CHAPTER 9

The Birth Centre: ideals, models and tensions

THE IDEAL SERVICE: THE MIDWIVES' VISION

The 13 midwives from the Birth Centre whom we interviewed were asked to describe what their ideal maternity service would look like. Their responses are summarised in Table 9.1.

TABLE 9.1 The Birth Centre ideals, models and tensions

Characteristics of ideal maternity service	Number of respondents
More/real choice for women	9
Midwife-led care	8
More midwives	7
The Birth Centre	7
Continuity of care from booking to postnatal/NHS Midwifery Model/ caseload midwifery/team midwifery	7
Home birth	3
Better birth environments and facilities	3
Independent midwifery	2
More local obstetric services/less distance to obstetric services	2
Woman-led care	1
Family-centred care	1

Choice for women and the need for more midwives were seen as being closely interlinked. Lack of true choice was perceived as a direct consequence of staff shortages, and these two issues were regarded as crucial by most of the midwives who were interviewed. The midwives felt that women were being 'conned' into thinking that they had choices when those choices were either illusionary or constrained by the shortage of midwives. Many were scornful or dismissive of the whole choice agenda, believing that women are not offered any choice worthy of the name in the maternity services at present.

Many respondents felt that the Birth Centre was still close to an ideal service, despite its problems:

> You should only go to hospital if you need hospital service. I think if you don't you should have your baby at home or in a birth centre. I think women should only be in hospital when they need to be. I think that rather than earn your right to be at home, you ought to earn your right to be in hospital. (Midwife 1)

However, one of the managers felt that there were good reasons why women may not prefer a free-standing birth centre at some distance from an obstetric unit:

> I think the women's preferred option would be a midwife-led unit next to a delivery suite, because that's something else that puts the women off – the fact that if there's a problem they've got to get in an ambulance and go 10 miles to the consultant unit. . . . I think women would choose to deliver there [the Birth Centre] more if the distances weren't so great. (Manager 1)

The opinion expressed above has a professional ring to it, although it was put forward as 'women's preferred option.' This view was not expressed by women who had used this Birth Centre or that studied by Walsh (2007).

Continuity of care was mentioned in various guises as fundamental to ideal midwifery care, including the NHS Midwifery Model (van der Kooy, 2006), the New Zealand model (Pairman and Guilliland, 2003), caseloading and independent midwifery. There was considerable criticism of the current state of the maternity services in the UK:

> I think maternity care in this country is absolute rubbish, you know: I think a whole load needs to be done and I don't know what the answer is. Well,

> I do, it's the independent midwives' community midwifery model.' [see www.independentmidwives.org.uk] (Midwife 2)

Some of the midwives felt that home birth was the ideal, and that birth centres and home births were similar in many ways:

> I always personally preferred home births, and I have got mixed views about birth centres, because I think . . . 'Why do you want to come into a building to give birth when you can get the same service at home?' (Midwife 4)

> There isn't a jot of difference to having your baby at the Birth Centre and having your baby at home . . . people do find it difficult to understand why somebody would choose a birth centre, but everybody has their reasons, it might just be that the walls are thin and they don't want their neighbours to hear or that they don't want the mess. (Midwife 1)

The issues raised here are interesting. There is clearly a lot of truth in the assertion that birth centre birth and home birth are very similarly positioned in relation to mainstream care. Matters of transfer and emergency care, which are the issues of safety that are of prime consideration, have to be addressed in broadly similar ways whether at home or in a birth centre. For midwives the concerns are the same, namely how emergencies will be dealt with and whether transfer can be effected quickly if the need arises.

WHY BIRTH CENTRES?

Midwife 4 asks a pertinent question. What is the point of birth centres? What do they offer over and above a good homebirth service? Midwife 1 suggests some answers (thin walls, and the mess involved), but these are only a partial explanation, especially in relation to the financial investment in birth centres. Manager 3 recognises that birth centres may require greater investment in midwifery time, too:

> It is exactly the same as having a home confinement, really. . . . Unless you're getting the numbers through, it's very inefficient in midwife time compared to a home confinement, 'cos with a home confinement you can go, can't you, deliver the woman and you can be out of the house in an hour, can't you. (Manager 3)

Understanding the purpose of birth centres is fundamental, and without this understanding of their role and their potential as effective and efficacious birth institutions, birth centres will continue to be favoured or threatened according to the limited personal, financial or political perspectives of those in charge of them. Understanding their role is crucial if they are to become a fully integrated part of maternity care.

