appropriate primary carers for women during pregnancy and childbirth as these are normal biological processes where most women will achieve successful outcomes if given support and patience. These conflicting philosophies on pregnancy and birth affect the models of care available to women today and also how women choose their preferred model of care (Armstrong 2005, p. 13; Forrest 2006, p. 4; Halliday et al. 1999, pp. 19-21) .

Women need quality, evidence-based information on various models of care to enable them to make informed choices during their pregnancy (Australian Health Workforce Advisory Committee 2002, p. 26). The *Who Usually Delivers Whom And Where Report* (WUDWAW) (Halliday et al. 1999, p. 33) found that the most frequently used model of care is specialist private obstetrician care.

Western countries place trust in more medicalised models of care (Reibel 2004, p. 329). Only 0.1 percent of women chose to have a midwife in private practice (MIPP) and 0.7 percent of women chose the caseload midwifery model of care for their antenatal and intrapartum care (Halliday et al. 1999, p. 24). This research clearly demonstrates that Australian women prefer the private and medicalised models of care. However, as a midwife-to-be, I am interested in the midwifery-led models of care where women and midwives are the powerplayers and how these models of care can best serve the needs of women.

Caseload midwifery is an example of a midwifery-led model of care. The philosophy in caseload midwifery is that a midwife enters into a professional partnership with the pregnant woman. This allows for equality, shared responsibility, informed choices, empowerment, individual negotiation and self-fulfillment for both the woman and the midwife. The care is woman-centred, pregnancy and birth are viewed as normal and healthy life events and continuity of care is ensured by having one primary midwife as the main caregiver (Forrest 2006, pp. 2-7). Usually, a midwife works with

a woman and has one or two midwives who act as “back-up” midwives for the primary caregiver and also meet the woman once or twice antenatally. The primary midwife meets the client six to eight times antenatally, referring the woman for doctor visits in weeks twelve to sixteen, thirty-six and after forty weeks (Johnson et al. 2005, p. 22). One of the three midwives known to the woman will be present for the intrapartum period. And postnatally, discharge within twenty-four hours is encouraged and the primary midwife does home visits for the first ten days and then up to six weeks postpartum as needed. This increases maternal independence and confidence while still having the guidance of a midwife on hand (Forrest 2006, pp. 11-12).

A full-time caseload is forty births per midwife per year plus back-up cases too. The caseload midwives work in collaboration with GPs, obstetricians, specialist obstetricians, child health nurses, drug and alcohol services, social workers and other relevant health professionals to provide a “seamless” service throughout the woman's antenatal, intrapartum and postnatal periods. Epidurals, inductions, episiotomies and other medical interventions are not first-line options in caseload midwifery and women are transferred to a tertiary hospital if these services are required (Tracy et al. 2005, p. 336). Forrest (2006, p. 13) states that Northwest Private Hospital already has the caseload midwifery model of care. She has presented a proposal to the Tasmanian State Government for implementation of caseload midwifery on a statewide basis. Midwives are covered by indemnity insurance within the public hospital system with this model of care, an important aspect to care that is lacking in the homebirth model at present (Tracy et al. 2005, p. 337).

Homebirth is another midwifery-led model of care available to women. It shares the caseload philosophy that childbirth is a normal part of life, not an illness, and that it is important to develop a rapport between woman and their midwives (Having a Baby in Victoria website, viewed 4 April 2006). Midwives in private practice (MIPP) work outside the hospital and assist women with uncomplicated pregnancies to birth at home. All of the antenatal, intrapartum and postnatal care is provided by one independent midwife, with one or two back-up midwives. The MIPP is on-call for labour and birth. Midwives in private practice work in collaboration with obstetricians, GPs and other health professionals and accompany the women to the hospital if there are any complications with the pregnancy or birth (Australian Health Workforce Advisory Committee 2002, p. 31; Maternity Care Options website, viewed 4 April 2006). Hospital is the most common place for Australian women to give birth, but studies in the United Kingdom, United States, Netherlands, Switzerland and New Zealand show that planned homebirth by a qualified MIPP is as safe as a

