WORKING WITH WOMEN IN CHILDBIRTH

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

Lesley Ann Page

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The development and editing of The New Midwifery: Science and Sensitivity in Practice was undertaken with the able assistance of Dr. Percival. Where the publications presented are multi authored they also represent a substantial participation in the development and drafting of the work by all authors. Joint authors of my chapters included: Ms Pauline Cooke, Dr Percival, Dr. Mills, Dr. McCourt, and Dr. Hirst.

The jointly authored publication Changing Childbirth: Changing Clinical Decisions was led by me and written in collaboration with Ms Jane Phillips whose care is described. Commentary is provided by an obstetrician Professor Drife. Jane's friendship has taught me a lot about the provision of One-to-One Care. In addition I should like to thank Ms Tess McKenney who has similarly been a source of support and learning.

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Publications submitted

Included separately:

Following Reference nos. 14–18 refer to the book included separately:

Reference included separately

McCourt, C., Page, L.A. (1996). *Report on the evaluation of one-to-one midwifery*. London: Thames Valley University, Centre for Midwifery Practice.

Page, L., Cooke, P., McCourt, C. (1996).Section 1: Introduction. In C. McCourt & L. Page (Eds.), *Report on the evaluation of one-to-one midwifery* (pp. 1–13). London: Thames Valley University, Centre for Midwifery Practice.

Stevens, T.A., Page, L.A., McCourt, C.(1996). Section 2: Implementing one-to-one midwifery practice: A case study. In C. McCourt & L. Page (Eds.), *Report on the evaluation of one-to-one midwifery* (pp. 14–23). London: Thames Valley University, Centre for Midwifery Practice.

Page, L.A., Vail, A., Beake, S.(1996). Section 4: Results of the clinical audit. In C. McCourt & L. Page (Eds.), *Report on the evaluation of one-to-one midwifery* (pp. 63–76). London: Thames Valley University, Centre for Midwifery Practice.

Piercy, J., Page, L.A., McCourt, C. (1996). Section 5: Economic study. In C. McCourt & L. Page (Eds.), *Report on the evaluation of one-to-one midwifery* (pp. 77–86). London: Thames Valley University, Centre for Midwifery Practice.

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Page, L.A. (Ed.). (2000a). *The new midwifery: Science and sensitivity in practice*. Edinburgh: Churchill Livingstone.

Page, L.A. (2000b). Putting science and sensitivity into practice. In L.A. Page (Ed.), *The new midwifery: Science and sensitivity in practice* (pp. 7–44). Edinburgh: Churchill Livingstone.

Page, L.A. (2000c). Using evidence to inform practice. In L.A. Page (Ed.), *The new midwifery: Science and sensitivity in practice* (pp. 45–70). Edinburgh: Churchill Livingstone.

Page, L.A. (2000d). Keeping birth normal. In L.A. Page (Ed.), *The new midwifery: Science and sensitivity in practice* (pp. 105–121). Edinburgh: Churchill Livingstone.

Page, L.A., Cooke, P., Percival, P. (2000). Providing one-to-one practice and enjoying it. In L.A. Page (Ed.), The new midwifery: *Science and sensitivity in practice* (pp. 123–140). Edinburgh: Churchill Livingstone.

Mills, B., Page, L.A. (2000). The growth of human love and commitment and implications for the midwife. In L.A. Page (Ed.), *The new midwifery: Science and sensitivity in practice* (pp. 223–224). Edinburgh: Churchill Livingstone.

McCourt, C., Hirst, J., Page, L.A. (2000). Dimensions and attributes of caring: Women's perceptions. In L.A. Page (Ed.), *The new midwifery: Science and sensitivity in practice* (pp. 269–287). Edinburgh: Churchill Livingstone.

List of tables and models

ABSTRACT

The selected publications presented here are concerned with the development of practice and knowledge in midwifery. The thesis underlying the publications is that the development of a positive personal relationship between women and their midwives is fundamental to effective and sensitive midwifery care.

The methodology used is essentially different to the thesis written prospectively. This is because the publications presented arise from years of work informed by 'hands on' practice, development of policy, leading change and development, supported by research and communicated and disseminated through writing. The work presented therefore could be viewed as a long research project, with these activities forming an iterative process in thinking through and writing for publication, as well as continuing practice development and research.

The extended essay serves to introduce the publications and show how they are linked through common themes developed over time. It also demonstrates the originality, importance and contribution of the publications. The publications presented may be viewed conceptually in a number of different ways however these are all related to the relationship between women and their midwives.

The essay is presented in sections. The first is the Introduction to key concepts and theories. The second is The Midwife with Woman Relationship. This introduces publications that describe the nature and purpose of the relationship. The third section, Changing Practice: the New Midwifery is concerned with what the midwife does in the context of that relationship. Publications introduced in this section propose ways of working in the best interests of women and their families. The fourth section, Influencing Policy Nationally and internationally, is concerned with the creation of national policy that has supported the development of what I have called the New Midwifery. The fifth section, Transformative Change and Rediscovering Midwifery is concerned with developing the organisation and culture of care, that is its context, to enable midwives to work in the best interests of women and their families. The sixth section Developing Patterns of Practice that Enable Personal Relationships Between Women and Midwives: One-to-One Midwifery introduces publications concerned with the development and evaluation of new structures that facilitate continuity of care and thereby relationship

SECTION ONE

INTRODUCTION

Aim of the essay

The aim for the extended paper in submission for a Doctor of Philosophy degree by publication is to show the way in which this work has developed, to demonstrate the contemporary relevance of the publications, to make clear the way in which the publications make an original and scholarly contribution to knowledge, and to provide a thematic overview which serves to link the publications as a whole.

The process of developing the submission, although requiring the same level of rigour, originality and importance of any doctoral thesis, is essentially different to the submission of a thesis that is developed prospectively. The publications presented arise from years of work in hands on practice, development of policy, leading change and development, while always continuing academic work. In a way the results of the work presented could be viewed like a long research project, with the movement between hands on practice, leadership and scholarly work and research being interwoven with writing for publication which, while aimed primarily at the dissemination of knowledge, has provided an iterative process encouraging thought and movement onwards. Because much of the work presented has resulted from the practical work of being a midwife, a leader of change and of services, a midwife politician and diplomat, it has not been possible to present the work chronologically. The real life work described does not happen chronologically; usually the work has been integrated, much of it happening all at once. Thus the extended essay has concentrated on drawing together concepts and demonstrating a progression of thinking through the publications. My work has been simply to bring about the development of services and practice so that midwives may 'help at the birth of babies, bringing to their birth safe passage, rich experience and love' (**Page, 1993b**, p. 85).

Structure of the essay

The first section forms the *Introduction*. The background and ideas underlying the changes and different perspectives are described here.

The second section is entitled *The Midwife with Woman Relationship*. This describes the importance of the individual relationship between midwives and women, and reviews briefly how and why it has been lost, and how it may be reinstated. Representing the development of concepts over time, the publications introduced will move from the recognition of birth as a social event and five principles of care underlying effective midwifery to more complex publications that argue for a movement of understanding beyond the simple basic outline of the role.

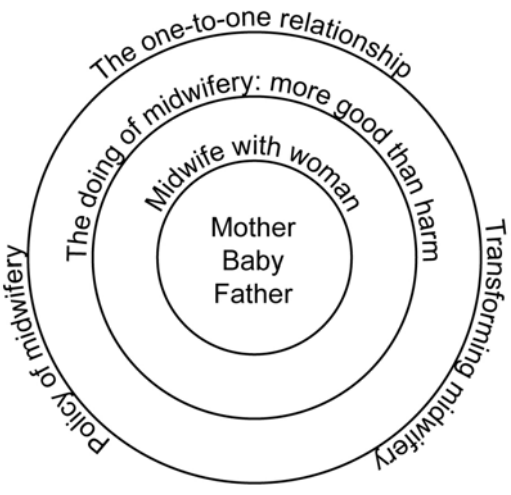
The third section, called *Changing Practice: The New Midwifery* presents the publications that have disseminated the ideas, knowledge and understanding that are intended to enable midwives to practise with the woman in the sense of providing skilled and sensitive care, and the use of evidence in practice. This section represents the crux of midwifery work, the practice that affects the woman and her family directly; it is the doing of midwifery that is conceptualised here.

The fourth section *Influencing Policy Nationally and Internationally*, presents

publications within and about policy documents that have reshaped ideas about midwifery and midwifery practice at local government and national level. This section represents the work of changing the broader policy context; crucial work that enables the changing of health services, and professional organisations, and that provides a framework for change and development.

The fifth section *Understanding Transformative Change and Rediscovering Midwifery Practice* is concerned with publications that explain the need for fundamental change of organisations, to alter power relationships, alter the culture of care, and place midwifery and women in powerful relationships of partnership with each other. Transformative change is taken to mean an alteration or clarification of the purpose and structure of the institution, and an alteration or clarification of the value system on which practice is based. The work is based on the theory that public institutions just gradually stop meeting the needs of those they serve to be governed by the routines and practices that are convenient to the organisation. Moreover, in direct relation to maternity care the technocratic care described by Davis-Floyd (2001) eclipses humanistic values. This then represents change in the direct context of care, the place where women receive care and where midwives practice. The argument is that organisations often prevent midwives from doing their work well rather than supporting them to work effectively, and that we need to intentionally 'transform' the organisation. Practices are evidence of the culture of an organisation and we can change culture by changing practices.

The sixth section *Enabling Personal Relationships between Women and their Midwives: Setting up and Evaluating One-to-One Midwifery* describes the development, establishment and evaluation of One-to-One Midwifery in West London in 1993. This was a major and highly innovative project. The practices were set up in a very medicalised service in a major London teaching hospital. The pattern of practice, that provided every woman with her own midwife who provided most of her care, was provided for about eight hundred women a year. The two evaluations included over three thousand women. This service was replicated in at least three other parts of Britain, and was acclaimed nationally by the media. It continues to run and has expanded. The publications of the report of the evaluations have been widely cited and have been influential. These publications will also show a deep understanding of complex methodological issues in research ahead of their time, and the complexity of evaluating changes in the organisation of care. Model 1 represents these sections:



Model 1. *Relationships of sections of working with women in childbirth.*

Where publications of my own are cited for the first time they are in ***bold****.*

The Nature of birth and the Story of Mowita

The story of Mowita is a myth from The First Nations of the West Coast of Canada. I have chosen to start with this myth because it conveys ideas that are beyond words, and helps place midwifery work in its proper context, in touch on an every day basis with the miracle of birth.

Cameron wrote (1981):

> *Her breasts grew large and tender, her belly filled until it looked as if the moon itself was trapped inside, and one day movement within her told her that she was no longer one person, but two, that there was another person living inside her body. Often she felt frightened and wondered at her own ability to care for this new person, and once or twice she chafed to think that she was no longer free to be herself, but had to think in terms of another. One night, with much pain and blood, there came from her a small version of herself … And Copper Woman looked at her daughter and felt the loneliness diminish until it was no larger than a small round pebble on the beach. Her breasts ached with a pulsation like that of the waves on the beach and when she had cleaned the blood from her daughter and the mucus from the small nose and mouth she wept with thanks for the secret magic the old ones had given her. Knowing the secret she had been able to lick clean her child and not feel revulsion. Rather, she felt that again, but in a different way she was giving birth to herself* (pp. 32–33).

This excerpt from the myth of Mowita, a myth of The First Nations from the West Coast of Canada, speaks to us of the universal elements of birth that are so central to human life. The miracle of holding another person inside you, giving up parts of yourself as well as your freedom while taking on the most important responsibility of all, the care of another human until adulthood. This myth conveys the transformation, an intensity of selfhood and growing confidence, fear that gives way to a sense of personal power. ‘Myth is “what is believed always, everywhere, by everybody … the man who thinks he can live without myth, or outside it, is an exception” myth is described here as “the root matter — the mother of all things”’ (Campbell, 1971, pxxi). I use this myth, partly because it derives from the country in which I rediscovered midwifery, but also because it places the work that follows in the context of birth and its meaning. It conveys the immensity of the work of midwives, and their potential to work in proximity to this individual and universal event that is of such fundamental importance. Pregnancy and birth are miraculous but everyday events. I well remember the words of a woman I cared for a few years ago. She was a born and bred Londoner, living in a tiny house in one of the poorest parts of London right next to the walls of a high security prison. I was palpating her abdomen to determine the position of her unborn baby and suddenly she said, ‘You know, I just can’t get over it, I just keep thinking and thinking about it, that I have another person growing inside me’.

Touching the promise of the life to come

I started my keynote presentation 'Midwives hear the heartbeat of the future' given to 3000 midwives at the International Confederation of Midwives in 1993 (Page, 1993b) with the story of Mowita. In this presentation about change and power and moving midwifery forward I described the fundamental importance of the way women and their families are cared for around the time of birth and the importance of the relationship between women and midwives in providing effective personally sensitive care. Midwives touch the lives of the family and newborn, and may have an effect on the newborn, the parents and family for generations to come. 'As we listen to the heart of the unborn child we touch, in a very special way, the promise of life to come, a person of a future generation, who contains the future of a rich and productive life' (Page, 1993b,p. 2).

Midwives are placed, by the virtue of their work, in the centre of this everyday human drama. In their potentially intimate contact with women they are in a powerful place to support women or to harm the outcome and experience of birth (**McCourt, Hirst & Page, 2000**). Sadly, over recent decades, the ability of midwives to support women and their families in most parts of the industrialised world has been limited by a number of complex factors.

Pregnancy, birth, and the early weeks of a life are a critical point in the life of the newborn, the parents and family. Sensitive effective care given at this time will affect not only physical health but also sense of self and competence as a mother and father, feelings of love for the baby, and memories of the experience of care. Positive care will make a huge difference to the outcome. Negative care is perhaps more powerful and may increase a lifetime of problems in relationships or physical problems. Both will be remembered. The care of the individual family will have reverberations into communities and society. Good care around the time of birth is claimed by others, as well as myself, to be fundamental to all of life (Winterton, 1992; McCourt, Hirst & Page, 2000).

The critical role of midwives

In Britain and many parts of the Western industrialised world most care is provided by midwives, who are in law usually autonomous practitioners able to manage care on their own responsibility. Thus midwives play a critical part in the provision of sensitive and effective care around the time of birth. Until recently, midwives were often a part of the community in which women lived. They may have been kith or kin; there was often some kind of blood or social connection. Even with the professionalisation of midwifery, midwives remained community based until relatively recently (**Page, 2003b**). 'In 1937, only 35% of all births took place in an institution, and by 1944 this was 45%. The period of greatest growth in hospital birth was in the 1960s and 1970s, a period which saw massive expansion in hospital building programmes and changes in the organisational structure of the NHS. By the 1990s universal hospitalisation for birth was almost complete (Hunt & Symonds, 1995, pp. 4–5).'

