Midwifery 50 (2017) 148–156

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

The motivation and capacity to go 'above and beyond': Qualitative analysis of free-text survey responses in the M@NGO randomised controlled trial of caseload midwifery

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ARTICLE INFO

Keywords:
Midwifery
Continuity of care
Patient empowerment
Psychophysiology
Qualitative research
Randomised controlled trial

ABSTRACT

Objective: to explore whether women allocated to caseload care characterise their midwife differently to those allocated to standard care.
Design: multi-site unblinded, randomised, controlled, parallel-group trial.
Setting: the study was conducted in two metropolitan teaching hospitals across two Australian cities.
Population: women of all obstetric risk were eligible to participate. Inclusion criteria were: 18 years or older, less than 24 week's gestation with a singleton pregnancy. Women already booked with a care provider or planning to have an elective caesarean section were excluded.
Interventions: participants were randomised to caseload midwifery or standard care. The caseload model provided antenatal, intrapartum and postnatal care from a primary midwife or 'back-up' midwife; as well as consultation with obstetric or medical physicians as indicated by national guidelines. The standard model included care from a general practitioner and/or midwives and obstetric doctors.
Measurements and findings: participants' responses to open-ended questions were collected through a 6-week postnatal survey and analysed thematically. A total of 1748 women were randomised between December 2008 – May 2011; 871 to caseload midwifery and 877 to standard care. The response rate to the 6-week survey including free text items was 52% (n=901). Respondents from both groups characterised midwives as Informative, Competent and Kind. Participants in the caseload group perceived midwives with additional qualities conceptualised as Empowering and 'Endorphic'. These concepts highlight some of the active ingredients that moderated or mediated the effects of the midwifery care within the M@NGO trial.
Key conclusion: caseload midwifery attracts, motivates and enables midwives to go Above and Beyond such that women feel empowered, nurtured and safe during pregnancy, labour and birth.
Implications for practice: the concept of an Endorphic midwife makes a useful contribution to midwifery theory as it enhances our understanding of how the complex intervention of caseload midwifery influences normal birth rates and experiences. Defining personal midwife attributes which are important for caseload models has potential implications for graduate attributes in degree programs leading to registration as a midwife and selection criteria for caseload midwife positions.

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http://dx.doi.org/10.1016/j.midw.2017.03.012
Received 3 November 2016; Received in revised form 7 March 2017; Accepted 24 March 2017

Introduction

Few interventions in maternity have been found to have as many benefits as midwifery-led models of care (caseload and team midwifery) which deliver beneficial clinical outcomes for mothers and babies including a lower risk of preterm birth, regional analgesia in labour, episiotomy, instrumental birth, fetal loss during the pregnancy and neonatal death (Sandall et al., 2016). Furthermore, randomised trials have demonstrated that caseload midwifery is cost-effective (Tracy et al., 2013) and increases the likelihood of maternal satisfaction across the spectrum of maternity care (McLachlan et al., 2016).

Caseload midwifery provides high-level relational continuity whereby childbearing women receive antenatal, intrapartum and postnatal care from a primary midwife and her/his back-up midwives (Beake et al., 2013). Consultation with and referral to other services and health professionals is foundational to midwifery practice (Sakala and Newburn, 2014); within caseload models it occurs as clinically indicated (Australian College of Midwives, 2014). Caseload midwifery is a complex intervention with a number of interacting components that take different forms in different contexts. However, any complex intervention must conform to specific, theory driven processes, which underlie contextual differences (Hawe et al., 2004). While it is unclear how the intervention exerts its effects, the benefits appear to derive from a 'therapeutic relationship' (Sandall et al., 2016) or are 'relationally mediated' (Walsh and Devane, 2012). In this paper, the term 'caseload midwifery' will be used interchangeably with Midwifery Group Practice (MGP); and the terms 'attributes', 'qualities' and 'characteristics' will be used synonymously.