hospital birth (Janssen et al. 2002, p. 315). Any woman with complications is transferred to a hospital. Consequently, the maternal and neonatal mortality and morbidity outcomes are higher in hospital due to higher intervention rates (Reibel 2004, p. 333). Cases that are ineligible for homebirthing are multiple pregnancies, breech presentation, bleeding during pregnancy or labour, pre-eclampsia, birth before thirty-seven weeks, birth after forty-one weeks, placenta problems and baby distress in labour (Homebirth website, viewed 21 April 2006). While homebirth is not a common model of care used in Australia, there is sufficient demand for homebirth to guarantee that it will remain a service that women will continue to utilise and MIPPs will continue to provide.

The caseload midwifery model of care gets positive reports from women. Women have higher satisfaction levels with their antenatal care and level of preparedness for birth and motherhood. Maternal outcomes of caseload care compared to standard hospital care demonstrate lower inductions, lower episiotomies, lower medical interventions and higher requests for pethidine. This last fact may reflect the strong rapport between the midwife and woman and the woman feeling comfortable enough to ask for pain relief or the midwife being more intuitive about the woman's pain relief needs. Infant outcomes are similar to standard hospital care (Johnson et al. 2005, pp. 22-26). Women have commented they felt more in control in labour and labour was a more positive experience with a known midwife in attendance (Flint & Poulengeris 1988, p. 1). Less conflicting advice from different caregivers, lower unnecessary admissions to hospital, reduced length of stay in hospital, lower anxiety and pain levels are all benefits associated with the caseload midwifery model of care (Swan 1993, p. 59). When I described the caseload midwifery model of care to a mothers group, every mother was excited about an option that involved a one-to-one relationship with a known midwife during the pregnancy, labour, birth and postnatally. They asked when this model of care would be available to women in Hobart and Tasmania (Birth and Beyond, attended 24 April 2006). The caseload midwifery model of care offers many improvements to the standard hospital care conventionally offered to women.

The homebirth model of care struggles to prove that it is a safe option for women and babies in the face of a strongly medicalised view of childbirth in Australian society. In the 1970's and 1980's, the hospital was considered the only safe place to give birth, and many people still believe this. There is mounting evidence that for low-risk pregnancies, there is no significant difference in clinical outcomes between homebirths and hospital births (Huisman 2003, p. 72). Many women have their first child in hospital and have a positive experience. Some women, in contrast, feel disrespected,

disempowered, scared, uninformed and disregarded by hospital staff, doctors and midwives alike (Birth and Beyond, attended 24 April 2006; Craven 2005, pp. 204-205). These are the women who may choose homebirth for successive births. A MIPP attends all the antenatal care of each woman and monitors for complications. If there are no complications, homebirth is a safe, empowering, affirming and amazing life event. Women find the environment more supportive, and therefore easier to birth in, empowering, women are in control of the situation, it is private, only people known to the woman are present and invited, there is a lower risk of infection, and women have an empowering start to motherhood (Huisman 2003, p. 72; *Network News* 2001, p. 2). Due to the birth taking place at home, women are free to express themselves in their own style and they do not have the threat or fear of medical intervention looming over them (Homebirth Australia website, viewed 21 April 2006). If complications do arise, the MIPP transfers their woman to hospital care. The most common complications are foetal distress and maternal bleeding. The key seems to be knowing when to move to hospital prior to an emergency situation developing (Bastian et al. 1998, p. 387; Reichert 2002, p. 70). This is where the rapport established by a homebirth midwife is crucial to a woman's care.