It is important to recognise that my publications are concerned with midwifery in the Western industrialised world. The problems we face are very different to parts of the world where mothers

often die in childbirth, where babies have a low chance of survival beyond the first year, and where many women have no trained attention at birth at all. The values of personal autonomy described here may also be at odds with other cultures.

However, the changes and principles I describe are concerned with the humanisation of birth, and reducing the powerful effect of medicalisation that as well as having some positive effects have also been harmful. There is a tendency to export many of the features of Western medicine long after their effectiveness has been questioned. So the ideas contained in the publications and my essay may not be entirely irrelevant to other parts of the world. While women giving birth in non industrialised and developing countries, and indeed in some parts of the industrialised world, may suffer the lack of health care facilities and resources such as trained carers it is important to recognise the social structure that may often provide inherent support. It is important to ensure that this social structure is not disrupted, either by removing women from their home community to give birth, or by replacing traditional birth attendants with professionals who may not stay in an area in the long term (**Page, 2001c**).

Loss of the midwifery role

As birth moved from the home to the hospital, in the main ostensibly on the grounds of increasing safety, the place of practice of midwifery moved with it (Hunt & Symonds, 1995). Allocated to wards and departments rather than working with individual women and their families in their communities care became fragmented, and the possibility of the development of a personal professional relationship over time was lost. With the increasing medicalisation of birth it became more difficult for midwives to retain professional autonomy (Robinson, 1989). The reduction of the midwifery role around the time of birth is associated with changes in societal norms and values, and with different paradigms of health care and science. Davis-Floyd (2001) describes the technocratic model that stresses mind body separation and sees the body as a machine. Evidence of this separation can be seen in any hospital providing maternity care, where the emphasis is on assessment of labour with fetal monitors, and where women may often be left unattended in labour, one of the most stressful of life events. This model is associated with the alienation of practitioner from patient, and aggressive intervention.

Re-establishing midwifery

The publications I present tell the story of over 25 years work in re-establishing positive personal relationships between women and their midwives, and developing an understanding of how the traditional values and approaches of midwifery may be expressed in modern health care services. The changes that these publications represent have been profound and important. The idea of establishing relationship between women and their midwives may sound like motherhood and apple pie, an obviously good thing. However, in a number of ways in technocratic bureaucratic structures the idea is usually ignored, with more emphasis on medical and technological intervention than the purposeful development of relationship between childbearing women and those caring for them. Sometimes the idea of relationship is reduced to rhetoric or management

jargon like the phrase ‘continuity of care’. From the earliest publications presented here the explicit importance of the relationship was addressed at a time when few were focusing on this. These papers are unique in that they describe the process of developing structures that allow that relationship to develop as well as the outcomes of evaluations that have specifically sought evidence to see if the structure works, and what the relationship means to women and midwives.

Although it is beyond the limits of present day science to say with certainty that the relationship has caused particular outcomes, the knowledge developed and disseminated in the publications presented provide a detailed picture or story that leads to some understanding of the meaning of the relationship, how midwives may best work within the relationship, and some firm ideas of the effects of the relationship. Moreover, the publications give an account of some very successful developments of organisations that allow women and their midwives to work ‘in relationship’ even in large medically oriented institutions. The knowledge represented in the publications arises from the experience of making changes in practice, organisation of care, policy and structure of care, and complex rigorous research. The first ideas that early publications represent were original and pioneering. Since those early days the publications represent a growth in complexity and understanding. The concepts continue to progress and to hold relevance for modern day midwifery.

The publications represent work that has been to develop, what has been called the ‘New Midwifery’ (**Page, 2000a**). This new midwifery is based on the enduring and vital traditions of midwifery, with a focus on interpersonal relationships, but developed to fit into modern health care systems. The fit however has not always been easy. This new midwifery provides a personalised service within a system that is designed to care for large numbers of women with the least resources possible, and where routine policies and procedures have been applied to women and their families whatever their needs. To provide such a personalised service in what are essentially institutionalised structures is not always easy or comfortable. The work is highly political and is often seen as subversive.

The development of relationship

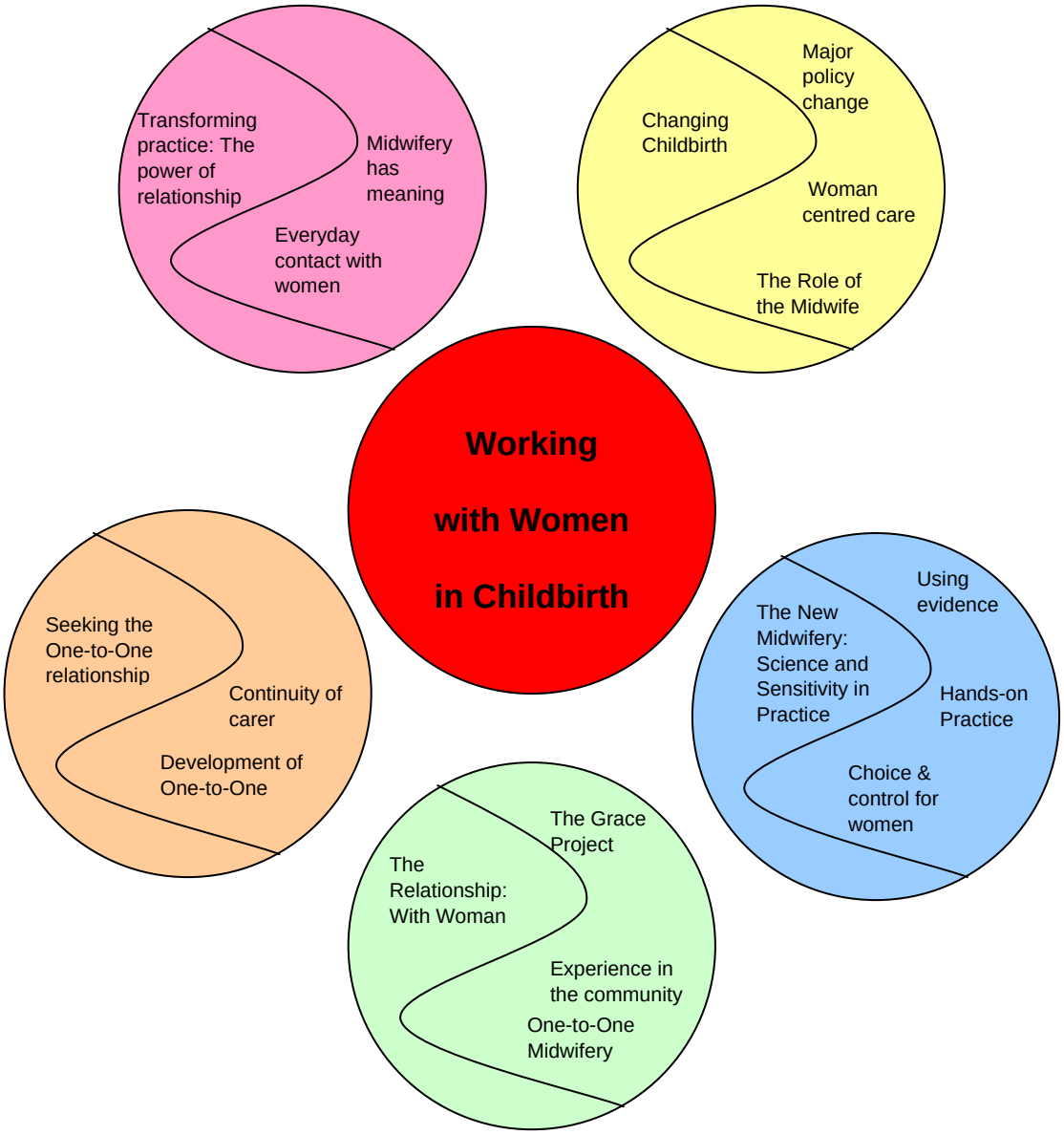
My thesis is that the development of a positive personal relationship between the woman and her midwife is fundamental to effective and sensitive care. The reorganisation of care to allow midwives to follow women through the system of care rather than putting women on a conveyer belt, that is having women progress through care, meeting teams of different individuals at each stage of their pathway through care, allows this relationship to develop. In my essay I will examine the contribution my publications have made to an understanding of how organisations of care may be changed, the assumptions underlying such change, and the theories that may explain the effects of such change. Integral to the development of a positive working relationship with women is using the necessary skills and being able to help women make their own decisions based on the best evidence possible while helping women to hold true to their own values, beliefs and sense of self.

Changing and evaluating practice

The publications presented have arisen from the work of changing and evaluating practice, and from knowledge gained in practice. They have influenced policy and practice nationally, locally and internationally to create fundamental change. They may be viewed conceptually in a number of different ways; these all pertain to the relationship between women and their midwives. In turn an essential part of midwifery is not only to support optimal health for mother and baby, but also to recognise that the relationship between the baby, mother and family is fundamental to the survival and future well being of the baby, and that care during the time of pregnancy and birth may support or harm the potential for the development of the attachment of mother, baby and family. If we fail to support, or damage this relationship, we may damage the basis on which the baby will grow, develop, stay healthy and form other relationships throughout life (**Mills & Page, 2000**).

The publications presented represent a number of styles of writing. Many are written with the purpose of helping others 'see' their practice in a different way, to re-conceptualise practice. They have been written to simplify some of the ideas, concepts or theory behind the work. Some of them that appear the simplest and are written in a readable and accessible style may have taken considerable work to 'boil down' to the essence. For example, the chapter on *The midwife's role in modern health care* (**Page, 1989**), was written after consideration and reflection over a number of years of practice within The Grace Midwifery Project. However, a number of chapters and articles are presented in traditional academic and scientific report writing style. My publications demonstrate the ability to address different audiences, and to write for different purposes.

The essay is about working 'with the woman' the original meaning of midwife in the Anglo-Saxon language. The first section starts at what I see as the centre with the relationship between women and midwives, the nature and purpose of the relationship. Then there is the concept of midwifery practice in itself, the 'doing' of midwifery that happens within the relationship. It is seen as fundamental to the relationship that the midwife works in the best interests of the woman and her family, knowing as far as possible that she is likely to do more good than harm (which is an essential part of working 'with'). In its turn the context of this relationship between women and their midwives is the organisation and culture of care. This organisation and culture of care needs to be developed with the intention of providing every possibility of women and their midwives forming continuous relationships over time, and to have the autonomy and resources to practice effectively and sensitively. This context of care in its turn sits in another context, that of policy, both local and national. The appropriate policy supports practical and academic work at a local level intended to develop positive professional relationships. *(See Model 2 on following page).*



Model 2: *Experience, ideas, and the fundamental meaning of midwifery.*

SECTION TWO

THE MIDWIFE WITH WOMAN RELATIONSHIP

Why and how the relationship was lost

The word midwife is Anglo-Saxon meaning 'with the woman'. Until the middle of the 20th century in the UK and many other parts of the world midwives remained a part of the communities in which women lived. Although history marks the beginning of the erosion of the midwife's role with the development of obstetric forceps by Chamberlain, and the professionalisation of midwifery in 1902 in the UK was seen by some as a means of controlling the profession by doctors, it was perhaps the movement of birth from the home to the hospital that made the most fundamental changes to midwifery. While birth was community and home based midwives were in touch with the everyday lives of women, and were able to work in some kind of continuous relationship with them. Stevens describes the midwife as 'a known and trusted community figure' (2003). With the movement of birth to the hospital, the majority of midwives started to practise in the hospital setting. Allocated to wards and departments rather than being responsible for the care of a community of women care became fragmented. As the number of medical interventions in birth increased so the possibility of midwifery autonomy decreased. By the late 1970s most midwives were 'independent practitioners in their own right' in name only, although a small number of independent and community midwives continued to work in relationship with individual women, utilising all of their skills and knowledge. The majority of midwives experienced little autonomy, and the role of midwifery had become confused with the role of nursing. Often not only professional autonomy but also any sense of a professional role was lost. For example many midwives acted as receptionists in clinics for much of their time.

My own education in the 1960s had given me the experience of a system that was divided even then. The first part of my training in the hospital was in what can only be called a factory. Women progressed through the antenatal ward, labour ward and postnatal ward. Babies were kept in the nursery to be taken to their mothers for strict four hourly feeding after a Phisohex wash[1]. Pupil midwives were summonsed to witness or do deliveries by a flashing light, to attend the woman only for a brief moment to catch the baby and enter the birth in the record of training. The second half of this education and training however was situated in the community. There we lived in the community midwives' house and visited women at home and attended home births. This other half of the system could not have been more different, leaving memories of pregnancy and birth as an everyday part of life, birth in the surrounds of the woman's home, calm and comfort, siblings spilling on to the mother's bed after the baby was born (**Page, 1995b**).

A few years later, when circumstances took me to Canada, where midwifery was not at that time a formal part of the health care system (Barrington, 1985; Burtch, 1994), I was involved in establishing and practising within the first recognised pilot project to evaluate midwifery in the hospital system (Weatherston, 1985). Here I and three other midwives and four obstetrician colleagues set up a

[1] Phisohex is a sterilising fluid that was later withdrawn from use on babies.

system where midwives provided care that was continuous. This beginning experience, in the community midwifery service in Edinburgh and the pilot project at the Grace Hospital in Canada formed the roots, concepts and theories contained in all my publications.

The two extremes of practice experienced in my education as a midwife exemplified the change that was occurring in the maternity services in the 1960s. The more personal community system, which sat alongside the hospital system where the change to a factory or assembly line approach prevailed, provided a stark contrast. This system was seen by many at the time as a way of improving the safety of birth, and of using resources efficiently.

The move to universal hospitalisation in the industrialised Western world, to almost routine induction of labour in the 1970s, to systems where women were routinely shaved and given enemas in labour continued into the 1970s. What is important to this essay is to examine briefly why women and their midwives were alienated from each other, with the purpose of understanding the context for the changes that were to follow, and my part in bringing about those changes.

Why institutions alienate women and midwives

During the 1970s and 1980s the real problems being experienced in the maternity services were becoming apparent. Despite the improving perinatal mortality rates, there was a seemingly paradoxical sense of discontent amongst women and the frustration of midwives with the increasing limitation of their roles was becoming obvious (Robinson, 1989). The situation in much of Canada was worse with an extremely high intervention rate, and dehumanised practices in some areas (Page, 1996b), and no midwifery as part of the established maternity services apart from remote areas. In the UK, not only was there an increasing rate of medical intervention, inductions, epidurals and operative births, but the organisation of midwifery, on an acute nursing model, was not appropriate to midwifery. Midwives could not follow women through the process of care; neither could they maintain all of their skills. In most services a process of rotation was developed in order to ensure that midwives could maintain their skills in all areas. This however, prevented team development and building in wards and departments and created its own problems.

