



## The Albany Midwifery Practice (2)

This is the second of two articles by Becky Reed, a midwife with the Albany midwifery practice. The first article, describing the development of the practice was published in the March 2002 edition of *MIDIRS Midwifery Digest*, pages 118–121. Here, Becky discusses the day-to-day reality of practising within this model of midwifery care.

*‘Perhaps the biggest challenge facing midwives today is how to stop the seemingly inexorable march towards an exclusively medical model of childbirth...it seems obvious that if we are to have any impact in promoting normality, we need to look at alternatives...’<sup>1</sup>*

In my previous article<sup>2</sup> I documented the development of the Albany Midwifery Practice, a self-employed, self-managed partnership of seven midwives and a practice manager, working within the National Health Service offering continuity of midwifery care to women in Peckham, South East London. In this article I will explore the feasibility (for midwives) of working in this way, and look at the day-to-day reality of being a true individual caseload midwife. Not long ago in our practice our one thousandth baby came into the world, so with statistics for our first thousand births I will also discuss how this model of midwifery care impacts on outcomes for women and babies.

‘Individual caseload’: this phrase seems to pose a myriad of questions to midwives practising within what has become over the last forty years or so the conventional system of midwifery care. For many midwives who harbour a keen desire to get away from the fragmented hospital-based system that they have trained in and become accustomed to, the idea of practising with their own caseload is very tempting, but there are nagging doubts about whether it is really possible. Midwifery managers, sensing the discontent among midwives and women at the lack of continuity in the service provided, have set up many different models of working for the midwives in their respective trusts. They almost always



Michelle with her 7th baby a VBAC born at home

© Annie Lester 2002

balk, however, at the idea of true individual caseload midwifery. Why is this? And what is it about carrying an individual caseload that seems to frighten so many midwives and, for that matter, their managers?

Let us look at the obvious advantages of individual caseload practice. Carrying your own caseload is the only way to be able to offer true

continuity of carer, and the benefits of this for women, babies and midwives have been clearly shown.<sup>3</sup> Looking after a woman from booking through to discharge from midwifery care at 28 days postnatally brings immense satisfaction. It means practising to your full potential as a midwife, using all the skills learned during training and built upon since. It means getting to know each woman as a person in her own social context, getting to know her partner (if she has one), her other children, her wider family. We book women in their own homes so that we are their guests, and based on this we can begin a process of mutual trust and respect as we embark on this journey together. It is a wonderful feeling, when booking a woman, to be able to promise that you will almost definitely be there when her baby is born, and be looking after them both for the first few weeks afterwards.

So how do we manage this, and what does it mean for us as midwives on a daily basis? Organisationally, since pregnancy and the first four weeks after birth adds up to the best part of a year, we have to plan well ahead. All the midwives in the practice, both full and half caseload, have twelve weeks holiday a year, and the rest of the time we are on call for our women (and only our women). Holidays are therefore arranged well enough in advance



© Jackie Moulla 2002

An Albany antenatal group

for each woman to be allocated to a midwife who will not be on holiday around her expected date of birth, ideally with two weeks leeway on either side of this date. This does often take a fair bit of organising (especially as quite a number of the women in our caseload have no idea at first when their baby might be due), but since the principle of total continuity of carer underpins our model of care we are prepared to commit ourselves to spending time on it.

Once we have booked a woman, in the full expectation that we will then be caring for her throughout, we are on call for her at all times until her baby is approximately four weeks old, except when we are on holiday. This is all discussed with the woman when we first meet her; we explain how the pager system works and, more specifically, how and when to call us. The midwifery notes, which the woman holds, contain clear instructions about using the pager: 'When you call, the operator will ask you who your message is for or what the call sign is. You say....' Because we are on call all the time we work hard to help women to understand what this means, ie we are not 'on duty' in an office at night-time waiting for her to contact us! In fact, we are all (hopefully) asleep in our beds unless we are with a woman in labour, and almost all problems and queries can wait until a civilised hour in the morning. Therefore, after explaining how to call us we state very clearly in the notes: 'After 8 pm and at weekends please only call if it is urgent' and 'Please do not say it is urgent or to call as soon as possible unless you have a real problem and need to speak to your midwife straight away'. Because women get to know us and understand how we work it is very rare for us to be called at night, except by a woman in established labour who needs her midwife to come and visit her.

