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Being safe practitioners and safe mothers: A critical ethnography of continuity of care midwifery in Australia

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ABSTRACT

Objective: to examine how midwives and women within a continuity of care midwifery programme in Australia conceptualised childbirth risk and the influences of these conceptualisations on women's choices and midwives' practice.
Design and setting: a critical ethnography within a community-based continuity of midwifery care programme, including semi-structured interviews and the observation of sequential antenatal appointments.
Participants: eight midwives, an obstetrician and 17 women.
Findings: the midwives assumed a risk-negotiator role in order to mediate relationships between women and hospital-based maternity staff. The role of risk-negotiator relied profoundly on the trust engendered in their relationships with women. Trust within the mother–midwife relationship furthermore acted as a catalyst for complex processes of identity work which, in turn, allowed midwives to manipulate existing obstetric risk hierarchies and effectively re-order risk conceptualisations. In establishing and maintaining identities of 'safe practitioner' and 'safe mother', greater scope for the negotiation of normal within a context of obstetric risk was achieved.
Key conclusions and implications for practice: the effects of obstetric risk practices can be mitigated when trust within the mother–midwife relationship acts as a catalyst for identity work and supports the midwife's role as a risk-negotiator. The achievement of mutual identity-work through the midwives' role as risk-negotiator can contribute to improved outcomes for women receiving continuity of care. However, midwives needed to perform the role of risk-negotiator while simultaneously negotiating their professional credibility in a setting that construed their practice as risky.

Introduction

The term continuity of care has been defined in a variety of ways (Hatem et al., 2008; Sandall et al., 2013) and for the purposes of this study was defined as a midwife with responsibility for providing antenatal, intrapartum and postnatal care to the women in her caseload and sharing these responsibilities with medical colleagues for women at higher risk. Literature over the last 15 years documents the effectiveness and safety of midwifery continuity of care and demonstrates women's preference for such care (Homer et al., 2002; Tracy et al., 2005; McCourt et al., 2006; Henderson et al., 2007; Hatem et al., 2008; Turnball et al., 2009; Fereday et al., 2009; Improving Maternity Services in Australia, 2009; Sandall et al., 2013). A recent randomised controlled trial of midwifery caseload *versus* standard maternity care for 2314 low-risk women in Australia (McLachlan et al., 2012) has further confirmed that continuity of care can significantly reduce intervention in birth, particularly caesarean section, and improve outcomes for babies while maintaining safety. However, despite research findings supported by numerous federal and state government reviews, evidence for the safety and suitability of primary midwifery care for low risk women has not yet resulted in major change in Australia. Currently less than 10% of Australian women are able to access primary care from a midwife (Laws et al., 2010).

Much of this lack of reform has been attributed to the effects of childbirth risk reconceptualisations over the last century (Murphy-Lawless, 1998); effects which continue to dominate today (MacKenzie Bryers and van Teijlingen, 2010). Medicalisation of childbirth was supported by the accumulation of mass statistical data on individuals and quickly became estimates of risk applicable to whole populations (Lupton, 1999). When subsequently

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re-applied to childbearing women, risks were not only factual entities able to determine the likelihood of danger but were embodied in outcomes for which women were increasingly responsible. Lupton (1999, p. 66) argues this resulted in the assumption that if childbearing women know about their risks, they will (and should) take precautions to avoid them. Such assumptions have shaped maternity services policy worldwide and, despite being safer than ever in the developed west, birth is an event for which risks must be identified, calculated and managed (Lane, 2006; Tracy, 2006).

Edwards and Murphy-Lawless (2006) argue that medical control of childbirth was inevitable once doctors offered guarantees of safety, and such assurances remain the foundation on which medical dominance of childbirth rests (Skinner, 2003; Symon, 2006; Reiger, 2006; MacKenzie Bryers and van Teijlingen, 2010). As Tracy (2006, p. 232) acknowledges, medical assurances countering the 'inevitability of risk' in childbirth were a compelling directive for women, a directive Dahlen (2010) argues is now conflated with an unwarranted emphasis on catastrophic adverse events in childbirth. Such events, though relatively uncommon in the west, have nevertheless become powerful determinants of care provision (Dahlen, 2010) and have significantly affected women's outcomes (Stahl and Hundley, 2003; Redshaw et al., 2007; Fahy, 2011). The most recent figures from 2008 show just 36.9% of women in Australia gave birth according to a definition of 'normal' which excludes induction, augmentation, instrumental birth, spinal, general or epidural anaesthesia (Laws et al., 2010). Increasing intervention brings additional risks to mother and infant from a rising caesarean section rate (Gilliam et al., 2002; Souza et al., 2010) and its well-documented psychosocial sequelae (Parratt, 2002; Beech and Phipps, 2004).