There are a number of theories or theoretical perspectives that may be used to explain the sense of frustration of midwives and the dysfunctional organisations and culture of care that exist to this day (Barclay & Jones, 1996; House of Commons (HOC) 2003a, 2003b, 2003c; Hunt & Symonds, 1995). There are of course powerful political and social factors that affect our approach to birth and to midwifery. The focus in the publications presented makes reference to these factors, but are more concerned with the theories of organisation within the health service. These theories include the simple explanation of the way the structure of care, that is fragmented care, has separated women from their midwives, to theories about the behaviour of oppressed groups (Kirkham & Stapleton 2001, 2004), to psychoanalytical theories about the maladaptive containment of anxiety (Menzies, 1988), to theories about a technocratic culture of care (Davis-Floyd, 2001).

Causes of alienation

Having now been involved in 'turning around' the culture of care in a number of large maternity services, the work of Menzies holds some resonance for me (Menzies, 1988). This work that arose from nursing in the 1960s seems to help to explain the frustration and alienation experienced by many midwives, and the difficulty of retaining and attracting midwives to practice. Working from a psychoanalytical perspective, Menzies proposed that in their contact with illness, death and dying, pain and other extremely distressing situations, nurses had to confront their most primal anxieties. In order to contain their anxieties nurses chose a maladaptive response. Rather than confronting their fears and anxieties and building structures that allowed them to support those they cared for, they separated themselves by developing hierarchical and task oriented care, thus avoiding the need to confront their extreme anxieties.

With the move from home to hospital midwives took on nursing structures and the hierarchical task oriented approach of nursing at that time. Although this theory may explain destructive effects to nursing the effect on midwifery may have been more pronounced. Midwives who were to leave behind a tradition of being part of the communities of women they cared for with the hospitalisation of birth, moved into structures of care where separation of women and their midwives was institutionalised in the hospital. As with nurses this maladaptive way of containing anxiety by socially constructed defence mechanisms may have led to unresolved tensions and increased frustration for midwives as well as women, and an inevitable alienation. A more effective way of resolving the anxieties engendered by facing intense and often difficult situations is to work to reduce the anxiety by recognising it and support those being cared for while recognising the complexity of problems that are inherent, and require complex problem solving in turn.

Midwives as an oppressed group

The work of Kirkham and Stapleton (2001, 2004) has been invaluable in helping to understand the prevailing culture of midwifery in the National Health Service in the UK that may be similar to the culture of other health services (Brodie, 1996). Kirkham (2001) described how: 'In less than a century English midwives became regulated, professionalised and medically controlled (as cited in Heagarty and Kirkham). The values reflected in the organisation of midwives were those of an organisational vision culturally coded as masculine (as cited in Witz and Davies). The domestic, caring female values (as cited in Bologh) became increasingly invisible, although remained essential, in the support of individual childbearing women. Adjusting to profound changes, midwives manifest the classic responses of an oppressed group (as cited in Freire and Roberts), internalising the powerful values of medicine and exercising "horizontal violence" towards colleagues seen as deviant (as cited in Fanon and Leap, p. 157). It is easy to see then, that the support of women in having choice and control of their own care, pregnancy and birth by midwives, may be limited in a profession that sees itself as powerless, and will control other members of the profession who are seeking change, and to empower childbearing women.

Reinstating the relationship: continuity of care

Work to reinstate the relationship between women and their midwives, the development of what was called at that time simply 'continuity of care' or team midwifery began in the late 1960s and 1970s (Seccombe & Stock, 1995). By continuity of care I mean the provision of a system of care where women are cared for by a named midwife who provides most of her care, with the midwife being supported by one or a small group of other midwives to allow time off. Team midwifery indicates that the emphasis is on providing care for groups of women by a team of midwives. There are other definitions and the lack of agreed definition has created many problems. The question of definition will be a major topic for the end section of this essay.

Definitions of continuity

Interest in the reorganisation of care grew with growing dissatisfaction with care (Seccombe & Stock, 1995). About this time the Association of Radical Midwives published The Vision. (Association of Radical Midwives, 1986). The Grace Project (**Weatherston, 1985**) and the Know your Midwife project (Flint & Poulengeris1987) had developed on different sides of the Atlantic. Although the scholarly work of analysing the nature of the relationship to be developed in these new patterns of practice had only just started, there was an assumption by many of us developing 'continuity of care' schemes that the continuing and continuous relationship was fundamental and would lead to increased satisfaction for women, and would decrease the intervention rates associated with birth. For my part at least my experience of practising in the Grace Project (Weatherston, 1985) had convinced me that continuity of care was the key to providing individual effective and sensitive care and more enjoyable and autonomous midwifery. It took me some time to understand that others may not be so convinced, or may even resist the idea that continuity is fundamentally important, or to appreciate the complexity of extending continuity across whole institutions.

Two of my earliest publications in midwifery described continuity of care as an essential element to the work of midwives making it easier to support normal birth, family formation, and to enable informed choices while recognising that birth was far more than a medical event. The first of these described the Grace Project (Weatherston, 1985), a highly political development in Canada where midwifery had no legitimate place in the health care system. This pilot project was the first of its kind in Canada to evaluate the effect of midwives in the health care system. The response of families to the care provided identified continuity of care as one of the most important aspects of care. 'Just knowing the midwife was waiting for us made such a difference; it instilled the tone for the entire experience' (p16). The chapter (Page, 1989), which had arisen from practice within the Grace Project, described midwifery as a bridge between 'medical' or 'routinised' care, and the highly individual experience of the woman who is undergoing one of the most important transitions of life. At that time there were few other midwifery publications that examined concepts of midwifery that went beyond a simple definition of the scope of practice (Bryar, 1995).

The concept of continuity of care was the catch all phrase for developments in midwifery that were seen by me and many others as the essential and necessary solution to many of the problems of midwifery, and crucial to the building of more humane, individualised maternity services. But the assumptions of many of us who undertook the work of developing continuity of care were that others would understand what this brief managerial phrase meant implicitly to us. I had experienced at first hand the importance of this relationship. I experienced how knowing the woman and her family and following their care over time gave the woman and her family power by being able to explain and convey what was important to them and their family. I experienced the way this personal relationship motivated me to challenge dogmas and routines because I could see how important it was to the woman and her family. I experienced the authority it gave me in a large busy medical system to know the woman personally. Crucially I experienced the responsibility felt but also the enjoyment of being at the centre with the woman during pregnancy and birth.

To this day misunderstanding of what continuity of care means creates problems, in lack of clarity about what is to be achieved when establishing new systems of midwifery practice, and in evaluation and interpretation of research findings. However, we are now getting a little closer to some conceptual clarity and an understanding of how and why continuity of care is important to women and to midwives. It is important then, to go no further in this essay until the concept of continuity of care is defined, and the purpose made clear. To do so I will advance in time to more recent work, but will stay close to the beginning core concept of my paper that is the nature of the relationship between women and their midwives. Because the purpose of this relationship is as I see it to support the power of the childbearing woman I will start with the words of women themselves, then move to a more academic definition, and explanatory theories of why continuity of care works.

What continuity means to women

Maureen Freeley, a well-known journalist in the UK wrote of her early experience of team midwifery, established in my service at the John Radcliffe in Oxford in the late 1980s (Watson, 1990); about her experience of team midwifery and of other experiences of fragmented care in the standard service that is replaced. She saw the continuity provided by team midwifery as taking the long view, of increasing the safety of care.

Freeley (1995) wrote, ‘after the placenta had been delivered, I felt strong enough to have a shower, and then it was up to the ward where I watched the other new mothers being subjected to the indifferent care of midwives on the shift, while I continued to get what looked like special treatment from the team midwives. In fact, if you added up the minutes of care we received, I probably took less time to care for, simply because my midwives knew who I was and what I had been through and so could use the shorthand of a working friendship … If the midwife had been a total stranger I might have been too embarrassed to ask her for help … but because trust was so well established I didn’t think twice about it … why? … because the care I received from them was care with a face and a memory and an ever open ear. It

made me feel like an active participant-and not as I had been on many other occasions, a vessel at the mercy of experts. It was not just woman centred. It was man centred. It was home and family centred even when we were in the hospital (pp. 6–7).

Freeley (1995) articulated and illustrated the principles described in the earlier publication by me (Page, 1989) but from the woman's viewpoint. Sensitive to the accusations that continuity of care schemes offered a 'Rolls Royce service' to middle class women the next development I led was placed intentionally in a deprived community with an ethnic mixture of families. The words of these women when interviewed by a researcher about their experience of One-to-One Midwifery care were just as, if not more, compelling, showing as they do a lack of familiarity with English. 'I knew exactly what was going to happen, when and how, that was one bit of it. Another thing is you knew the person there, and she was there only herself, no-one else.' Another woman said 'Well I could talk to her about anything and say to her everything, that's how much confidence I had in her' (McCourt, Hirst & Page, 2000, p. 282).

As noted in the chapter 'Dimensions of caring' from *The New Midwifery* women do not generally use the terminology of continuity of care that is so familiar to midwives, but talked instead of the value of knowing their carers and why it was so important to them (McCourt, Hirst & Page, 2000, pp. 282). We see in the comments made by women the concepts of friendship, of trust, of intimacy, of feeling in control and informed, of confidence in the midwife.

Types of continuity

A recent paper 'Continuity of care: a multi disciplinary review' describes three types of continuity:

- Informational continuity — the use of information on past events and personal circumstances to make current care appropriate for each individual.
- Management continuity — a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.
- Relational continuity — an ongoing therapeutic relationship between a patient and one or more providers.

In discussing relational continuity within primary care the main view of continuity as 'the relationship between a single practitioner and a patient that extends beyond a specific episode of illness or disease … implies a sense of loyalty by the patient and clinical responsibility by the provider … it fosters improved communication, trust and a sustained sense of responsibility' (Haggerty et al., 2003, pp.1219–1221).

This value based sense of loyalty and responsibility mirrors my own personal experience and the experience of others in midwifery practice. What differentiates continuity of care in midwifery is the context of care: that is the care of women around the time of birth that is not simply a health event or an illness but an event of fundamental importance to all, with important emotional, social and spiritual meanings (Page, 1989).

Later I will describe the development of services designed to improve continuity of care for women. Outcomes of studies show an association between a decreased rate of interventions in pregnancy and birth and a high level of continuity of care. Davis-Floyd (2001) described the technocratic model that assumes a separation between mind and body. Interestingly where women have had a good relationship with a midwife they describe the confidence that this provides. Given that the reproductive system is under the control of the autonomic nervous system it seems logical to assume that this confidence affects mind and body. My early assumption that the intervention rate would be decreased by a continuing relationship between midwife and woman were based on this idea and by providing the ability of the midwife to use all her skills. One of these skills that are central is the ability to provide a calm and reassuring presence (**Page, 2000d).**

However, we should not lose sight of the fact that this special relationship between the woman and her midwife is seen as an end in itself by many childbearing women, it is not purely functional (**Page, 2003a**, 2003b).

Because the relationship is, as Stevens (2003) describes so clearly, reciprocal, it is worth looking briefly at what the relationship means to midwives at this point. Stevens describes the responses of midwives practising in the One-to-One Midwifery Practice who felt like 'real midwives' for the first time. Emphasising the ideas of responsibility and trust Stevens elaborates on the idea of knowing and what it means.

Once the words of women and midwives who have had experience of getting to know each other over time are heard the word continuity becomes clearly inadequate to describe the complexity of what happens in this reciprocal process of midwife and woman working together in a relationship of trust and support for each other. This will be expanded in the last section of the essay.

The relationship is fundamental to effective sensitive midwifery. An integral part of this relationship is the ability to work in the best interests of childbearing women. The next section will describe this aspect of the relationship, describing what has been called 'The New Midwifery' (Page, 2000a).

SECTION THREE

CHANGING PRACTICE: THE NEW MIDWIFERY

Within the context of the relationship between the woman and her midwife what the midwife does to act in the best interests of the woman and her family is crucial. This idea of working in the best interests of the woman and family is implied in the meaning of working 'with the woman'. A number of the publications in this section describe how midwives may do this in modern day maternity services. This has been described as 'The New Midwifery', the title of my second book that took as its subtitle 'science and sensitivity in practice' (Page, 2000a).

The basis of this 'new' midwifery is an ability to be sensitive to the individual needs of each woman and her family, and to form and work from an individual relationship with each woman. It also requires an ability to use scientific knowledge to ensure that care is likely to be of benefit to individual women. In short, midwives need to bring together personal sensitivity, scientific understanding, and the ability to continue learning and effective clinical skills. They need to bring both science and sensitivity into practice (Page, 2000a, **Preface**).

The aims of the 'new' midwifery

The concept of this new midwifery is built on a broader sense of the aims of midwifery that go beyond simple definitions of the scope of practice. This aim is to 'provide care that improves the physical health of mother and baby, and also to support psychological and family integrity. This includes secure bonds of love between the baby and parents, increased competence and confidence in parenting, and joy and celebration at the start of new life' (**Page, 2001a**, p. 473).

This chapter, an invited contribution to one of the most important British textbooks of obstetrics, brings together changes in policy and practice internationally, acknowledges the common aim of all working in the maternity services, but also differentiates between the roles of different members of the maternity services team. Moving from the minimal definition of the scope of practice contained in the midwifery code of practice it describes three aims. These aims are intended to clarify the role and purpose of midwifery.

The first of these aims is to help the mother and her family make the transition to parenthood in the best way possible: that is to emerge from childbirth physically and emotionally intact, with relationships within the family, particularly the attachment between baby and parents as strong as possible, and to have the confidence, knowledge and commitment to care for the child until adulthood.

The second aim is to support physiological processes and healthy outcomes.

The third aim is to provide comfort and alleviate distressing symptoms of pregnancy and birth and the postpartum period.

The chapter goes on to set out in detail how each aim may be achieved and presents a midwifery matrix of ways of avoiding unnecessary intervention. This chapter was written just after the publication of *The New Midwifery* and encapsulates the themes of that book. Although the publishers added the note that this chapter draws on the chapter written by another author in the second edition it is in fact a radical departure from earlier thinking and may be seen as both visionary but practical.

The new midwifery: putting science and sensitivity into practice

The New Midwifery, Science and Sensitivity in Practice (Page, 2000a) my own book, has been an important book to midwives around the world. It has now sold nearly 7000 copies, a large number of sales for midwifery texts, and has been translated into Japanese. Work on the second edition has just started. The book was developed to help midwives and students of midwifery look at midwifery differently. The conception of the book, divided into three sections, 1) effective and appropriate care, 2) transition to parenting and adaptation and 3) growth in pregnancy birth and early life, was drawn from my own continuing work in practice. The academic conceptualisations arose from intensive study, reading and research.

This book describes the importance of the relationship between women and their midwives, and, as it were, how to 'do' midwifery within that relationship. It also provides some of the basic information that is important for midwives.