Midwives also report advantages to the caseload model of care. They act as independent and autonomous practitioners and are responsible for their own caseload of women. Higher levels of job satisfaction and more opportunity to develop and utilise midwifery skills are advantages as this model of care moves away from the current fragmented and compartmentalised service offered to women today. Midwives learn from their colleagues and relationships between doctors and midwives involve more understanding and appreciation for their differing roles (Stock 1994, pp. 33-35). This is opposed to midwives trying to carve out a profession in the shadow of obstetric dominance. Midwives expand their scope of practice to include health education and counselling, in accordance with the WHO definition of a midwife, with programs on immunisation, safe sex, family planning and preconceptual care (Swan 1993, p. 61). The caseload model of care has many benefits to offer midwives.

With homebirthing, midwives also can practice in their own style, work autonomously and collaborate professionally with other health service providers as appropriate to each individual client (*Network News* 2001, p. 2). Women and midwives have a personal one-to-one relationship and there are no rushed appointments or feeling part of a production line of childbearing women, a comment made at a mother's group (Birth and Beyond, attended 24 April 2006; Reichert 2002, p.

70). Women usually interview several MIPPs and can choose the one they feel most comfortable with (Homebirth website, viewed 21 April 2006). However, due to the lack of knowledge about homebirth, there are not many MIPP's to choose from. In Hobart, there are four. As homebirth becomes more accepted and more people learn about the advantages of homebirth, this may become a more popular and accessible option for women.

Naturally, there are some disadvantages to midwifery-led models of care. Caseload midwifery demands more flexibility from midwives as they are responsible for the “total care” of their clients, antenatally, intrapartum and postnatally. They are on-call and the frequency and length of these shifts can be draining. Some midwives find it hard to “switch off” from work when they are at home due to being on-call. The many on-call hours can lead to high burnout rates. Not all midwives are able to commit to this style of midwifery. Stock (1994, p. 34) found that younger midwives were more supportive than older ones of the integrated team care approach. Perhaps this is due to older midwives having more commitments outside work or being accustomed to the more compartmentalised model of care. One midwife in Stock's study stated that she would not be able to handle the caseload without a supportive family and partner. With the great improvement in continuity of care that the caseload midwifery model of care offers, challenges still remain for midwives.

Midwives in private practice find challenges within the homebirthing model of care also. Many MIPPs must maintain work outside their homebirthing to stay financially solvent. They are constantly battling against public and professional misconceptions and fear about homebirth. There is low peer support, professional isolation and the constant fear of jeopardising their professional status if anything goes wrong with a homebirth. Deregulation and loss of career are constant insecurities in the current climate of social, political and professional hostility toward homebirthing (Homebirth Australia website, viewed 21 April 2006). The policy that evidences this hostility clearly is the battle for MIPPs to have professional indemnity insurance. In 2001, the government revoked MIPPs' indemnity. The Northern Territory, South Australia and Western Australia now offer subsidised indemnity to MIPPs through their health departments (*Australian Nursing Journal* February 2005, p. 5). In Tasmania, no government-subsidised indemnity insurance is available to MIPPs. A midwife has the duty to inform her client of this on their initial consultation and then the relationship is entered into with clear knowledge of this fact. Clearly, the “underground” status of the homebirth model of care serves only to further call into question and stigmatise the women and

midwives who operate within this model. However, women will continue to choose planned homebirths and their midwives will continue to practice their skills because there is a need in the community for this option.

In conclusion, women are faced with a multitude of choices of maternity care when they become pregnant. These models of care vary from public to private, home or hospital, and obstetrician-led or midwifery-led care. There are problems commonly encountered by women and midwives with the models of care available today and one solution is the development and implementation of midwifery-led models of care. Two specific examples of these, caseload midwifery and homebirth, are defined and the effects on women, advantages and disadvantages to both women and midwives are critically analysed. The maternity care system in Australia currently is not satisfying its consumers or health care providers. Lesser-known models of care, such as caseload midwifery and homebirth, are being suggested as ways to increase satisfaction and continuity of care for women and their midwives.

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