Western childbirth practices that recruit women into high levels of risk self-surveillance also result in high levels of fear (Reiger et al., 2006). A study by Fisher et al. (2006) shows that women fear the prospect of a medical event over which they will have no control, and Nilsson and Lundgren (2009, p. e7) have demonstrated links between negative birth experiences and high levels of fear in subsequent pregnancies. Dahlen (2010) considers an increased fear of childbirth to also be a strong influence on midwives' clinical practice, determining the type of care they are willing to provide. Edwards and Murphy-Lawless (2006, p. 45) found many midwives practiced within the 'narrow parameter of risk management' which curbed their ability to provide individualised care, or to support women's choices. Similarly, a study by O'Connell and Downe (2009, p. 590) indicates that while many midwives continue to speak of a commitment to 'real midwifery', they practice 'in hierarchical, rule-governed hospital settings' that they feel powerless to change.

Ironically, the effectiveness of women's and midwives' opposition has been weakened by the consequences of legal interpretations of medical guarantees offered to women. When the inevitable ensued and the perfect baby could not be delivered (Wilson and Symon, 2002) recourse to the courts has seen an escalation in litigation that has become a central driver of obstetric practice in Australia and other western countries (Clark et al., 2008). Major increases in litigation settlements have driven exponential growth in premiums for Professional Indemnity Insurance and medical fears of an adverse birth outcome have intensified (Chandraharan and Arulkumaran, 2006; Seymour, 2010), leading to further over servicing of normal birth (Albers, 2005). Consequently, greater surveillance of low-risk women for medico-legal reasons has fuelled a rise in defensive practice in obstetrics (Mann, 2004; Williams and Arulkumaran, 2004; Fuglenes et al., 2009) and led to growing concerns about the effects of litigation on the obstetric professions' future (MacLennan et al., 2005; Bismark and Paterson, 2006; Hankins et al., 2006).

Unfortunately, such outcomes have not resulted in doctors' accepting greater responsibility for excessively negative perceptions of the riskiness of childbirth or for increased levels of fear. Calls for a more balanced view of childbirth risk do not appear to be gaining traction either (Weaver et al., 2005; Reiger and Dempsey, 2006; Skinner, 2011; Dahlen, 2012a), and the outcome is a birth culture where, on the basis of risk, primary midwifery care is deemed a 'luxury' unsuitable for most women (AMA, 2008, p. 11) and a woman's birth 'experience' is pejoratively judged as secondary to ensuring the safety of her infant (De Costa and Robson, 2004, p. 438). New Zealand, with a 20 year history of midwives working with greater autonomy, has provided valuable insight into how midwives challenge (or work around) medical conceptualisation of childbirth risk, and yet recent studies suggest midwives there still grapple with the effect of these medico-legal constraints. In accounting for this, Skinner and Foureur (2010, p. 34) suggest medico-legal concerns remain the primary driver for intervention in birth, and contrasting viewpoints between midwives and doctors still persist to such a degree that they remain 'the central challenge to collaboration' between the professions.

Midwives' and women's concerns have not gone unheeded, however, and in late 2010 Medicare[1] funding was extended to a new classification of midwife for the provision of primary maternity care – the eligible midwife – and a growing number of midwives are seeking the required accreditation (Nursing and Midwifery Board of Australia (NMBA), 2010). Ongoing medical opposition (Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 2008) has led to the inclusion of contentious and restrictive eligibility criteria for collaborative arrangements with 'a named doctor' in order to access Medicare funding (Lane, 2011), although attempts have been made to change this to the more generic 'health care provider', following doctors' reluctance to engage with midwives outside traditional hospital-based roles. Should attempts to loosen the eligibility criteria succeed, they represent an important step in reducing the medical monopoly on primary maternity care provision, and encouraging midwives in Australia to move into more self-determining roles (Dahlen, 2012b).

Despite the increasing focus on risk in maternity care there is little understanding of how midwives and the women they care for conceptualise risk and safety within the context of primary midwifery care. This study was undertaken (as a doctoral thesis) with the aim of examining how midwives and women within a continuity of care midwifery programme in Australia conceptualised childbirth risk and safety, and the influences of these conceptualisations on women's choices and midwives' practice.

Methodology

Ethnography was chosen for its historical and functional concern with the study of human culture, as observed through patterns of language, communication and behaviour, as well as for its ability to focus research attention on the lived context of participants' lives (Atkinson et al., 2001). In addition, because the aim of the study was to examine how childbirth risk and safety were conceptualised by participants, and the influences of these conceptualisations on women's birthing care choices and midwives' practice, a critical approach to ethnography (Carspecken, 1996, 1999) was chosen as this provides two additional strengths. First, it is a framework that acknowledges cultural impacts on practice as dynamic processes rather than fixed entities. Second, an orientation based on Habermasian critical social theory emphasises the emancipatory intent of the research endeavour (Habermas, 1984, 1987). Critical

[1] Australia's universal health care program funded by a levy paid through the taxation system.