Effective and appropriate care

The basis of effective and appropriate care is the ability to use evidence in practice while responding to the individual needs of the woman and her family and the context of care. Several of the publications presented in this section draw from my own practice to demonstrate how evidence was used in practice and my development of what I named the five steps of evidence based midwifery practice. This draws together the principles of evidence based 'medicine' making them appropriate to midwifery and ensuring that the importance of the women's values are incorporated and preferences and values are recognised, and that the information gained from the clinical examination is given some weight.

As a way of bringing the concepts together and relating them to real life practice I drew on my own experience of practice and, hating the idea of a 'case' study (calling women cases is extremely dehumanising, and the traditional approach to case studies reduces the story of the woman and her midwife). I used the term care story. Kirkham says that, 'our life is constructed as a myriad of linked stories. The construction of these stories renders our experience coherent and gives it meaning'. Kirkham goes on to say, 'A story … speaks of context and values' (1997p. 183). Jane's care story, told in a journal article together with Jane (**Page, Phillips & Drife, 1997**), and in more detail in a chapter in my book, provides a jointly constructed narrative. The story is important because it goes beyond concepts and academic theories to illustrate the complexity of practice. The story shows how evidence is only one form of information that is woven together with the information derived from the clinical history and examination, and the woman's preferences, values, hopes dreams and fears, to work together in reaching the right decision for the woman herself and her situation. The story also weaves together knowledge of the scientific process used in practice with a humane approach embedded in a relationship in which the woman is the centre, and the dilemma of the practitioner who must help the one woman in her care (n=1), on the basis of studies drawn from populations, and knowledge that is by its nature generalised. The recognition of the social context of pregnancy and birth (Page, 1989) is apparent in this story.

Evidence based midwifery

Evidence-based practice is an important part of modern midwifery and a sub theme of the publications presented. The term evidence-based medicine, coined by Sackett et al. (1997), has been substantially modified in the publications presented to make them applicable to midwifery practice and to help midwives use them. Sackett et al. (1997) made clear the importance of the use of evidence in practice, but also emphasised the importance of recognising that evidence is only one of the sources of information that we use in clinical work. They also emphasised that information about the values and preferences of the person receiving care, as well as information from the clinical examination, are other sources of information to be taken into account. The story or example I have told differs in that it describes the complexity of the decisions to be made in maternity care. Whereas the examples in Sackett et al's text are about single conditions, my example draws into consideration three crucial issues with acute and profound consequences. The steps are my development, drawn from my knowledge of teaching about steps or principles that can be counted on one hand!

The use of the scientific process in using and evaluating evidence is complex in itself. This requires the ability to search for evidence systematically with a clear question and plan for the search, and the ability to critique and interpret the outcomes of research. Moreover the midwife is required to integrate that evidence into practice. This requires communicating the information arising from evidence in an understandable way, and taking it into account alongside information from the woman's own values, preferences, and circumstances, together with findings from the clinical examination. In Jane's care story (**Page, 2000b**) based on a real life situation in which I had sought the evidence to inform care (Page et al., 1997), I developed the approach I called the five steps of evidence-based midwifery to help midwives understand this process. These steps are as follows:

1. Finding out what is important to the woman and her family.
2. Using information from the clinical examination.
3. Seeking and assessing evidence to inform decisions.
4. Talking it through.
5. Reflecting on outcomes and feelings.

The first care story required the synthesis of evidence on grand multiparity, meconium stained amniotic fluid, and place of birth. The results of the research on the first topic, grand multiparity, were surprising to me. Grand multiparity, or having had more than five babies, is widely believed to lead to greater risk for the mother, in particular a higher risk of postpartum haemorrhage; I concluded that the existing evidence did not support this belief and that home birth is a safe option (**Page, 1998a**, 2000b).

Of course the use of evidence in practice, as well as being complicated, is also politically difficult because of the challenge to long held beliefs, to the status quo, the difficulty of interpreting scientific evidence, and because of the place of midwives in the maternity services. A

number of editorials and articles (Page, 1996b, **1997a**, **1997b**, **1998b**)[2] deal with the complexities and politics of evidence based practice. These publications demonstrate an understanding of the wider issues affecting evidence-based care, and acknowledge and start to analyse the difficulties to this approach in practice.

Drawing from practical experience

The chapters in *The New Midwifery* that are cited are drawn from my own experience in practice, as well as theory and research. What is important about all of them is that while they synthesise knowledge from a number of sources they are drawn from practical experience and are written to provide practical application for midwives. So Chapter 2 'Using evidence to inform practice' (**Page, 2000c**), starts with my experience of providing continuity of care many years ago in the Grace Project, and my increasing awareness of wanting to do the right things for those I was caring for, and knowing that many of the institutional rules and routines were not in the interests of those I cared for. This was not to harm deliberately, but the routines, such as fasting women with no food or fluid for the whole of labour, were a reflection of the medical view of birth as dangerous where something could go wrong at any time. This chapter was focused around two important questions, 'Is what I am doing likely to do more good than harm?' and 'Am I spending my time doing the right things?' It was written after I had attended the Evidence-Based Medicine course for Teachers of Health Care Professionals at Oxford University and outlines what is a parallel to the scientific process in clinical practice.

Keeping birth normal

Chapter 5 'Keeping birth normal' (Page, 2000d), emphasises the unique role of midwifery in supporting normal processes, and attempts to clarify the concept of normal. The chapter emphasises the enormity of the day of birth for the woman and for the baby then integrates some of the best evidence and practical knowledge, touch massage and physical support, as well as emotional and psychological support, that may be used to support physiological processes. Again, the chapter draws from evidence but integrates this evidence with skills and elements of the personal relationship that are crucial at this time.

Providing one-to-one support

Chapter 6 'Providing one-to-one support and enjoying it' (**Page, Cooke & Percival, 2000***)* written together with Pauline Cooke and Patricia Percival draws on the idea that continuity of care nourishes the caregiver as well as the woman and draws on the metaphor of the midwife as skilled companion accompanying the woman through her journey to motherhood. The importance of clarifying the concept of continuity of care is emphasised in Section 1. This chapter works to clarify what this concept means for women as well as for midwives.

The growth of human love and commitment

Chapter 11 'The growth of human love and commitment' (Mills & Page, 2000) has a main section based on the mainstream theories and research on attachment supplemented by a section written by me on the application of theories of bonding and attachment by midwives. In this

[2] All solicited

chapter I propose that the ability of the midwife to provide a nurturing relationship with women may provide an example or a mirror even, for the relationship between mother and baby.

Dimensions of caring

Chapter 13 ‘Dimensions and attributes of caring: women’s perceptions’ (McCourt et al., 2000) clarify concepts of caring and support and describe these concepts in the words of women. The main message of the chapter is that the relationship between women and their carers may have a powerfully positive or negative effect. These chapters are drawn on in other sections of this essay.

This section about publications, situated in the ‘doing’ of midwifery, and the meaning of working with woman as working in her best interests, illustrates the complexity of holding all in balance, while practising ‘with the woman’ rather than ‘with the institution’. In all they provide a different picture of midwifery, drawing on old concepts but fitting them to a modern health care system to create what has been called the ‘new midwifery’. The new midwifery is intended to put women at the centre of the care of the midwife, what recent policy for the maternity services in the UK has called woman centred care.

SECTION FOUR

INFLUENCING POLICY NATIONALLY AND INTERNATIONALLY

How do we create woman centred services that serve the needs of childbearing women and their families and put their needs above the institutional routines rules and 'staff centred' care of many maternity services? The publications related to this section of the essay are concerned with the wider policy context of maternity care that is so important in the development of services. Such policy documents both reflect and influence change. I have been involved in creating new policy for 'woman centred care' at a national level, disseminating this policy by publication and lecturing, and putting it into practice. My involvement at a national level has been with the wider policy about maternity services as a whole, developing new principles values and structure of care, and the creation of policy on clinical practices. The publications presented are actual policy documents **(Page, 1993f**; **1994; DOH, 1993**) and publications about the policy (**Page, 1992; 1993a**, 1993b, **1993c; 1993d; 1993e; 1995a;** 1995b; **1995c; 1995d**; **1995e**). Two others frame Changing Childbirth Policy within a framework of humanisation of birth (Page, 2001a; **2001b**).

Changing childbirth

My involvement in the preparation of The Report of the Expert Maternity Group: *Changing Childbirth* (DOH, 1993) is undoubtedly one of the most important pieces of work in my career. *Changing Childbirth* that formed government policy for England has also influenced maternity services in many parts of the world.

The report starts with the words:

> *Pregnancy is a long and very special journey for a woman. It is a journey of dramatic physical, psychological and social change; of becoming a mother, of redefining family relationships and taking on the long-term responsibility for caring and cherishing a newborn child. Generations of women have travelled the same route, but each journey is unique'* (DOH, 1993, Foreword).

The words were taken, by Baroness Cumberlege directly from my presentation to midwives at the ICM in Vancouver (Page, 1993b). The description of birth as a social event in the policy document for the maternity services in both *Changing Childbirth* and The Winterton Report (Winterton, 1992) was a major departure from other policy documents in the UK.

Changing Childbirth (1993) was written as a response by the DOH to the Winterton Report (Winterton, 1992). *Changing Childbirth* (DOH, 1993) is an easy to read, radical document that talked about birth as a journey, and gave three principles of good maternity care. These principles were intended to shift power from a monopoly by professionals to those individuals using the service and the public. The principles are of universal relevance. They are as follows:

1 The woman must be the focus of maternity care. She should be able to feel she is in control of what happens to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.

2 Services must be readily and easily accessible to all. They should be sensitive to the needs

of the local population and based primarily in the community.

3 Women should be involved in the monitoring and planning of maternity services to ensure that they are responsive to the needs of a changing society. In addition, care should be effective and resources used efficiently (DOH, 1993, p8).

Reception to Changing Childbirth

This document was highly acclaimed by most stakeholders including consumer groups, many midwives and journalists.

However the report also received some criticism. These criticisms at the time were concerned with the lack of the recognition of the effects of poverty on childbirth within the report. Another criticism was about the apparent failure to understand that interventionist approaches to care had actually reduced safety. Many maternity services were concerned because they would need to make change without adequate resources. The most powerful critic in the first instance the Royal College of Obstetricians and Gynaecologists (RCOG) was highly critical of it, although eventually they became supportive.

The main concern of the RCOG was that it was believed that the organisational targets within the report were not based on evidence. This refers in the main to evidence within the limited definition of scientific experiment. However, the process of gathering information and developing the ideas underlying the report had much in common with the scientific process, and could be classified as 'evidence'. Firstly individuals and groups gave their own evidence, and the Expert Maternity Group visited a number of services with different characteristics to collect evidence. Questions were agreed in advance to ensure we got a good picture of what went on in the maternity services, transcriptions of the visit were prepared and examined. Secondly MORI (1993) were commissioned to undertake a poll of users of the maternity services. In addition members reviewed current published best evidence as a basis to the writing; much of this evidence was within the experimental scientific paradigm. Any points of disagreement were dealt with by intense and open discussion, and we were sometimes asked to prepare a paper for presentation on a point of contention. Eventually true agreement of outcomes of discussion was reached. The report combines principles, detail of changes to be achieved and targets. It is a report meant for action.

Opinions vary as to how far the maternity services have actually changed as a result of this report. The language of maternity services has changed, although often this is nothing more than the use of rhetoric. Kirkham and Stapleton (2004) describe the extent and difficulty of achieving the deep cultural change required, particularly in large maternity services. However, there were undoubtedly pockets of development that have persisted (House of Commons, 2003a, 2003b, 2003c). My impression from the evidence given to the Health Care Select Committee of the House of Commons was that success was related to effective multi-disciplinary leadership and consumer involvement in different services. Policy alone rarely changes services, but does enable such change to develop. It is an important framework for reform. The development of One-to-One Midwifery

described in the last section gives an example of reform that was enabled by this new policy.

Other policy involvement

I have been involved in the development of policy at government level, with professional organisations and others a number of times. I gave evidence to the Winterton Committee (1992) as part of the delegation from the Royal College of Midwives. Recently I was midwife advisor to another House of Commons Select Committee reviewing the Maternity Services ten years following Changing Childbirth (House of Commons, 2003a, 2003b, 2003c). So I have developed and influenced the broad policy for change at government level on a number of occasions.

The publications related to this section of the essay also include an introduction to the Winterton Report, with a number of recommendations made on how to move forward while awaiting the government response. Here the idea of transformative change, the need for consumer involvement, and restructuring the services to provide 'continuity of care' is introduced (Page, 1992) Other publications make reference to the report and draw from the paper *Midwives Hear the Heartbeat of the Future* (Page, 1993b) given at the ICM to talk more specifically about midwifery practice, describing the hallmarks of good practice, and make wide proposals for organisational change. These papers specifically bring together some of the traditional roots of midwifery, while recognising the needs of modern health care, a changing world, and complex problems that are faced (Page, 1992, 1993a, 1993c, 1993d, 1993e). These publications were intended to disseminate information about Changing Childbirth and help put policy into practice. They provide a synthesis of the report and a reference to the need for organisations to review public purpose (**Page, Bentley, Jones & Marlow, 1995a**) to helping midwives understand what phrases like woman centred care and evidence-based care were meant to mean (Page, 1995f).

A monograph published at this time gave very practical information on how services could be structured to increase continuity of care **(Ball, Flint, Garvey, Jackson-Baker & Page, 1992; Ball, Garvey, Jackson-Baker & Page, 1995**).

The policy meeting hosted by the RCOG intended to move forward on the policy of *Changing Childbirth* (1993) includes a chapter on 'Balancing Risks and Choice' (Page, 1994) that analyses the concept of choice defining it as a process of informed decision-making in which the woman must have the final say. This chapter also starts to examine the consequences and effect of the woman of being involved in decision making in regard to her transition to the new role of mother.

The idea of this transition from 'woman to mother' is continued as a theme for later work, and is treated in more detail in this work. An examination of the shift from the perception of birth as a medical event to one that is social, the importance of autonomous midwifery while working in role together with doctors and others, and the need for a scientific basis for our practice links the new policy to the creation of One-to-One Midwifery Practice (Page, 1995c, 1995d).

The last section of this essay provides evidence of the way my own work in practice and service development has made concrete changes to services built on the principles of Changing Childbirth.

National clinical policy

A chapter on monitoring of the heartbeat of the fetus in labour (Page, 1993f), given as a paper to the RCOG scientific study group, takes as a basis the common aim of maternity care, with recognition of the different roles and approaches to achieving the same aim to be taken by midwives and obstetricians. This important chapter draws both from the experience of care and the published literature to describe barriers to effective care, and includes the results of a critical review and synthesis of the literature on evaluations of intermittent fetal monitoring vs. electronic fetal monitoring. Again, the humanistic elements of care are combined with the scientific elements. This paper was influential in changing national policy to endorsing the use of intermittent auscultation in labour.