Kirkham (2003) has outlined some of the underlying purpose and meaning of birth centres. They offer a community and geographical locus and focus for the rite of passage of birth, bringing together women, midwives and the community in a public and clean, but private and homely place. Birth centres help to build a common culture of nurture or 'pampering' and midwifery skill to aid physiological birth and the transition to mothering (Kirkham, 2003; Walsh, 2007). This makes them more than a mirror image of home birth. Birth centres represent or offer:

- choice
- location of birth within a community or geographical area
- homebirth-like facilities for women who are homeless or who have poor housing
- inclusion and welcoming of partners and family into the birth environment
- a place of safety and retreat from daily life
- a community hub
- a valuing of social outcomes from maternity care.

Boulton *et al.* (2003) have listed the following reasons why women choose a birth centre over home birth:

- the availability of facilities such as pools and birth stools
- having a midwife present at all times
- less mess
- home life and children not disrupted
- a break from domestic responsibilities
- cleanliness and tidiness.

The purpose and value of birth centres are therefore more cultural and social than medical, and they help women and midwives to share experience and meaning as well as physical space.

A SOCIAL MODEL FOR MATERNITY CARE

Birth centres have been described as providing a social model for maternity care (Kirkham, 2003), where the woman is seen as able to birth her baby with support from those close to her and from her midwife. Relationships are central to this model, and every effort is made to foster trusting, enduring, equal relationships between the woman and her peers and her midwife. This is a partnership model that minimises power differences, develops women's strength, and is experienced as mutually enabling for mother and midwife. This model emphasises the need for the woman to feel safe, thus promoting the production of the childbearing hormone oxytocin, which is essential for labour and breastfeeding. This is very different from the medical model, with its emphasis on expert knowledge and technology, and the power of the obstetrician to rescue the woman and her baby from the defects of her body. This can devalue women's knowledge and strength and leave them feeling fearful, which increases the production of adrenaline, an oxytocin antagonist. Clearly women need choice, and different models suit different people and different circumstances.

A social model and its potential were clearly stated in the feasibility study for this Birth Centre (Shallow, 2003), and were espoused as a philosophy by those in the health authority who originally commissioned the Birth Centre, and by the midwives who initially came to work there. However, there is very little evidence that this model was valued or even acknowledged by management at any level within the trust. Many of the problems of the Birth Centre could be seen as originating from management attempts to enforce one model of care across all of the maternity services locally, as symbolised by the issue of uniforms (see below).

We could find no evidence of attempts to foster the collegiality and interdisciplinary support that are seen as so important in establishing and providing role models for a social model of maternity care (Brodie and Leap, 2008). Inter-professional collaboration and trust are regarded as essential for developing a social model of maternity care, promoting physiological birth and improving services (Brodie and Leap, 2008; Homer *et al.*, 2008; Page, 2008). However, no one in this study saw it as their role to facilitate the development of such trust and collaboration between professionals. Indeed many of the events relating to the Birth Centre demonstrated a lack of collaboration and served to undermine trust (*see* Chapters 5 and 6). The Birth Centre midwives themselves had little power to develop the social model of birth at any wider level than their relationships with individual

mothers. When their antenatal role was removed and the opening hours of the Birth Centre were restricted, even this central relationship was threatened. This threat to relationships was not acknowledged by management when these cuts in service were instituted. Indeed it may be argued that these relationships were curtailed because they were seen as 'elitist' and deviant from the medical model, rather than as representing a very different social midwifery model which could, with mutual benefit, exist alongside the medical model.

PLACE AND TERRITORY

The physical setting is important, as it can help to reinforce the 'specialness' of the rite of passage of birth and the care of women undertaking this. It can help women to feel safe at a very vulnerable time. Women who visited the Birth Centre responded to its homely environment, and this often prompted them to choose to give birth there:

> Most women are really enthusiastic, but some women were very definitely 'Oh, I couldn't do that, it's not my thing', and other women are sort of in the middle ground and will come and have a look. And to be honest, if they are middle ground, when they come to look, most of them end up coming [to give birth here]. (Midwife 10)

The physical ambience of a birth centre is therefore important. Walsh (2007) has discussed this extensively with regard to the decoration and maintenance of the birth centre that he studied, and he links it to the idea of 'nesting' (Walsh, 2007, p. 46). Boulton *et al*. (2003) found that environment was important to women using their local birth centre (in Edgware). The importance of environment was recognised by the midwives who worked in the Birth Centre that is the subject of this study:

> I think it's lovely. I think as a building it's been done really nicely, and also the concept behind it and sort of the philosophy behind it, which is really part of what encouraged me to apply for a job in the first place. (Midwife 10)

Midwifery managers also showed awareness that a special environment for birth was integral to the birth centre concept:

> I know a lot of people have actually said that there was too much money spent on the Birth Centre, but I mean if you're doing something, it's got to be done right. (Manager 2)

Beyond the physical space, the Birth Centre midwives succeeded in creating 'birth territory' (Fahy *et al.*, 2008, p. 12) where women felt safe and able to give birth. The early statistics verify this, as do the views of service users.