All this is very important to understand when thinking about working with an individual caseload; in talking to other midwives we have learned that they often equate being on call all the time with being called all the time! In fact we think that the reverse may well be true: we are called less often than midwives working with group or team caseloads, *and then only by women who we know.*

Knowing the women well obviously also affects the way we can respond; for example, if we have seen the woman recently and know that she has a normal-sized, head-down baby either in or just over the pelvis then there is no need at all to see her immediately when she lets us know that her waters have broken and the liquor is clear. It is also worth remembering that with a defined caseload (we look after 36 women a year as a primary midwife and 36 as a second midwife) there are only so many women who can call us at any one time, and only a very small number of those women who could be calling because they are in labour. And we know them all: their social and family circumstances, the story of their pregnancy, their hopes and wishes for their births. Postnatally, we know the story of the birth (because we were there), how the baby fed after birth, how the mother felt both physically and emotionally. Because we are on call all the time, unnecessary postnatal visits can be avoided, as women know that they can call us if and when they need us.

I do not wish to underestimate the reality of 'living with a pager'. We know it is not for everyone, and some midwives who have tried it have found it incompatible with their lifestyle. But for those of us who are working in this way (and some of us have been for many years), the benefits far outweigh the disadvantages. When you have booked a woman and got to know her throughout her pregnancy, you really look forward to her birth and positively want to be there, which of course affects how you feel when she calls you in labour. Not only that, there is also a sense of making a difference for those women whom you are caring for and have got to know. Maybe you can offer her choices that in a different system she would not have been offered; maybe you will have the privilege of watching her make her choices and feel truly empowered by what she has done. Maybe you will then have the totally affirming chance to hear from the woman how that felt for her, which will help you build your future midwifery practice.

On a day-to-day basis, work as an individual caseload midwife is arranged to suit both the midwife and the woman. It is only births (an average of two a week for a full caseload midwife) that cannot for obvious reasons be moved; everything else that we do can be arranged around our own personal lives. We have nine children between us (ranging in age from two to 25) and one more on the way. We all lead busy lives outside midwifery, doing normal social things. We have many other interests, although admittedly midwifery is a passion for us all. In short, we have learned to live with our pagers, because the rewards are great and none of us can imagine working in a different way. For all of us, what makes this way of working possible is the mutual support within the practice: we work together and support each other both clinically and emotionally;

we divert our pagers to each other if we need sleep in the day or if we are going out; we cover for each other for special, unmissable social or family events.

In the early years of the South East London Midwifery Group Practice (now the Albany Midwifery Practice) we developed a philosophy which is the cornerstone of how we work:

- pregnancy and birth are seen as a normal part of a woman's life
- midwifery care is a trusting, mutually respectful partnership between the woman and her carers
- each woman is entitled to get to know the midwives caring for her throughout her pregnancy and childbirth regardless of recognised risk factors, complications or place of birth
- women should be able to give birth to their babies in a safe and satisfying way in the place of their choice
- the midwife 'follows the woman', thereby enabling care either at home or in hospital, appropriate to the woman's needs and choices
- women have the right to be given research based information in order to make informed choices throughout pregnancy and birth and the postnatal period.

In the Albany Midwifery Practice we see ourselves primarily as guardians of normality, during pregnancy, labour and the postnatal period. In this increasingly technological age of inductions, caesareans, and interventions of all kinds we would include in our definition of normality going into labour spontaneously, progressing in labour at the woman's own pace, and a physiological third stage, all of which are currently denied to an increasing number of women. We try to see birth as an 'everyday miracle', which means that, for many women, it can and should take place where they feel most comfortable — at home. We feel very strongly that women in normal labour should not be subjected to the unnecessary, undermining and unhelpful 'procedures' that commonly take place on modern-day labour wards. We encourage women and their partners (or mothers or sisters) to attend our antenatal groups, which are facilitated by a midwife but women-led, and often include visiting parents with their new baby who have returned to the group to proudly tell their birth story. We visit women at home at 36 weeks for a 'birth talk', when we talk with them and their partners and birth-supporters about labour and birth and the many choices available. We use photographs of other women giving birth to facilitate discussion about positions in labour and birth, perineal stretching and physiological third stage. We explain that if a woman is undecided about her place of birth, and even if a hospital birth is definitely planned, we will still visit her at home in labour. If all is going normally she can then make a choice at that stage to stay at home if she wishes. (We all carry a full set of equipment at all times to make this option possible and, in our