Similarly the RCOG (1995) policy group on communication standards on which I worked, includes a section prepared on this critical issue, again informed by my midwifery experience, on helping women cope with the pain of labour, with a table taken from current best evidence on information items.

The wider policy context described here has enabled many of the shifts in maternity services to more woman centred care, that have allowed transformation of services so that midwives may work with women, using all of their skills, rediscovering the meaning of midwifery and making their work more meaningful.

SECTION FIVE

TRANSFORMATIVE CHANGE AND REDISCOVERING MIDWIFERY

Transformative change implies a change in the organisation of care that goes beyond restructuring and superficial changes, that brings about clarification of purpose, clear values, and involvement of staff in the change. The idea of transformative change appears in early publications and is described in more detail in *Effective Group Practice* (Page et al., 1995a), and *Developing Woman Centred Midwife Friendly Care* (Page, 2003a).

The woman centred care described in the previous section is concerned with giving women and communities a place of power in the maternity services. By this I mean that women should be in control of what happens to them, and that services should be responsive to the needs of the local community, and include representatives of that community in planning and monitoring care. This section introduces the publications that are concerned with making changes in the organisation, both structure and culture of care, that are intended not only to alter power relationships between individual women and their midwives, but also to alter the relationships between communities and the maternity services. Making services accessible is particularly important to more vulnerable women and populations where there is poverty, deprivation, and diversity of ethnic groups.

Giving women power

Power is achieved by strengthening the individual power of women and their families, and by the authority that knowing women as individuals and understanding their needs, gives to midwives. Personal power for the woman and the midwife is increased by supporting the development of relationships between childbearing woman and midwives and developing a supportive culture and structure of care. Midwives by virtue of their professional status and expertise hold the potential of power over women. If they are able rather to work in the best interests of or 'for' women, an ethical relationship of care, both become empowered. It is working for the woman by knowing her and responding to her needs that authorises the midwife. Pairman (2000) illustrates this principle in the recorded interviews with midwives working in New Zealand. The description of the relationship of a partnership in this context is apt.

The idea of transformative change in an organisation mirrors the transformation of the woman as she becomes a mother (Page, 1993b). This is a fundamental change in role, a transition that requires new behaviours and skills and ways of seeing the world. Effective midwifery supports the woman to feel powerful as a mother, and the family to hold the personal power to care for the child. This idea of personal power reflects back to the idea of recognising the parent's central and active role in caring for the baby until adulthood (and sometimes after!) (Page, 1989), and the importance of love and commitment of parents to the child for survival and reaching their full potential (Mills & Page, 2000), to the need for respecting the personal autonomy of the woman, and trusting her to make the best decisions for her and her baby and family with the support of family, friends and professionals (Page, 1992).

Making the meaning and purpose of midwifery clear

Transformation is a particularly important idea in midwifery because a central concern of transformation is to help to make the purpose and meaning of work clear. This essay started with the dramatic and 'miraculous' nature of birth, and the idea that midwives accompany women at this crucial stage of life, playing a key and important role, the inherent meaning of midwifery therefore could not be clearer. Yet many midwives are dissatisfied and demoralised in part by the lack of opportunity to use all their skills (Robinson, 1989) and in part by the dysfunctional nature of many of the services they practice in (Kirkham & Stapleton, 2001; Kirkham, 2004b). The changes described in these publications are intended in great part to help midwives to discover those meanings in practice, often through this closer relationship with women, but also through the ability to work autonomously and flexibly with management support rather than control. The context of midwifery in many parts of the industrialised world is on the conveyer belt of busy acute care hospitals. Evidence of inflexible and uncaring services (DOH, 1993) was fundamental to the need for the changes proposed by *Changing Childbirth.* Other specific problems of maternity services in much of the industrialised world, high intervention rates, postnatal depression and low breast-feeding rates may be related to lack of support of women by midwives (Page, 1993b). Where in the developing world the problems may be lack of a midwife or trained attendant at birth at all, and a real risk of not only baby and mother dying, through lack of professional attention and medical resources. The basis of the work published is that the development of more personal and individual systems of care will put midwives closer to those they care for and therefore back in touch with the fundamental purpose of midwifery and its meaning.

Fragmented structures: fragmented relationships

The essay started with the thesis that the reorganisation of care to allow a positive and continuing relationship between women and their midwives is essential to effective and sensitive midwifery and that many present day organisations restrict the ability of midwives to do their best rather than enhance it (Page, 1993b). The difficulty being experienced by midwives who are working in dysfunctional organisations is also described. The theory of Menzies (1988), introduced in Section 1, who proposed that nurses, separated themselves from those they cared for by hierarchical structures and task oriented care in order to defend themselves from strong primal anxieties, is particularly relevant here. For the most part midwives work in fragmented structures that prevent the development of a continuous and trusting relationship. Thus, while for the most part midwives are not in daily contact with sickness, death and dying in the same way that nurses are, they do need to care for women going through a dramatic life transition, and may if they are working solely on a labour ward, be expected to care for and support many women who are in intense pain, day in and day out. In addition, the decisions made by midwives often have dramatic consequences and make the difference between life and death, health and severe morbidity. Yet, if for example a midwife is working on a labour ward, she may have had no say in earlier decisions or omissions, for example to induce, or in missing a

sign that the unborn baby is compromised in some way. It is often these earlier decisions or omissions that may be associated with problems in labour, even to the extent of hypoxic ischaemic encephalopathy and permanent brain damage, or death in labour. For example, if intrauterine growth retardation is missed problems in the antenatal period may emerge in labour. Or a woman may have had labour induced without real indication, and the use of oxytocin may lead to hyperstimulation and compromise the health of the baby.

Working in relationship with women

Yet the midwife caring for the woman in labour may bear the brunt of the outcome, even if she has had no prior responsibility for care. In creating systems where midwives follow women through the whole system of care, being responsible for and having authority within the medical system to make clinical decisions together with the woman, a healthier adaptation to the reduction of anxiety is possible. Of course the midwife must have the skills, knowledge, and aptitude to provide effective care. But rather than being alienated from those she cares for, she is in touch with women in a way that gives both the woman and the midwife together the agency to make appropriate decisions and act on them. So, rather than a sense of free-floating anxiety, concerns for the woman will be felt but may be acted on. In addition, the evidence shows that there is intense satisfaction to be found not only for the woman but also for midwives practising in relationship with women. However, it is particularly important that the organisation provides support, not only for the woman, but also for the midwife, who will inevitably make some mistakes, and may well be involved in care where the baby may suffer long-term damage or die, or be involved in the care of families in extremely difficult circumstances and with horrendously difficult lives. (In my present service for example, in the centre of London, we care for women who are refugees from countries with extreme abuse of human rights, including torture, and women from war torn countries who may have suffered multiple rape or even be pregnant as a result of rape, women who are extremely poor, and some who may be sex workers or substance abusers.)

The publications presented are important in that they make clear how and why this supportive structure may be developed.

Developing a positive culture and reviewing purpose

All organisations tend to develop routines and rules that become self-serving to those working in them, for example bringing all women into hospital-based clinics to save staff having to go out into the community, rather than meeting the needs of the people who should be served. This tendency is more pronounced in public service organisations where failure to meet the core needs of the organisation will not automatically result in the failure of a business to survive. The organisation can easily go off the tracks if it is not intentionally steered to meet the central purpose. ‘Organizational transformation requires a review of purpose, and in meeting this newly defined purpose people working within the organization find new ways of doing things. Beckhard (as cited in Page, Bentley et al., 1995, p. 77) suggests that transformation of an organization requires fundamental change at every level, of relationships between people, of employment practices, often of

the structure of the organization.' Transformation also involves commitment to a set of values, expressed through practices.

The idea of reviewing the central purpose then is important in all organisations, but this has been more complex in maternity services where societal changes, such as the emancipation of women and feminism, and more consumer oriented approaches may be seen reflected in the public and consumer voices that let us know that 'all was not well with the Maternity Services' (Winterton, 1992). This discontent, given that mortality rates were lower than they had ever been, was difficult for many to understand and seemed paradoxical.

Culture of care

Culture of care is an expression of centrally held values in an organisation. *Changing Childbirth* (DOH, 1993) described what is known as 'woman centred care' and Winterton (1992) spoke of putting women 'central stage'. Organisations should be clear whom they are meant to be serving, and what their service is. Woman centred care requires that we focus on the needs of woman while supporting staff to serve those women. The process of reviewing purpose and values in the establishment of One-to-One Midwifery is described in some detail (Page, 1995a; Page et al., 1995). This clarification of values and purpose may be somewhat easier when a service is being restructured and staff will be recruited to join a new service, but the process can and should be as effective in more traditional standard organisations (Page, 2003a). The idea of clarifying purpose is also important to changing the structure of care. Many innovations were developed over the last decades that were said to be aimed at improving continuity of care, while the set up, a large team of midwives, could never achieve continuity of care. One of the important aspects of the publications presented is that they are very clear about what continuity is expected to do, and exemplify the attention to detail and practical elements that are needed to develop a service where the purpose is clear and there is an ability to meet that purpose (Page, Bentley, et al., 1995; **Page, Jones, Cooke, Harding, Stevens & Wilkins, 1994; Page, 1996a**). Later publications make reference to the effect that wider systems of care, for example the nature of the health service and the particular country, will affect attitudes to birth and midwifery and the ability to develop midwifery (Page, 2003a, 2003b).

The development of One-to-One Midwifery Practice that is the focus of the next section aimed to enhance the outcomes and experience of birth for women and their families, to enable midwifery autonomy, and to improve the satisfaction of midwives with practice. It will be seen from the publications presented that attention was paid to support for midwives to develop and enjoy their practice. This consisted of not only supporting professional autonomy, but also providing flexibility and encouragement of reflective practice. Thus all the criteria that Sandall (1997) has established in factors that prevent burn out in midwives were met. These are occupational autonomy, developing meaningful relationships with women, and social support. As part of our evaluation of One-to-One Midwifery, Trudy Stevens undertook a longitudinal study of the experience of staff, including midwives, who were involved in the change. The report of the study shows how midwives felt like real midwives for the first time (Stevens, Page & McCourt, 1996)

The PhD thesis published later by Stevens gives responses of midwives and the organisation in rich detail (2003).

The publications presented in this section move from vision to the nitty gritty work of change (Page, Bentley et al. 1995a). This movement between policy, theory and practical insights and their coherence adds great strength to the chapter and adds to its originality. This section has been concerned with the process of developing change and transforming the organisation. The sixth and last section will be concerned with restructuring or redesigning systems of care to enable continuity of care.

SECTION SIX

ENABLING PERSONAL RELATIONSHIPS BETWEEN WOMEN AND THEIR MIDWIVES: SETTING UP AND EVALUATING ONE-TO-ONE MIDWIFERY

In previous sections I have described the importance of the relationship between women and midwives, about working with women in the sense of working in their best interests, or for the woman, and about developing policy and organisations. This section is concerned with the development and evaluation of a new service within the National Health Service called One-to-One Midwifery. This service structured care to enable women and their midwives to work in relationship with each other. One-to-One Midwifery differed fundamentally to the standard care provided within the NHS Trust it was developed in, and differed substantially to many of the developments in many parts of the world that were designed to improve continuity of care. The standard care that One-to-One Midwifery replaced consisted of a system where midwives were allocated to community or wards and departments within the hospital, and women progressed through each part of the service in different stages of parturition. The care in this system is fragmented and there is no one person who is responsible for following the woman and her care, and ensuring appropriate care is provided. Many of the developments in other places that were intended to increase continuity of care failed to do so for a number of reasons (Seccombe & Stock, 1995).

The publications that form this section describe this unique and original development of practice; describe the organisational change including the principles and theory underlying that change, and the methodology and complexity of evaluating fundamental change in the pattern of practice. They were ahead of their time but remain relevant. Two other publications refer to other studies of continuity of care schemes and other approaches, to moving away from the institutionalisation of birth by, for example the creation of birth centres (Page, 2003a), and developments in other parts of the world, thus giving a broader context to the development and evaluation of One-to-One Midwifery.

Although the evaluation of One-to-One Midwifery included quantitative and qualitative methodology it was framed within a quasi-experimental design. So I have chosen to describe the publications within the framework of intervention, outcome measures, methodology, results and discussion.

The intervention one-to-one midwifery

One-to-one Midwifery was established to 'seek ways of promoting excellence in midwifery practice which provide an individual service to women and their families, respecting their rights, beliefs and values' (**Page, Bentley, Jones & Marlow, 1995, p. 87).** Earlier I described the fragmented and impersonal service it was built to replace. The main way of achieving the aim described above was by providing continuity of care. By continuity of care is meant the creation of a system in which women and their midwives could get to know each other over time and may build a relationship of trust. Structurally this means each woman having a named midwife who is responsible for and provides most of her care, and that the woman also gets to know one other midwife partner who will provide care when the named midwife is unavailable. Moreover, in keeping with the principles of effective sensitive organisations that are able to achieve their key purpose, described in Section 4, the organisation of

care was intended to support midwives to achieve their potential and to be rewarding to them. It was hypothesised that if women and midwives could work closely together, within a supportive organisational structure, both would become more powerful, and more satisfied with the process of practice/care. Flexibility allowing a work life balance and time off call was built in (Page et al., 2000; **McCourt & Page, 1996**; Stevens, 2003).

One-to-One Midwifery provides each woman with a named midwife who provides most of her care. This midwife works with a midwife partner who also gets to know the woman. Each midwife takes a 'caseload' of 40 births a year. Midwives follow women through the process of care looking after women with low risk and high-risk pregnancies in a geographical catchment area. Much care is provided in the community (including the woman's home) as well as in the hospital. The midwife partners work in group practices of 6 to 8 midwives, to provide support, planning of work and reflective practice. Twenty midwives took on their caseloads in 1993 caring for a total of 800 women a year. The service was situated in Queen Charlotte's and Chelsea Hospital and The Hammersmith Hospital in West London. This is a National Health Service Trust and both are major London teaching hospitals. The aims, methodology and instruments of the evaluation of One-to-One Practice were developed alongside the development of the innovation (**Page, Wilkins, Bridges, Garcia, Hewison, Lathlean et al., 1995b**; McCourt & Page, 1996)

The publications describe clearly the process of organisational change (Page, Bentley et al., 1994; Page 1995a; McCourt & Page, 1996). This careful organisational change is a crucial part of the intervention. What the publications demonstrate is a clearly defined purpose, ethos, appropriate leadership and careful planning. In the development of this innovation careful regard was paid to the problems created in other parts of the country in which fundamental mistakes had been made. Moreover, my own experience in developing The Grace Project (Weatherston, 1985) and later in developing The Kidlington Team in Oxford (Page, 1995a; Watson, 1990), had given me considerable background in establishing systems to support continuity of care. The elements of leadership, planning, creation of ethos are crucial to such fundamental developments.