However, the midwives themselves did not feel safe and able to fully use their skills in the birth territory of which they sought to be the 'guardians' (Fahy *et al.*, 2008). They lacked autonomy and were unsuccessfully *'fighting really to be left alone, for them to leave us how we were working'* (Midwife 1). They felt powerless and frustrated (*see* Chapter 6). Just when the Birth Centre's birth rate was showing a healthy increase, the midwives' 24-hour presence in the centre was threatened. This left the Birth Centre midwives in a very difficult position. Birth centres have long been established as midwives' territory (Kirkham, 1987, 2003), where they feel secure, to which they are committed (Walsh, 2007), and which provide a safe base within which they can exercise their clinical skills. The midwives in this study were not able to establish their territory. It is difficult for midwives to facilitate safety and empowerment for women if they are feeling threatened and undermined in their work setting.

THE SOCIAL ROLE OF THE BIRTH CENTRE

The Birth Centre did not live up to all expectations, particularly with regard to the ideal of birth centres as 'community hubs':

> I was very disappointed when I first saw the building . . . I expected it to be a building where people could meet, when they thought 'I need to breastfeed, oh let's go to the Birth Centre' . . . I suppose a bit like what the Children's Centres are trying to encompass. (Midwife 4)

It is difficult for employees of an NHS trust that is focused on acute hospital-based care to achieve such a community focus. Nevertheless, the literature suggests that a social model of maternity care needs to be rooted in its community:

> We suggest that midwives are only able to facilitate a social model of birth if they [re]claim a style of working that is both physically and philosophically based in the community. It is ultimately questionable whether midwifery can flourish within the hegemony of fragmented hospital systems that stifle the ability to practise 'woman-centred care' in a way that enriches the potential for women, and therefore their families and communities, to be more powerful. (Brodie and Leap, 2008, p. 157)

The low level of home births locally suggests that although the community midwives were working in their community, they lacked such philosophical grounding.

This community-centred aspect of birth centre practice was not mentioned in the 'ideal service' descriptions of the midwives, and may have left them vulnerable to criticism by their many detractors. One manager made the following interesting comment:

> The community midwives expected the Birth Centre to be run as a community service. . . . I expected there to be drop-ins, parentcraft sessions, breastfeeding support, more of a community facility, but the core midwives ran it as a mini-hospital. They ran it as a delivery suite with an elitist antenatal and postnatal service. (Manager 1)

This interesting comment, whether justified or not, demonstrates that other notions of an 'ideal service' were and are current. The constraints on developing the full potential of this Birth Centre from the outset have been described elsewhere (Shallow, 2003). However, it is clear from this study that opportunities for building a mutually shared vision or ideal once the Birth Centre had been opened were not taken. The 'ideal service' dialogue that occurred to some extent during the planning stage (Shallow, 2003) seems to have been quickly superseded by preoccupation with, metaphorically speaking, choice of sticking plaster with regard to the cracks that inevitably appeared, as discussed elsewhere in this work.

It is interesting that in the recent study published as *Birth Models that Work* (Davis-Floyd *et al.*, 2009), one of only two examples from the UK is a birth centre (Walsh, 2009). This long established birth centre acted as a focus for 'rejection of assembly-line birth' (Walsh, 2009, p. 165) and 'resisting bureaucracy' (Walsh, 2009, p. 168). The midwives there and in other birth centres we know had developed a way of assisting birth that is flexible,

trusting, respectful, democratic and sustainable. The network of reciprocal relationships and the common values in such a model are seen as enhancing social capital for the local community and the individuals concerned. Such achievements are rarely seen in relation to birth, and are more familiar in relation to community health and development endeavours. The benefits of 'a common ideology that birth is normal and that women are its protagonists' (Davis-Floyd *et al.*, 2009, p. 442) are personally and socially far reaching. Sadly, in the birth centre that we studied they were not allowed to develop.