Therapeutic relationships

Rogers (1965) first described the core conditions under which a therapeutic relationship could occur: 1) a genuine and authentic professional who uses appropriate levels of self-disclosure, 2) unconditional respect for the client regardless of their thoughts or actions, and 3) empathy. The concept of therapeutic relationship is explicitly and frequently used in the nursing literature (Milton, 2008; Welch, 2005). Muetzel's model of therapeutic nurse-patient relationships includes the concepts of partnership, intimacy and reciprocity (Richardson et al., 2015). Several authors suggest that nurses require specific personal attributes to engage therapeutically with patients including being caring, compassionate, sensitive and empathetic (Richardson et al., 2015; Shields, 2014; Attree, 2001). In midwifery, instead of a therapeutic relationship the widely adopted 'Partnership Model' characterises the relationship as one of "trust, shared control and responsibility and shared meaning through mutual understanding" (Guilliland and Pairman, 1995, p.7); a 'professional friendship' (Pairman, 2000; Walsh, 1999). The personal characteristics midwives need to work effectively in partnership relationships have not been articulated (Pairman and McAra-Couper, 2015).

Personal attributes

Qualities including being intelligent, friendly, honest and trustworthy, a good listener and communicator, patient and tactful, sensitive and compassionate, positive and tolerant (Waugh et al., 2014; Nicholls and Webb, 2006; Powell Kennedy 2000); are as important to childbearing women as the midwives' clinical knowledge and competence (Borrelli, 2014; Butler et al., 2008). A phenomenological study in the United Kingdom developed the concept of 'emotional capability' as an attribute, which includes empathy and the ability to connect with women (Byrom and Downe, 2008). A Delphi study conducted in the United States identified that the qualities of 'exemplary midwives' included philosophical commitments to: normal birth, family-centred care, women's empowerment, and the midwifery profession (Powell Kennedy, 2000). A systematic review of women's satisfaction with childbirth reported that feeling supported by caregivers, having a high quality caregiver-patient relationship, and feeling involved in decision-making were factors so important to women that they overrode differences in age, ethnicity and socioeconomic status (Hodnett, 2002).

The midwife's personal characteristics and philosophical commitments affect the nature and quality of the partnership in caseload midwifery models (Allen et al., 2016). In the largest trial of caseload midwifery (n=2314), participants allocated to the intervention: "felt more in control during labour, were more proud of themselves, less anxious, and more likely to have a positive experience of pain" compared to participants in standard care (McLachlan et al., 2016, p.465). Although caseload midwifery is a 'package of care', researchers have hypothesised that midwives drawn to work in caseload models might have different personal attributes or philosophies of care compared to midwives who elect to work standard shifts (Newton et al., 2016). The purpose of this paper is to explore whether women allocated to caseload care characterise their midwife differently from women allocated to standard care.

Methods

Aim

The aim of this study was to address one of the secondary outcomes of the M@NGO randomised controlled trial (RCT) of caseload midwifery: women's satisfaction with care. The research question which drove the analysis was: *How do the midwife's personal attributes affect women's satisfaction with care?* The objective was to analyse participants' responses to open-ended questions about their maternity care experiences according to allocated model of care.

Design/Methodology

The methodological orientation that underpinned the study was Pragmatism (Creswell and Plano Clark, 2007) whereby researchers pose and attempt to answer specific research questions "in a way that offers the best chance to obtain useful answers" (Johnson and Onwuegbuzie, 2004, pp.17).

The study methods and primary outcomes are described in detail elsewhere (Tracy et al., 2013). Briefly, we conducted a multi-site unblinded, randomised, controlled, parallel-group trial: Midwives @ New Group practice Options (M@NGO: Trials Registry, number ACTRN12609000349246) at two metropolitan teaching hospitals in Australia. Pregnant women booking-in to give birth at one of the two sites during the recruitment period were given written information about the M@NGO study by the booking midwife. Women of all obstetric risk were eligible to participate in the study. Inclusion criteria were: 18 years or older, less than 24 week's gestation with a singleton pregnancy. Women were excluded if they were already booked with a care provider or planned to have an elective caesarean section. Interested potential participants were referred to a research midwife who obtained written informed consent before participants were randomly allocated to receive caseload midwifery or standard care. In both the intervention and control groups care was provided according to the same hospital guidelines and protocols. During the study period, the intervention of caseload midwifery did not deviate from how it was described in the research protocol.

Data collection

Participants' baseline demographic characteristics and birth outcome data were extracted from medical electronic records. Women's experiences of antenatal, intrapartum and postnatal care were collected via email (with link to the survey URL) or postal hard-copy surveys, sent to women approximately six weeks after birth. One week later, a