It is important then to recognise that what was being evaluated here was a whole package of change. In order for this to be replicated it needs detailed description such as is included in the report of the evaluation (McCourt & Page, 1996). Green et al. (1998) suggest taking individual elements of change and testing them separately. Although an appealing idea this denies the nature of change which is about altering both structure and culture of care to achieve holistic change, that can be greater than the sum of the parts (Page, Bentley et al., 1995b), and breaking apart different aspects of the change is not appropriate to complex interventions.

The evaluation

There were two evaluations, one being undertaken soon after the introduction of the service, and another when it had become embedded as a more routine part of the service. As far as we know this is the only time that such evaluation has been undertaken twice in regard to one innovation (McCourt & Page, 1996; **Page, McCourt, Beake**,

Hewison & Vail, 1999; **Page, Beake, Vail, McCourt & Hewison, 2001; Beake, McCourt Page & Vail, 2001).**

The nature of the evaluation of organisational change

A number of the publications presented in this section give a full account of the dilemmas that undertaking an evaluation of such complex organisational change presented (McCourt & Page, 1996; Page, Wilkins et al., 1995; **Beake, McCourt, Page and Vail, 1998)**. Much of the discussion between the research team, our advisors and me was ahead of its time in the field of medical or health services research. We sought to develop a rigorous study that would be useful to others wanting to replicate the intervention, that would evaluate in as unbiased a way as possible any differences that there might be in outcomes, and to have a rich account of the experience of women using the service and the staff associated with it. The dominant paradigm for research within the maternity services is the randomised controlled trial (RCT). The publications presented here provide strong and relevant reasons why this design may not be possible or appropriate.

Design of the evaluation

Eventually it was decided to undertake both a historical comparison and a comparative study using methods appropriate to the questions we were asking in relation to particular areas of the study and to use regression analysis to control for possible confounding variables in the clinical outcomes. We also undertook analysis to compare differences in socio economic characteristics between the two groups, in order to understand whether or not socio economic differences may have been responsible for any differences that might arise between the groups (McCourt & Page, 1996; Page et al., 1995, 1999; Page, Beake et al., 2001).

In essence, evaluation of change should be designed to see whether or not a change actually works in terms of both the targets set for it, the economic resources available, and the practicality of the change and the differences that arise from the change in practice, both anticipated and unanticipated. This was then, an evaluation of a complex intervention, a change in the system and philosophy of care for about 800 women and their families a year. There are a number of potential approaches to the evaluation of organisational change, each holding different merits. This evaluation was designed to measure the achievement of predetermined targets, women's responses and responses of staff, clinical outcomes, use of economic resources, and standards of care (McCourt & Page, 1996; Beake et al., 1998; **McCourt, Page, Hewison & Vail, 1998**, 2000; Page et al., 1999, Page, Beake et al., 2001; Stevens, Page & McCourt, 1996; Stevens, 2003). Both quantitative and qualitative methods were used, because we wanted not only to be able to evaluate outcomes but also to interpret and understand the outcomes and to provide a rich description of the change. Randomised controlled trials do not consider organisational context per se, as they are designed to test an intervention. So, in the evaluation of organisational change it is crucial to use qualitative methods, to pay regard to and appreciate contextual factors. Qualitative aspects proved to be extremely useful in helping to explain some of the outcomes after analysis.

The evaluation of One-to-One Midwifery comprised what might be seen as a number of

different studies looking at different aspects of the new service, but conceived to be a part of a large evaluation giving a broader picture than the reduction of the evaluation to one or two aspects, for example clinical outcomes and economic evaluation, would have done.

The questions outlined at the beginning of the study were as follows:

- Φ What will it mean for the women — what do they value?
- Φ What is the impact on midwives of working in this way?
- Φ Will care be as safe as under the traditional system?
- Φ Will it be more expensive — can we afford it?
- Φ What about the impact on the service of making changes?
- Φ What will the outcomes be for the mothers and babies?

Aims and outcome measures

The primary consideration in any evaluation of organisational change is whether or not the innovation achieved its purpose and goals (Page et al., 1995b). An important part of this study was to describe clearly values, aims, and targets to ensure that what we set out to do was actually achieved in practice. These are described in detail in the reports of the study (McCourt & Page, 1996; Beake et al., 1998, p. 6). The targets for continuity of care were set out in great detail.

Although conceived as an integrated study it is convenient to view it within the following areas:

- Φ A rich description of the nature of the intervention.
- Φ Achievement of predetermined targets.
- Φ Women's responses to their care using quantitative and qualitative methods.
- Φ A comparison of clinical outcomes including intervention rates between One-to-One Care and the system it replaced (standard care).
- Φ A comparison of standards of care between One-to-One Care and the system it replaced.
- Φ The use of economic resources.
- Φ Staff responses to the change.

The population of the studies

One-to-One Practice was provided in the postcode areas of W3 and W12, and the comparison groups were women living in W4 and W6. The first evaluation included all women receiving One-to-One Care (postal districts W3 and W12) and all women receiving standard care (postal districts W 4 and W6) who were expecting to give birth in the same NHS Trust between 15 August 1994 and 14 August 1995, and the second cohort included a random sample of all women receiving standard care (postal districts W3 and W12) who were expecting to give birth in the same NHS Trust and all women receiving One-to-One Care between 15 May 1997 and 14 May 1998.

Methodology

The studies included a complex mixture of methodologies, with each aspect providing genuine dilemmas in the planning phase. Publications describe these challenges in detail and make an important contribution to not only the literature on evaluation of organisational change but also the general evaluation of maternity services and women's and staff responses to them. The following table provides a summary of different aspects of the study and relevant references:

Table 1: *Outcomes, methods and results of evaluation of One-to-One Midwifery — a summary.*

Outcomes	**Methods**	**Results**
Organisational targets	Audit	Mainly achieved (see McCourt & Page, 1996; Page, Wilkins et al., 1995b; Page et al. 1999; 1996a; Page et al., 2001; Page, 1996a).
Clinical outcomes and interventions	Case note audit and questionnaire	Reduction of interventions in association with One-to-One Care (McCourt & Page, 1996; Beake et al., 1998, 2001**; Page, Vail & Beake, 1999**, 2001).
Outcomes for babies	Case note audit	Limited by size of study. No differences in death rates (McCourt & Page, 1996; Page, Vail & Beake, 1996b).
Women's responses	Questionnaires, interview and focus groups	Women more positive about experience of parturition and care in association with One-to-One Care (Bulman & McCourt, 1997; McCourt, 1997; McCourt, Vail, Pearce, Beake, Rutter & Harper, 1996; McCourt, Page,et al.,1998; McCourt, Hirst, et al., 2000; McCourt & Pearce, 2000).
Midwives responses	Interviews, observation and questionnaires, participant observation	Those midwives who wish to practice in this way intensely satisfied (Stevens et al., 1996; Stevens, 2003).
Use of economic resources	Hospital activity data, audit of case notes, log of care provided, modelling exercise	No greater use of resources with One-to-One Practice. May be cheaper (**Piercy, Page, & McCourt, 1996**; Piercy, Wilson & Chapman, 1996).
Standards of care	Specially tailored audit tool	No reduction in standards with the new pattern of practice (Beake et al., 1998).

Summary of results

It proved to be difficult to interpret the outcomes of the historical study because of differences in characteristics of the groups. In the cohort studies although not all the targets were achieved much care took place in the community and in the woman's own home. Achievement of continuity of care was higher than the targets set by *Changing Childbirth* (1993). Most women received one-to-one care in labour, the majority of them by their named midwife. A number of interventions such as the uptake of epidural were reduced in the first evaluation, but there were no significant differences in the instrumental and caesarean birth rate. In the second evaluation there was a significant difference in the caesarean section rate and instrumental delivery rate with a lower rate in association with One-to-One Care and a higher normal birth rate and a shorter duration of second stage labour between groups all in favour of the One-to-One group. There was no evidence of poorer outcomes for babies in the One-to-One group, Apgar scores were similar in both groups and fewer babies had a pH of less than 7.05 in the One-to-One group. It is not possible to draw inferences from the study about perinatal mortality, as the study was not powerful enough to estimate any differences there may be between groups. Deaths counted from audited records were two stillbirths in the One-to-One group and one stillbirth in the control group, one neonatal death in the One-to-One group and one neonatal death in the control group.

Women's responses, to pregnancy and their care, including satisfaction, emotional well being, and adaptation to being a mother were in general more positive in the One-to-One group, and the detailed account of women's views of their experience and care in both the study and control groups provide a rich account of their experiences. Women in both groups wanted continuity of care throughout the process, although this was more marked in the One-to-One group. Accounts of women who had experienced such care explained why this was important to them. Midwives who chose to practise in this way were intensely satisfied although it is accepted that not all midwives would want to practise in this way. In the early stages of the project there was some tension between midwives who worked in One-to-One Care and midwives who remained in the standard service; this problem was resolved over time. The use of economic resources including midwife time was no greater in the One-to-One group. If the reduced intervention rate in the second evaluation is taken into account the use of resources is less. Standards of care as measured by case note audit in the innovation were no less than in the standard service, although there was room for improvement of recording in the medical records in both groups.

Discussion

Publications describing the innovation, materials and methods and research design, and outcomes of the two evaluations of One-to-One Midwifery demonstrate clearly the rigour and comprehensiveness of the thinking behind the innovation and the evaluation. Although many services had implemented group practices and

team midwifery in the UK and many parts of the world One-to-One Practice provided greater continuity of care than most others, and represented a service in which support not only for women and their families but also for midwives had been carefully designed and implemented. The first evaluation took place soon after the service was started in its innovative stage, the second was undertaken once the service was more routine, and some of the original pioneering midwives had been replaced by other midwives who might have been more cautious of entering a new development, and who could be considered to be more representative of the 'average' midwife. The different outcomes of these two studies are of note. Whereas there was a lower rate of interventions in the use of analgesia and epidurals in the first study but no statistical difference in the operative births (caesarean section, forceps and vacuum extraction deliveries) between the two groups, the second study shows a statistical difference between the operative birth rate in the two groups (Page et al., 2001). A later reading of other studies aiming to achieve continuity of care led me to believe that in studies where continuity of care had actually been achieved, the caesarean section rate and instrumental delivery rate were lower or the normal birth rate was higher (Page, 2003a, 2003b). This finding needs to be confirmed with an appropriate systematic review.

While Green, Curtis, Price & Renfrew (1998) propose that the differences found between the study groups may have been related to characteristics of the groups rather than the different form of care, the findings were confirmed when controlled for potentially confounding variables by regression analysis. So any predetermined differences there may have been between groups have been controlled for by regression analysis. However, there is still a possibility that outcomes might have been different as a result of other group differences that were not controlled for in the regression analysis. It was recommended that One-to-One Midwifery be extended and replicated in other services under continuing evaluation. The evaluation here tested the intervention in one particular NHS Trust and the effect may have been different in other contexts (McCourt & Page, 1996; Page et al., 1999, 2001).

Continuity — continuing controversies

This final section, concerned with the setting up of a structure that allows for a positive and trusting relationship between women and their midwives (Page, 1999), brings us full circle. The development of One-to-One Midwifery was a large complex project that was extremely successful. When the evaluation was published every major television and radio channel carried the story on prime time news. The press also carried major stories. There was a resonance in the idea of a woman being cared for by a midwife she has grown to know and trust that appeals to most. Ten years before I had hoped to see every woman in the NHS cared for in this way. However, given the complexity of the change and the evaluation this may have been overly optimistic. One-to-One Midwifery has been extended and replicated in a number of areas, but still the majority of women in the UK are cared for in systems that are fragmented and medicalised. While systems such as One-to-One Midwifery may be situated in medicalised services they seem to move the model

to a more humanistic or holistic one, even when medical care and treatment is required.

This essay traces the importance placed on the relationship between women and their midwives in my publications. Although much of my leadership work has been in improving the whole of maternity services for women and midwives, I have committed considerable time to the development of services in which women can receive continuity of care. This final section has introduced publications about the development and evaluation of One-to-One Midwifery. It will be noted from my earliest publications that they are explicit about the importance of developing a relationship of trust between women and their midwives. In these publications it is made clear that the provision of continuity, that is developing and sustaining the relationship over time, is seen merely as a mechanism to enable the development of this relationship.

Meta-views of continuity of care

Questions continue to be raised about the importance of continuity of care to women, and the outcomes associated. Given the complexity of the redevelopment of standard fragmented maternity services such questions are appropriate. Sadly, despite so much development work around the world to provide continuity of care there are few evaluations and many of the evaluations are marred by inadequate description of the 'intervention', different approaches to the change process, and organisation of care. These very difficulties are reflected in the two reviews that are to be described here. *Continuing to Care* (Green et al., 1998) is a 'structured review' of the evidence on different organisations of midwifery care that includes a critique of the first evaluation of One-to-One Midwifery. The second is a systematic review comparing continuity of midwifery care with standard maternity services (Waldenstrom & Turnbull, 1998). Both of these publications have been extremely influential, despite clear methodological problems. There are fundamental flaws in both of these reviews and it is important to be aware of these flaws while recognising that more recent research, and high quality qualitative research, indicates that continuity of care is important to women and midwives, and the system of care, in a number of diverse ways that go beyond simply considering any reduction that there might be in the intervention rate.

Continuing to Care is a structured review 'that followed some of the conventions of a systematic review' (Green et al., p. 13) of the evidence relating to the organisation of midwifery services, to help inform the commissioning and provision of services, and the need for further research (p. 4). Such reviews bring together relevant studies and critique the research to lead to recommendations. As with primary research, overviews should avoid bias in the search for and interpretation of evidence. However, the issue of fundamental importance in the evaluation of organisational change and in the overview or meta-analysis of evaluations of organisational change is to ensure that the primary purpose of the change is clear, and that the change proposed is actually achieved. This may be extremely difficult where change is brought about to put into practice a concept such as continuity of care or carer where not only is there clearly difficulty in definition, but also major differences in how the concept is put into practice. Even in the review by Green et al. (1998) that emphasises the importance of the definition of

terms such as continuity of care, difficulties of definition occur. In the section on terminology used in the review continuity of care is defined as 'The same health professional(s) providing care throughout the childbearing period. It can also be used to indicate the same caregiver throughout a specific episode of care, such as during labour and birth (Green et al., 1998, p. 10)'. In the findings on continuity of care in the review in question reduction in the number of caregivers is also considered. This is very different to creating a system with the intention of enabling the formation of relationships between women and their midwives. In their meta-analysis Waldenstrom and Turnbull (1998) describe continuity as a midwife or small group of midwives providing care from early pregnancy to the postnatal period.