UNIFORMS: A SYMBOL OF THE TENSIONS RELATING TO THE BIRTH CENTRE

One of the midwives mentioned 'no uniforms' as being part of her ideal service. The issue of uniforms arose several times during the interviews in different contexts, and has been mentioned elsewhere in this study. The importance of uniform or rather 'no uniforms' seems to be intrinsic to many of the midwives' visions and aspirations.

Conversely, uniforms were seen as emblematic of the tensions between different models of care and concepts of midwifery:

> The Director of Nursing . . . took umbrage at the fact that we were not wearing uniform and hadn't asked – my god we are only adults after all (can you tell I am very bitter?) – so we had to go back into uniforms . . . how pathetic, so pedantic, so petty, absolutely petty they were. (Midwife 2)

Clearly uniform represents something important, not only for the midwives but also for the manager who insisted on it. Although the midwives at the Birth Centre did stop wearing uniform again for a while, the midwives who were working there at the time when the interviews were conducted were wearing uniform again.

Uniform represents conformity (Flint, 1995). It marks the wearer out as one of a group, as belonging to or loyal to an organisation or institution, and it represents a subsuming of the individual or personal in a collective mission. It also sets the wearer apart from the general population and emphasises one aspect of their being over all others. Thus the individual becomes a nurse, a scout, a schoolgirl, or a soldier, for example, and this role is emphasised over and above that of the individual personality:

> She [the manager] wants us to all look the same, she wants us to look clinical so we look like professional people. The Birth Centre midwives didn't wear uniform until they were asked to change when the Birth Centre and community [midwifery service] got back together. I just can't see why we need to be in a building with uniform on. (Midwife 4)

'New midwifery' (Page, 2000) emphasises relational, personal and individual aspects of care. This social model of midwifery demands that midwives face outward from their employing organisations and form personal alliances and relationships with the women and families whom they serve. Individualised care cuts both ways, as understanding a woman as an individual, and building a relationship of trust and support with her, can only be predicated upon offering oneself to some extent as an individual personality to her. The idea of 'knowing one's midwife' involves more than just having that midwife's name and contact number. Our choice of clothes is one way of helping others to know and recognise us, and it conveys messages about us that others can interpret:

> I used to think uniform didn't matter, but now I think it does. It gives the wrong messages. (Midwife 13)

> We're talking about a home [type] environment, so for me that means sort of casual [clothing], not specific nursing or midwife uniforms. 'No, they have to wear uniforms.' . . . I got quite involved with that and then we said 'OK, we'll have some sort of dress code' but, you know, that still defeats the object if you're trying to put a woman at ease. . . . I think, on the whole, ordinary clothes in that particular setting would have been fine . . . it seemed as though 'OK we can facilitate that', but then I know, a few months after I left, it came back as completely uniforms. (Midwife 6)

The fact that this issue proved so obdurate suggests that it represents the crux of the tensions between opposing models of care and midwifery ideals. Uniforms and what they represent need to be carefully considered when developing services, and not dismissed as a minor or inconsequential detail. The midwives in this study recognised the importance of uniform as a symbol of the conflicts in which they were caught up, and the failure to recognise that birth centre care was a different model of care from that practised in a consultant unit.

There seems to be a resonance between what women and midwives want from maternity services. In terms of the range of services, the environment in which these are offered, the purpose of these services, the culture of birth, the emphasis of care, the importance of relationships and the social nature of birth, the needs and desires of women and of midwives are parallel. The midwives whom we interviewed had briefly come close to creating their ideal service, and research conducted with local women (reference has been withheld to maintain anonymity) shows that they succeeded in delivering what women want, too. It is unfortunate that the ideal could not be sustained and that it was achieved at such a high personal cost to so many of the midwives whom we interviewed.

POWER, AUTHORITY AND MANAGEMENT

The Birth Centre was established at the instigation of the health authority, not of the trust which was required to run it. The members of the health authority who had instigated the plan soon moved to other areas. It was therefore of crucial importance that there was an advocate for the Birth Centre who had easy access to senior trust management. This key voice was lacking. The Birth Centre coordinator was of a grade that did not give her access to senior management and its planning processes – a problem that was forecast in the feasibility study. The lack of an authoritative link with senior management constrained the autonomy of the Birth Centre midwives and prevented them from fulfilling all the potential of their role.

