



Commentary

Working out what works: The case of midwife led care – Commentary on: Is model of care associated with infant birth outcomes among vulnerable women? A scoping review of midwifery-led versus physician-led care



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The earliest published randomized trial of midwife led antenatal continuity of care appeared more than 25 years ago (Flint, Poulengeris, & Grant, 1989). The recent Cochrane review of all eligible midwife led continuity of care trials since then shows impressive clinical and psychosocial benefits for women randomized to this approach to maternity service delivery, when compared to other models of maternity care (Sandall, Soltani, Gates, Shennan, & Devane, 2015). The outcomes include reduced rates of prematurity, and of foetal/neonatal death. However, while the Cochrane review authors note that the benefits held true for both healthy women and babies and those with clinical complications, the review did not undertake a sub-analysis for women who were socio-demographically marginalised. These women and babies are particularly at risk of adverse clinical outcomes in pregnancy and labour, and so an assessment of the potential benefits of different models of maternity care for them could have significant implications for the future. The authors of the scoping review in this edition of the journal have undertaken this important task. They have also provided a careful analysis of what the potential mechanisms of effect might be for the results emerging from their review. This analysis provides a valuable basis for further commentary on what might actually be working in the context of midwife led care.

All but one of the studies in the Cochrane review took place in high income countries where midwifery is established and widely available (Australia, UK, Ireland). 'Usual' care, the comparator in most of the studies, therefore generally included some degree of midwife input for the women randomized to that arm. The remaining study took place in Canada, where the status of midwives at the time the study reported (1996) was much less certain, and the comparator was

physician led care. For most of the included studies in the Cochrane review, therefore, the difference between the control and the experimental arm was usually either the intention to limit the number of midwives the woman saw (the new schemes were usually around 6–8 midwives in a group or caseloading scheme, though they were as few as 1 or as many as 20 at the extremes) and/or the degree of autonomy for the midwives in their decision making. This raises a question as to which component(s) of midwife-led continuity of care might be the mechanism of effect for the beneficial outcomes that are observed in the review, and that might logically underpin the outcomes for marginalised women and families in the current scoping review.

If the effective component is related to the social and therapeutic effects of always seeing the same person, or a small group of people, throughout the maternity episode, this could be independent of the type of care-giver involved, or the philosophy of care being enacted.

It is likely to be based on the development of some degree of reciprocal trust and mutual respect between the care giver and the person receiving care. This could not only increase a sense of social support (with clinical and psychological benefits), but also encourage disclosure of adverse clinical and psychosocial circumstances, based on trusting relationships. Caregivers who form positive relationships with pregnant women are more likely to integrate knowledge about the individual and their wider social and historical circumstances, and to suggest treatment and referral only where really where necessary for that particular woman, with an increased chance of uptake of such an offer. But this is not exclusive to midwife practices. Being in physician led care could entail continuity of care with the same doctor, or a small group of doctors, and the consequent formation of trusting relationships, with stress reducing consequences.

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The authors of the scoping review provide a convincing explanation of the relationship between mutual trust and social support, consequently reduced stress, and improved outcomes. The pathway to this outcome is particularly well described for the specific group that seems to benefit most from midwife led care in the scoping data, African American women at low SEC. However, the review does not demonstrate that the interventions were, in fact, based on small groups of staff, and/or on continuity of care(r). In contrast to the Cochrane review, the included studies were undertaken only in North America (8 in the USA and one in Canada) where the status of midwives and midwifery practice is relatively marginalised. In addition, the professional landscape in North America includes obstetric nurses as well as midwives and physicians, introducing another layer of complexity in the mix.

Beyond the potential for different approaches to continuity of care (r), midwife led and physician/obstetric led care both include at least three underpinning elements: what a midwife/obstetrician is trained to do; what a midwife/obstetrician is enabled to do; and the enactment of a philosophy of midwifery/obstetrics in practice. In terms of the first dimension, for women who might have complex social problems, but who do not have medical complications, there is, in theory, little difference in the skills and competencies of educated and trained midwives, and physicians working in obstetrics. In terms of the second dimension, where a midwife is enabled to practice to the full extent of their training and education, there is also, in practice, little difference between what a midwife can do and what a physician can do for such women.

So it could be that at least some the effects seen in both the midwife-led continuity of care Cochrane review, and in the scoping review presented in this edition of the journal could be attributed to the enactment of the philosophy of midwifery as opposed to that of obstetrics. Testing this hypothesis comparatively is not straightforward, as there does not appear to be an internationally accepted definition of obstetrics, or of the scope of the obstetrician. As a minimum, therefore, analysis of two authoritative statements relating to midwifery provides the best available basis for hypothesising about what might be operating in midwife-led studies (with or without continuity).

The International Confederation of Midwives (ICM) definition of the scope of the midwife is as follows:

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care (International Confederation of Midwives, 2011).

This definition is focused on clinical aspects of care, and on what the midwife, as a specific professional, is educated and trained to do. In contrast, the international group working on the recent Lancet Series on Midwifery set out to find out, from qualitative research, what women want and need in their maternity episode (Renfrew et al., 2014). The resulting data were used to define a philosophy and practice of midwifery, which is usually (though, as the authors point out, not always) undertaken by those educated and trained as midwives:

Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum

throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families.

This stands in direct contrast to the risk-and-rescue based, intervention focused, technocratic praxis of maternity care that is the norm in most high and middle income countries, and which has been argued to be the basis of care provision in settings where obstetric-led care is the norm (Arney, 1982, Davis-Floyd, 2004). It is possible that the differences between midwife and other models of maternity care are more fundamentally about the enactment of these different philosophies of care, than are about a priori differences in social support and/or continuity of care. Indeed, as the authors of the scoping review observe, the differences between the outcomes for women allocated to clinic based midwives versus private midwives raises interesting questions about whether the active ingredient is midwives (the professional group), or midwifery (the active enactment of a particular philosophy of care).

As the authors of the scoping review note, none of the studies they included were graded as being of high quality. They conclude that finding out if midwife-led care (with or without continuity of carer, and with or without the power to enact midwifery) is effective for marginalised women and families is an area that is crucially in need of investigation with well-designed and adequately powered good quality comparative studies. Appropriately, they argue for the benefits of undertaking qualitative work alongside effectiveness research. However, given the uncertainty of the underlying mechanisms of what might be working in midwife-led care schemes, any large-scale research could usefully be preceded with detailed mixed methods work, to identify existing schemes in which outcomes are particularly good for specific groups of marginalised women, and to describe the core components of the service provision in these successful settings. As well as assessing the degree of continuity of both care and carer inherent in the service provision, researchers might also pay attention to the three components of maternity care provision set out above: what the care provider is educated and trained to do; what they are enabled to do; and what philosophy of care they are able to enact. Definitive comparative studies could then be appropriately designed and targeted, for women in general and for those who are disadvantaged. This would ensure that the assumptions inherent in the intervention and control groups are explicit and well-grounded, rather than implicit and unclear. The authors of the scoping study in this edition of the journal have provided a welcome first step along this route.

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