Apples and oranges

Imagine that it has been discovered that a group of women who have taken a diet that includes apples and oranges seem healthier than other groups of women. Studies are set up to provide one group of women with apples and oranges. Nobody checks to see if women have actually eaten both the apples and oranges, and the group who were meant to eat the apples and oranges didn't and outcomes are not improved, but the conclusion is drawn that apples and oranges don't work. To take this analogy further, it may be that the orange is more effective than the apples, but some of the women are given only the apples. The conclusion is then drawn that apples and oranges aren't effective. The lack of validity in these studies is clear. This precise difficulty is seen in the comparison, analysis, and interpretation of the studies of 'continuity of care'. Of course the evaluation of a change in the organisation of care is far more complex than the evaluation of the effectiveness of oranges and apples, but the point is of crucial importance, and principles may be drawn from this analogy.

Comparing like with like

It is of the utmost importance therefore that where a structured or systematic review is concerned with comparing and synthesising evaluations of organisational change that like is compared with like, and that the aim of the change has been achieved. Both the structured review of Green et al. (1998) and the meta-analysis of Waldenstrom and Turnbull (1998) aim at least in part to draw conclusions about the outcomes of continuity of care, and the desires of women to be cared for by a midwife they know from 'start to finish' (Green et al., 1998), and to synthesise the outcomes of randomised controlled trials that aim at comparing continuity of midwifery care with standard services (Waldenstrom & Turnbull, 1998).

One of the difficulties in interpreting the effect of change from the reviews is in understanding the nature of the change that has been undertaken. While Green et al. (1998) provide useful tables of details even here it is difficult to get a holistic picture, and Waldenstrom and Turnbull (1998) provide inadequate detail about the nature of the 'interventions' that are being reviewed. It is unclear therefore that all the studies included in these reviews actually provided continuity of care, or even aimed to provide continuity in the study groups. To take *Continuing to Care* first, the seven core comparative studies that form the basis of the review by Green et al (1998, p. 19) include four that have the additional aim of having an individual or a small group of midwives who look after a woman through the whole process from

booking to discharge. They refer to these as start to finish schemes.

In order to evaluate the studies then it is important to know to what extent the aim has been achieved. This is similar to checking for 'compliance' in evaluations of treatments. The assessment of continuity is difficult. It requires methods such as the counting of signatures in the notes, or a specially created audit form. Also, women may be asked whether or not they knew their carers and how many carers they knew. To establish whether or not women felt they knew their midwife some kind of questionnaire or process of interview is required. Even then the interpretation of what it means to know will vary. Studies have used a variety of approaches and so the measures of whether or not continuity has been achieved may not be reliable. In all four studies of interest here there seemed to be difficulty in interpreting to what extent the aim of continuity had been achieved.

Assessing continuity

To be brief I will focus here on continuity in labour, although it is important to enable continuity throughout care. In at least one of the studies there was a trade off between antenatal and postnatal continuity, and continuity in labour and birth.

The verification of whether or not continuity was achieved in another one of these studies is difficult. From the information provided it seems that only three of the studies achieved continuity of care, and there seems to be a difference in the extent of knowing the midwife.

Like the structured review by Green et al (1998) the review of Waldenstrom and Turnbull (1998) suffers from a fundamental problem of lack of clarity about the intervention and whether or not it has been achieved in all the studies under review. This systemic review was undertaken to review randomised controlled trials of alternative maternity services characterised by continuity of midwifery care. The seven trials identified included 9148 women. However, while this review seems to be methodologically more rigorous than the review by Green et al. (1998) it contains a greater problem in that a meta-analysis has been undertaken to synthesise the outcomes of a number of studies of systems described as continuity of care, that are very disparate in nature, neither is it clear that all studies included achieved or even aimed to provide continuity of care. Moreover, the meta-analysis includes one study in which care was provided in a birth centre. This difference of context is important, particularly because it is in the birth centre study that the perinatal mortality rate is higher than in other studies included in the meta-analysis, possibly weighting the whole meta-analysis. The authors have urged caution with the interpretation of these data.

Drawing conclusions from studies of continuity of care

While making the concern about the problematic nature of multiple comparisons explicit the authors have still undertaken a meta-analysis. The authors conclude that continuity of care is associated with lower intervention rates during labour (induction, augmentation, electronic fetal monitoring, obstetric analgesia, instrumental vaginal delivery and episiotomy) and while no statistically significant differences were observed in maternal and infant outcomes they go on to say that 'the difference in perinatal deaths was bordering on statistical significance (OR 1.60; CI 0.99 to 2.59)'. Strictly speaking where there is not a significant difference

there is no difference, and while recognising that the evaluation of safety is crucial, it is important that scientific conventions are observed in the reporting of such outcomes.

Team midwifery versus personal caseload midwifery

More importantly because a greater degree of continuity of care than may have been provided in some of the studies under review may have a protective effect, that is care might be safer, it is of concern that the analysis has included such disparate studies. Of note the studies include home from home, and what is known as team midwifery.

A number of models have evolved over recent years that have ranged in the amount of continuity achieved. It is convenient here to divide them, somewhat simplistically, between those that have aimed to provide what has come to be called a 'team caseload', that is a team of midwives cares for a group of women, and a 'personal caseload'. A personal caseload implies each woman having a named midwife who provides most of her care, with the named midwife being supported by one or a small number of partners. These differing systems may have different outcomes for women as well as midwives, and the differentiation in research is crucial. The apparent attraction of team midwifery is easy to understand, because it appears to put less of an on call burden on individual midwives, and seems to be easier to arrange. However, it may not provide as many advantages to women, and may create problems for midwives (Sandall, 1997). Innovations in care may also be divided into those that aim at increasing the autonomy of the midwife by midwife led care, rather than in increasing continuity, and those that do both. One element of successful leadership and development is clarity about intention. This clarity in itself will be effective in achieving the desired aims. A number of studies that have been included in both of these reviews are intended in the main at increasing autonomy by developing midwife led care, rather than continuity of care. The studies included in both of these reviews provide a range of these models.

Creating reciprocal relationships

Given that it may be the creation of reciprocal relationships in which women and midwives get to know and trust each other over time that is fundamental to a range of improved outcomes of care; it is not clear whether or not this is the intervention that has been evaluated in a number of the studies reviewed. Stevens (2003, p.304) comments on the issue of minimal change and misleading evaluations. This is a crucial point. Many of the changes implemented have taken a 'tinkering at the edges' approach, presumably because it seems easier and less disruptive. But these schemes 'failed to embrace the fundamental change laid down by Winterton and Cumberlege, that of replacing the medical model of childbirth with one that is woman centred. In Davis-Floyd's (2001) terms this required replacing the technocratic model with a humanistic or even holistic model' (Davis–Floyd, 2001). Interestingly, Stevens (2003) sees one of the evaluations that Green et al. (1998) describe as impartial as reflecting a particular view of childbirth as a medical model.

The two reviews by Green et al. (1998) and Waldenstrom and Turnbull (1998) under discussion are both fundamentally flawed in that they draw and interpret results from some studies that may not have aimed for, or achieved, the

provision of continuity of care, and that have used very different models of change and of practice, and vary in context. They have not synthesised or drawn their conclusions from similar services, and some of the studies included may not have achieved the object of the new organisation of care. To return to the earlier analogy some studies have compared apples and oranges, and some have drawn conclusions from studies in which apples or oranges may not have been given at all.

Differences between evaluation of organisational change and treatments

The flaw in both of these reviews draws attention to the crucial differences between the evaluation of organisational change and the evaluation of a discrete treatment. Where the development of an organisation is aimed at changing the structure of care or practice, the way this change is conducted is of paramount importance. Effective change will require a number of elements including strong leadership, clear goals and good planning, preparation of staff, allocation of resources, and ensuring at least on a logical level if not by more detailed modelling that the desired outcome is likely to be achieved in practice. This is particularly important in the case of providing continuity of care because the way midwives are structured or deployed is important. In some cases, including one of the studies described by Green et al. (1998), continuity was actually decreased in the study group by the change intended to provide 'continuity of care'. Given that much of the review is not concerned with evaluations where continuity of care has been achieved, the conclusion of the review that 'there is no justification for making attendance in labour a main determinant of the service (p. 135)' is not supported. Moreover, evaluations were undertaken at an early stage in the development of innovations. Given the differences in the first and second evaluation of One-to-One Midwifery, it is possible that outcomes of any evaluation undertaken when a new service is more firmly established may have different outcomes. In addition to other weaknesses of the study the conclusions of Green et al. (1998) may also be premature.

Have the reviews avoided bias?

Aside from the fundamental problems described earlier in relation to the two reviews in question, it is not clear whether or not the review by Green et al. (1998) has avoided bias in the selection and interpretation of findings. Thus the validity of the review is in question.

In addition to the core studies the review includes some multi site studies, and a kind of 'catch all' of other studies. The search and selection methods for these later studies are not clearly stated. It is impossible to know from the review why studies in this section have been included, whether any studies have been omitted, and why. The authors claim that multi scheme descriptive studies provided breadth and other studies have been included to shed light on some details of care, and because there is much to be learned from reading them (p. 15). The methodology of these studies is not described clearly, neither is there a critique of methodology.

Can evaluators ever be independent?

Green et al. (1998) propose that independent evaluators present a less rosy view of

'organisational change' because they are more likely to be objective. Yet the less rosy view is not necessarily more objective, there is always the possibility of an inherent bias. There is no such thing as a neutral stance in the interpretation of research, particularly research concerned with evaluating the organisation of care.

Being separate to the evaluation does not necessarily ensure independence of view. Especially when qualitative and descriptive research is being undertaken it is safest to recognise that everyone has a point of view and that this point of view should be made clear.

There is an alternative view to that of Green et al. (1998), which is that it is important for those leading the evaluation of change to be expert in change processes and to understand the nature of the service to be developed. It is important if those leading the change are also involved in leading evaluation, that there should be an external process of monitoring the process, and that any data collection or interpretation that may be skewed, is not undertaken by that person. This approach was employed in the One-to-One evaluation, to ensure an unbiased evaluation.

Is continuity of care what women want?

Perhaps the perception of the importance of having 'a known and trusted midwife' as a consumer choice, rather than a fundamentally important part of a safe effective and responsive service has been one of the major problems in the development of true continuity of care and its evaluation. The unclear use of the term continuity of care and lack of a clear definition has undoubtedly created problems. Similarly lack of clarity about the aims of continuity has created a minefield of problems in setting up new systems of care and in research and evaluation, and the outcome measures used. It is clear from my publications (Page, 1989) that it was an understanding drawn from my experience that led me to believe that the care provided in large bureaucratic organisations could be made more humane and personal by the creation of personal relationships between women and their midwives. Particularly in the Grace project (Weatherston, 1985), developed in a large tertiary care centre, I experienced what it meant to work 'for' the woman and her baby, and the ability it gave me to understand what was important to them. It was easier too to employ the whole of my midwifery knowledge, develop and use the skills to provide safer care thus reducing the need for surgical interventions such as caesarean section, forceps delivery and episiotomy. In this relationship it seemed natural to involve women in making decisions about their care, and to ensure that they had the final say. The experience I had in which I practised in the context of a reciprocal relationship with women is hard to break down into component parts.

The three C's: Continuity, Choice, and Control

Working in a continuous relationship was fundamental to involving women in making decisions about their care (giving choice) and ensuring that they were truly in control of what happened in their care. Continuity, choice and control became a rallying cry for the changes to be brought about by the Winterton Report (1992) and *Changing Childbirth* (DOH, 1993). These were described in Page (1992, 1994). Although continuity allowed the other two C's of choice and

control it was still necessary within the relationship to ensure that the woman was enabled to make choices and be in control of the treatment she received around the birth of her own baby. This ensuring choice and control was integral to the relationship, it was one of the intentions or purposes of the relationship. As policy within the maternity services has developed over the last decades the rallying cry of the three C's, of choice, continuity and control (Page, 1992) has been useful in one sense, but has perhaps been harmful in the long run. The reduction of a complex process to a three-word slogan seems to have led to a belief that we can separate the concepts in practice, providing some or one without the other. Most importantly, in our attempt to make maternity services more responsive to women and their families, the provision of 'continuity of care' to women has been seen as an option or choice in itself, something that women may or may not want. Thus the desire or not of women for 'continuity of care' has been treated as an outcome measure in many studies and surveys.

The difficulty of understanding what is important to women is compounded by surveys that have asked women to rank items that are important to them. Many of these surveys, rather than assuming that a registered midwife would be competent and kind ask women to choose between a competent and kind midwife and one known to them. These are false hypothetical choices that have led to misleading information in the evidence on maternity services.

If we do ask women what they want from maternity care they usually describe what they know they can have. The phenomenon of 'what is must be best' has been recognised for many years (Porter & McIntyre, 1984; McCourt & Page, 1996; McCourt, Page et al.,1998). Much of the research reviewed by Green et al. (1998) confirms this phenomenon with women who have received care from a known midwife saying how and why it is important to them

What does it mean to know your midwife?

Perhaps one of the most useful questions for future research is 'what does it mean to "know" your midwife (Green at al., 1998, p. 60)?' This moves the issue of the potential relationship between women and their midwives to a deeper level than one of a consumer choice. Of course continuity is not an aim in itself, it is the development of a relationship in which midwives and women can get to know and trust each other, because this leads to so many of the other things, that make up effective and sensitive midwifery care. In the evaluation of women's responses to care in the evaluation of One-to-One Midwifery both those women receiving standard care and those women receiving One-to-One Care preferred to be cared for by a midwife for labour and birth (84% study group vs. 70% control group) and by a person they knew with a greater number in the One-to-One group (75% study group vs. 50% control group).

What is important about the study is that it provides explanations of why this was important to women. Women relied particularly on the named midwife for support encompassing clinical care, companionship, information giving and advocacy (McCourt, Vail et al., 1998, p. 77). Amongst those who responded to the open-ended questions on the questionnaires provided to women in the study the most common theme across all responses and both groups was continuity and knowing one's carers.

‘The character of the responses paints a picture of very different experiences of care across the two groups. One-to-One women described the value of a known midwife, guiding them through all stages of care, including birth. Control group women described a more fragmented picture, often disparate and confusing, with different doctors and midwives seen at each hospital visit’ (McCourt et al., 1996, pp. 47–48).

‘The words used to describe what we have termed continuity reflect different levels of awareness of the options available. … most women who had a named midwife gave details of why they valued this kind of care, emphasising the confidence, support and reassurance, which knowing your midwife provides’ (McCourt, Vail, et al. 1996, p. 48).