None of the midwifery managers were energetic advocates for the Birth Centre, as it was an additional area of responsibility that they had not chosen. No one with management authority in the trust identified the Birth Centre as their project or as one worthy of their energetic support. As it was no one's priority within trust management, the Birth Centre languished due to lack of funding, management and publicity.

This lack of an authoritative advocate for the Birth Centre who had access to management differentiates this Birth Centre from many others which were successful, such as the Edgware Birth Centre. In the early days of the Edgware Birth Centre, the supervisor of midwives played a key role in building midwives' clinical skills, confidence and autonomy. One of the ways in which this was achieved was through her facilitating the midwives in their development of clinical guidelines for the birth centre:

> It was considered important that midwives should be able to decide what guidelines they should use and be actively involved in the development and implementation of these guidelines. To enable them in this activity they needed to understand the theory underpinning the design and use of guidelines. Whilst they were encouraged to undertake the work themselves, the supervisor was available to give advice on the process. (Jones, 2000, p. 156)

The supervisor of midwives at Edgware also facilitated group reflection on practice, which served to test and further develop the guidelines. These supervisory activities were experienced as empowering by the birth centre midwives. The supervisor there also saw it as part of her role to identify and endeavour to deal with resistance to the Edgware Birth Centre in its early days. The interpretation of supervision at the Birth Centre that we studied was very different, with no perceived need for guidelines specific to, or owned by, the Birth Centre. It is noteworthy that the additional training that was received by the newly recruited midwives before the Birth Centre opened took place within the consultant unit, not in the Birth Centre or specifically related to the practice and philosophy of the latter. Enhancing the clinical autonomy of these midwives was not an aim for supervisors or management.

Midwifery autonomy can be seen as an important issue here. Lack of autonomy to achieve what they see as good practice is one of the reasons why midwives leave the profession in England (Ball *et al.*, 2002). Lack of autonomy is also consistent with working to an 'economies of performance' model (Stronach *et al.*, 2002), where clinical work depends on midwives becoming obedient technicians in order to sustain working within bureaucratic structures and imperatives (Deery, 2010; Deery and Fisher, 2010; Deery and Hunter, 2010).

Alternatively, 'ecologies of practice' develop when midwives are facilitated to draw upon a wealth of diverse knowledge, experience and influences, including relational and experiential knowledge developed in their private lives and in the communities in which they live. However, when clinical work is overly determined by managerialist practices, holistic and authentic forms of care, such as birth centre work, can become stifled (Deery and Fisher, 2010). Therefore 'ecologies of practice' that promote the development of autonomy are unlikely to develop in a birth centre setting that is overly determined by rigid and codified practices associated with an 'economies of performance' model.

The midwives in the area studied had recently experienced major changes in their work, as well as the closure of their maternity hospital despite their best efforts to retain it. In all of this they can be said to have experienced a loss of autonomy at a political as well as a clinical level. Yet birth centres are associated with considerable autonomy for midwives (Hunter, 2003), and the setting up of such a centre, staffed by midwives from outside the area, must have generated mixed feelings among local midwives, clinicians and managers. Since no help had been available to work through the losses that these midwives had experienced, it is not surprising that their attitude to the Birth Centre and its midwives was less than welcoming.

The Birth Centre midwives had the enthusiasm and knowledge but lacked the authority to undertake tasks that would have strengthened the Birth Centre and increased its bookings (e.g. in publicising the centre, organising a well-publicised opening event or revising its clinical guidelines to include women having their first babies). They did what they could (e.g. by organising the garden parties, with a striking lack of support from midwifery managers), but no one else took on these crucial tasks, and the midwives' frustration mounted.

In the history of this Birth Centre there was no strong, organised user support group that could petition senior management and other professionals. Such a group was crucial to the success of the Edgware Birth Centre (Manero and Turner, 2003), which was set up in otherwise similar circumstances. This is partly because the Birth Centre was instigated by the health authority, not by the local service users. It also shows a lack of strategic vision on the part of the trust, since user involvement was seen as important in the pilot study. However, the Birth Centre was not part of the strategy of the trust. When the numbers of births were growing (between 2002 and 2004), it would have been possible for a strong user group to be created that could have publicised the Birth Centre's presence in the community and argued for its continuance and growth. However, this was just the point at which the service was reduced, the original midwives had left and staff morale had fallen. The community midwives who were then operating the reduced service lacked the authority and the motivation to facilitate a user group.

This Birth Centre was no one's baby, and as such it is scarcely surprising that it failed to thrive.

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