experience, women positively like the idea of choosing their place of birth in labour).

### Last year in our practice 43% of the women had their babies at home.

The birth talk is also an opportunity to make our lives easier. We strongly encourage women to draw on support from their partner or other chosen person during pre-labour and the early part of established labour, and we explain very clearly when to call the midwife. We leave a copy of these guidelines on the front of the notes as a reminder in the heat of the moment. Our suggestions are:

Call during the day (9am–8pm) if:

- your waters break and they are clear
- you think you are in labour.

Call anytime, night or day, if:

- your waters break and they are coloured green or brown
- you have any fresh red vaginal bleeding (as much as a period)
- you are having strong painful contractions three minutes apart lasting one minute and you need your midwife to come
- you are worried about anything/you think you need to go to hospital.

We also leave instructions for what to do if labour is fast, and talk it through with women, especially if they have had a previous quick birth.

However, all this preparation is not just about easing the workload for us as caseload midwives. It is primarily about being firmly committed to a philosophy of keeping birth normal. There has been some discussion recently about what could be said to constitute 'normal birth' in Britain at the start of the 21<sup>st</sup> century.<sup>4</sup> In our practice we believe that a woman having a normal birth:

- goes into labour spontaneously at term
- does not have her labour stimulated or augmented
- labours without an epidural
- pushes out her baby without an episiotomy
- delivers her placenta without the use of oxytocics.

According to this definition, 76% of the women who have had a vaginal birth since the practice began have given birth normally. Compared to our local hospital we have achieved a higher spontaneous vaginal birth rate (78%), a lower caesarean section rate (17%), and a lower forceps/ventouse rate (5%). When considering the difference that continuity of carer can make, perhaps some of the most interesting statistics are those for use of analgesia: 72% of the women laboured and gave birth with no analgesia (including 16% who used a pool), 11% used Entonox, 13% had an epidural, and 1% had pethidine.

We are continuing to explore ways of encouraging other midwives (and their managers) to set up midwifery practices carrying individual caseloads. We are thinking of restarting workshops for midwives to be held on a regular basis at Peckham Pulse in South East London. We are always happy to welcome midwives or student midwives to visit us, and to work alongside us if they wish. If you cannot visit us, we can arrange to come and talk to you at your place of work. We would like all midwives to have the opportunity to practise midwifery in a way that gives them the best job satisfaction possible, as well as giving women and their families what we believe to be the best possible care.

You can contact the Albany Midwifery Practice on: 020 7525 4995, e-mail: [albanymidwives@ukonline.co.uk](mailto:albanymidwives@ukonline.co.uk) or write to: Peckham Pulse, 10 Melon Road, Peckham, London SE15 5QN.

### References

1. Frohlich J. From the editor. *MIDIRS Midwifery Digest* 2002;12:7
2. Reed B [Reid B]. The Albany Midwifery Practice. *MIDIRS Midwifery Digest* 2002;12:118-21.
3. Sandall J, Davies J, Warwick C. *Evaluation of the Albany Midwifery Practice: final report March 2001*. London: Florence Nightingale School of Nursing and Midwifery, Kings College London, 2001.
4. Downe S. Defining normal birth. *MIDIRS Midwifery Digest* 2001;11(suppl 2):S31-3.

**Reed B. MIDIRS Midwifery Digest, vol 12, no 2, Jun 2002, pp 261-264.**

*Original article written for MIDIRS by Becky Reed, Albany Midwifery Practice midwife. © MIDIRS 2002.*