An independent analysis of open ended responses was undertaken by Rutter who was provided with codes to separate the two groups but not told which was One-to-One (in McCourt, Vail, et al.,1996, p. 53). In the summary of findings it was stated ‘Respondents wanted personalised and continuous care from the same known midwives throughout pregnancy and birth. Those who had experienced the One-to-One scheme were overwhelmingly appreciative and felt it should be expanded to provide for more women. Knowing the midwife who would deliver enhanced confidence’.

These themes were continued in the analysis of the interviews. One-to-One women emphasised the benefits of having a midwife ‘who gets to know you, sees you through, understands your needs and is there for the birth and afterwards’. (McCourt et al., 1996, p. 61).The importance of these selected but representative comments is that they indicate the meaning of continuity to women, of why it is important to them.

In addition, the exploration of the views and experiences of minority ethnic women who did not respond to a postal survey through a semi-structured interview was undertaken to evaluate responses to their care and to assess whether the concept of continuity mattered to them. The key findings of the study were that ‘The women valued concepts such as communication, support, and control highly but those receiving conventional care were disappointed with their care, particularly in hospital settings and did not feel it was focused on them as a person’. Women receiving caseload midwifery held more positive views and emphasised the role of having ‘their own’ midwife in supporting such concepts. They showed greater trust and confidence in the professionals and in the personal transition of giving birth (McCourt & Pearce, 2000, pp. 145–154).

Knowing the woman: the reciprocal relationship

Stevens (2003) provides a different and helpful perspective from the midwives point of view. She suggests that rather than asking what it means to ‘know’ your midwife, identification of the implications for the midwife of ‘knowing’ a mother may prove more fruitful for service development considerations. From the findings of her study of One-to-One midwives she provides the benefits that became transparent. ‘Knowing’ for caseload midwives meant having clinical, social and psychological knowledge about the mother. Such knowledge would deepen over time, continuing into subsequent maternity care ‘episodes’. This held important implications for care delivery: The implications indicate that the

knowing would give a depth of clinical care that would enhance assessment and increase safety, not only physical safety but also social safety. For example disclosure of important information such as previous sexual abuse was only made over time later in the pregnancy. 'Knowing' for the midwife also involved a reciprocal relationship, which had implications for the midwives themselves and the sustainability of their work (p. 308)?

Studies tend to have evaluated the responses of women and midwives separately. What Stevens work demonstrates is the importance of considering both in tandem. This makes sense given that relationships by their very nature affect both parties being mutual and reciprocal.

Should continuity be a choice?

In framing continuity of care (or rather having a known midwife through the whole of care) as a consumer choice that women may or may not want, the relationship is treated as something of a luxury, the icing on the cake. In fact the development of an effective working relationship is a matter of providing safer care and is fundamental to more humane care. Safer in terms of the reduction of unnecessary interventions, but also in terms of social safety. The idea of social safety is important. By this I mean enabling the family to remain integrated, enabling the mother to emerge from care feeling good about the experience and confident in herself and her parenting skills. Whether or not midwives work in fragmented systems or have a caseload practice (that is providing continuity of care) they need to develop at least a fleeting interpersonal relationship with women they are caring for. Developing that relationship is easier and more likely to be effective if this can happen over time. Rather than using the term continuity as a substitute word for relationship it might be more helpful to recognise that continuity (over time) is only one characteristic of relationship.

The questions that researchers like Green et al. (1998) raise are legitimate. Is it necessary to create fundamental reform that may if handled poorly cause major disruptions to services in order to have midwives provide care from 'start to finish' (Green et al., 1998)? Is it safe to allow midwives to provide continuity of care (Waldenstrom & Turnbull, 1998)? Undoubtedly however personal preferences and attitudes to the nature of organisational change are important to conclusions drawn. Green et al. (1998) seem concerned above all in minimal disruption of services, yet it may take fundamental change to achieve the cultural change that was the aim of *Changing Childbirth* (1993) and new policies published since then. My vantage point is of a person who has worked and had a leadership position within four large maternity services in two countries over a number of years. I have been successful in all of them in leading the creation of improvements within standard services for women and for midwives. It is clear from my experience however that the extent of improvement is limited when we cannot break down the institution to enable continuous working relationships between women and their carers, and to form small working groups of midwives and professionals. There is a persistent trend to alienation in large fragmented services. This alienation is apparent in the recent work of Kirkham (2004).Good midwives may well be reasonably effective in large services where there is no continuity, they can do more however where continuity of care is possible. First hand accounts

including my own (also see for example Couves, 1995; Bissett, 1995, 1996; Farmer & Chipperfield, 1996) and the research of Stevens (2003) gives detailed accounts of this.

Colleagues (but interestingly in my experience not members of the public) sometimes ask the question, what happens if a woman is stuck with a bad or unkind midwife? Or, but what if the midwife is not skilled? Despite professional regulation there are midwives who may be less skilled, respectful, or kind than they should be. However, these midwives may do as much if not more harm in a standard fragmented service.

What is important about the publications presented is that they point to a very clear definition of the relationship. The midwife works 'with the woman' in the sense of working for her rather than the institution and in her best interests (refer to Section 2 and Section 3). This working in her best interests requires skills, knowledge, and the ability to find, interpret, and convey information. It also requires that the midwife have interpersonal skills and self-understanding

All relationships contain the Janus face of power that can be used for good or harm. Even, or perhaps especially, within the family, members are abused, neglected and ignored by each other. In any relationship there is always the possibility of exploitation. However, the human relationship is the most important source of support and nurturing in the world, and may be in itself a source of therapy and healing. The ethic of care where midwives and women work closely together requires that neither is exploited. So the midwife should not use the relationship to have power over the woman, nor should she use the relationship to meet her own needs over those of the woman.

What the publications about One-to-One Midwifery demonstrate is that midwives moving from institutional to personal midwifery have to learn how to 'manage' such relationships. They need to learn how to provide support while avoiding the development of dependence that takes away the woman's self-confidence. They need to learn how to manage their own time so that their life needs outside of work are met. It is clear that with appropriate support midwives will manage this transition to effective sensitive relationship, and find in it a source of reward (Stevens, 2003).

Of course if midwives are to work within relationships with women it is important that they have their own sources of support. An interesting finding when working in a continuous relationship with women is that women and midwives support each other. Support may also be from family and friends, and colleagues; however, an important source of support is from the group of midwives with whom they practice. Of course there can be dysfunctional conflict in such groups, and this needs to be prevented or defused. Such dysfunctional conflict will be more visible in small groups. In larger teams attached to wards departments or communities such conflict may stay underground while doing tremendous harm to an organisation. Often we see problems or sense an atmosphere where the roots are unclear. The work of Stevens (2003) will help in understanding these dynamics. The fifth section of the essay makes clear the need for the organisation or the institution in which midwives practice to support them and shows how that support may be provided. This context then is crucial to the support of the midwives, and to their professional development and continuous learning.

Thus the relationship aimed for in effective continuity of care schemes is one underlaid by the fundamental knowledge and trust established between the partners, the woman and her midwife, but also by the skills, attitude and knowledge of the midwife. In its turn midwives need support to work in such a relationship with women.

The need for a further review

Since the two studies of Green et al. (1998), Waldenstrom, and Turnbull (1998) described in some detail here the results of further primary studies have been published. Another review needs to be undertaken avoiding the fundamental problems associated with the reviews of Green et al. and Waldenstrom and Turnbull. The crucial variable in reducing interventions and improving safety may be whether or not the women and midwives were able to develop a relationship in which each got to know and trust the other, and where one midwife took responsibility for providing most care and coordinating all care from beginning to end of pregnancy.

More recent studies published since the two reviews in question have been mentioned in my publications (Page, 2003a, 2003b). At least one study by Homer, Davis, Brodie, Sheehan, Barclay, Wills, et al. (2001) was omitted from these articles, and more may be missing. There is also an area of debate that has not been addressed in my work about the possibility that doulas (companions without a professional training) may be more effective in providing support and continuity during labour, than professional midwives.

Future reviews should include evidence other than randomised controlled trials. They should also include a meta-synthesis of qualitative evidence. Reviewers should include people with an understanding of organisational change, who are able to analyse and make transparent personal views as a basis to analysis and interpretation of data.

Revisiting evaluations of changes in the organisation of care

It seems that the starting point of evaluating changes in the organisation of care to enable the development of a relationship of trust between the childbearing woman and her midwife/midwives must be an assumption that this relationship is likely to be beneficial. In order to test the null hypothesis therefore we would need to demonstrate that the relationship is harmful in some way. Of course other subsidiary questions about use of resources and the practicality of reorganisation are of importance. It may be that it is difficult to get enough midwives who want to provide continuity of care, or that there is not strong enough leadership to develop such systems, but they are separate issues that should not cloud and confuse the interpretation of evidence.

Careful consideration needs to be given to hypotheses to be tested, questions to be asked, and outcomes to be assessed. It is possible that the most relevant are questions about the associations between positive continuous relationships and relationships with the baby and within the family following birth. Whatever the outcomes we assess it is unlikely that we will ever reach the level of certainty, the Holy Grail, proposed by Green et al. (1998). What we can aim to do is to build up a detailed account of the development of new patterns of practice, that is as close to the truth as is possible and that rings true. What we must not do

is close the possibility of developing new patterns of practice that may have a profound effect on the care of women and give midwives who wish to do so a chance of practising in this way.

The growing scholarship concerned with the nature of relationships between childbearing women and midwives (Kirkham, 2000; 2004a; Pairman, 1998; 2000; Stevens, 2003) is crucial to our understanding of what happens at the intersection of the relationships between women and their midwives in different configurations of service.

One of the problems with many of the evaluations of changes in the organisation of midwifery care has been in confusion about the nature of the change. Changes will occur in different ways and it is important to evaluate them. My work has always been in large teaching maternity services, with an aim to provide more humane care for all women, and to enable midwives to practice to the full of their abilities. Whereas I have been involved in developing birth centres and changing the physical environment, I still believe that the route of more humane supportive effective and personal services is through the potential for women to be cared for by professionals who they can get to know and trust. Because it seems to me that there is considerable evidence of good effect of continuity of care it has been important to situate these developments in more deprived areas. Arguments about lack of equity are misplaced because a service that provides true continuity is actually less labour intensive than standard fragmented care (McCourt & Page, 1996; Piercy, Page et al., 1996; Beake et al., 2001).

It may be that the efforts to provide continuity of care may not be as necessary in smaller more personal services, such as birth centres. It may be more difficult to change a service that is large and centralised with midwives hospital based and institutionalised than providing a new form of care that does not require such reorganisation. Perhaps it is more difficult but also more important. All large institutions tend towards dehumanisation and personal relationships may be the only way to retain personal effective care. What studies have done, quite rightly, is put a new service under the microscope. What it is more difficult to do is to see the problems of the service we have grown used to, what I will call the standard service, and how difficult it is to resolve them. Some studies have highlighted the depersonalisation that seems inevitable unless we change the organisation of care (Hunt & Symonds, 1995; McCourt & Page, 1996; McCourt et al., 2000). Good studies of standard care are long overdue.

The Maternity standard of the National Service Framework

The newly published *Maternity Standard, National Service Framework for Children, Young people and Maternity Services* (DOH, 2004) calls for further development of the maternity services over the next ten years in England. The standard 'Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies (p. 4)' will be best achieved by care that is embedded in the primary care sector, with care pathways to appropriate medical and social and educational services. Managed maternity care networks are proposed. This provides the ideal opportunity for the development of services like One-to-One to be

embedded in a different and perhaps more appropriate context. Extension of what is now often called caseload practice(where midwives provide continuity of care by taking on a personal caseload), has already started, although the extent is not known it is apparent that many have been developed in a number of 'Sure Start'[3], and other areas. It was also apparent in my recent visit to Australia that there has been considerable development of 'caseload practice'. Particularly when continuity of care systems are applied in areas of deprivation the issue of social safety, that is supporting individual, family and social cohesion and integrity, is crucial and worthy of further exploration.

Epilogue – how may we best work with women?

In the organisational change that has been intended to make maternity services more humane the ideas, concepts and theories that underlie all of the publications presented can be seen in the very first publications. They started as ideas and knowledge that arose from my own practice. Since then they have grown in complexity through the work of continuing practice development, research and scholarship, practice and reflection. Throughout my career writing itself has been a method of thinking through and clarifying ideas. Many of my publications have been pioneering, but retain relevance. Perhaps the most unique aspect is the bringing together of so many elements of work, that have added a richness and depth. Finally however the essence of all the publications is clear and simple. Birth is a mystery and a miracle, although an everyday one. Many of our institutions have led to the reduction of birth to a clinical medical process, and would have women delivered of their babies rather than giving birth to them. The development of personal relationships within our institutions is a powerful step in rediscovering midwifery, and reclaiming the power of birth, and helping midwives work once again with women, helping at the birth of babies and bringing rich experience, joy and love.

Any research is by its nature reductionist. It can only explore, illuminate, evaluate limited outcomes. In my years of seeing the effects of different patterns and quality of care at first hand, I am still struck by the power and extent of influence a positive and continuous relationship between childbearing women and their midwives (and doctors) can have. It is perhaps by film, poetry, literature and the words of women themselves that the nature of such a relationship is best conveyed.

The myth of Mowita that started this essay is being superseded by a myth that woman can no longer give birth to their own babies, that they need to be delivered of them, and by a myth that caesarean birth is safe. Such myths both represent and inculcate a view of birth that says much about our beliefs culture and attitudes to women, to mothers and to the family. It is a myth of arrogance that implies we know everything there is to be known, and can measure everything concerned with the finely balanced processes of psychology; emotional responses, hormone secretion, spirituality, and can literally cut into the birth of

[3] Sure Start Programmes are a government initiative to reduce the effects of deprivation on families by care through multi agencies.

babies and fully understand what the effects may be.

The stories told by women about the experience of being attended by a midwife they can get to know over time and learn to trust, and the stories told by midwives about the experience of working in relationship with the woman, are building another reality.

Unlike Mowita who undertook her journey to motherhood alone, the modern myth developing is of the strength that may be experienced by the woman becoming mother when she is allowed to undertake her own journey, while accompanied by the midwife who will not only assist her in giving birth to her child, but also in giving birth to her stronger better self, a self that is able to take on the long and fundamentally important task of being a mother, while building and enjoying the support of the family around her. Such a myth places midwives back in the centre of it all, not as employees of an institution, but as the midwife who works with the woman, in the sense of a relationship, caring for her and about her, and able to work in her best interests. The work of placing midwives so that they can work in close relationship with women also helps them find the meaning of their work.

This essay tells my own story of my rediscovery of the midwifery relationship of being with the woman, and my work in building organisations, policy and practice that enable that relationship to develop. Much remains to be done, but the compilation of publications and this essay should provide unique knowledge, insight, and ideas to help others in continuing to build structures that support midwives to give of their best, and to find for themselves the power of working in relationship with women, so they may support childbearing women to the full extent of their abilities.

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