AIMS For a better birth...

Facilitators and barriers to the implementation of a physiological approach to care in labour

AIMS Journal, 2023, Vol 35, No 2

Editor's note: In this article, PhD student Florence Darling shares the findings of her study that looks at the facilitators and barriers to the implementation of a physiological approach to care in labour. Florence presented these findings at the international labour and birth research conference in April this year, and is now completing her thesis.

No blades of steel,

No pulls nor tugs,

It comes when the time is right,

I bring it forth from me,

Time, time, endless as it may seem,

Time is all I need.

By Florence Darling

Introduction

The AIMS position paper on a physiology informed maternity servicesstates that a failure to recognise the link between safe care and an understanding of physiology can result in ways of working that routinely disrupt, rather than protect, physiology. Practices may include inappropriate medical tests,

interventions, and treatments with little consideration of the iatrogenic harm,[1] both physical and emotional, that these can cause.

Whilst recognising the importance of providing "timely, safe and effective medical treatment when this is beneficial and wanted", the AIMS statement reflects deepening concerns about the increasingly routine use of clinical interventions in childbirth. Despite evidence of iatrogenic harm to women and babies, an interventionist approach using routine risk surveillance and clinical interventions to actively manage labour is entrenched and difficult to shift (Miller et al., 2016).[2] A physiological approach, recommended to address this problem, is also identified as varied in implementation (McFarlane et al., 2015).[3] In a physiological approach, care practices during labour use expectant management of watchful attendance, responding to the woman's and her baby's needs; informing and using interventions only when there is a clinical indication (De Jonge et al., 2021).[4]

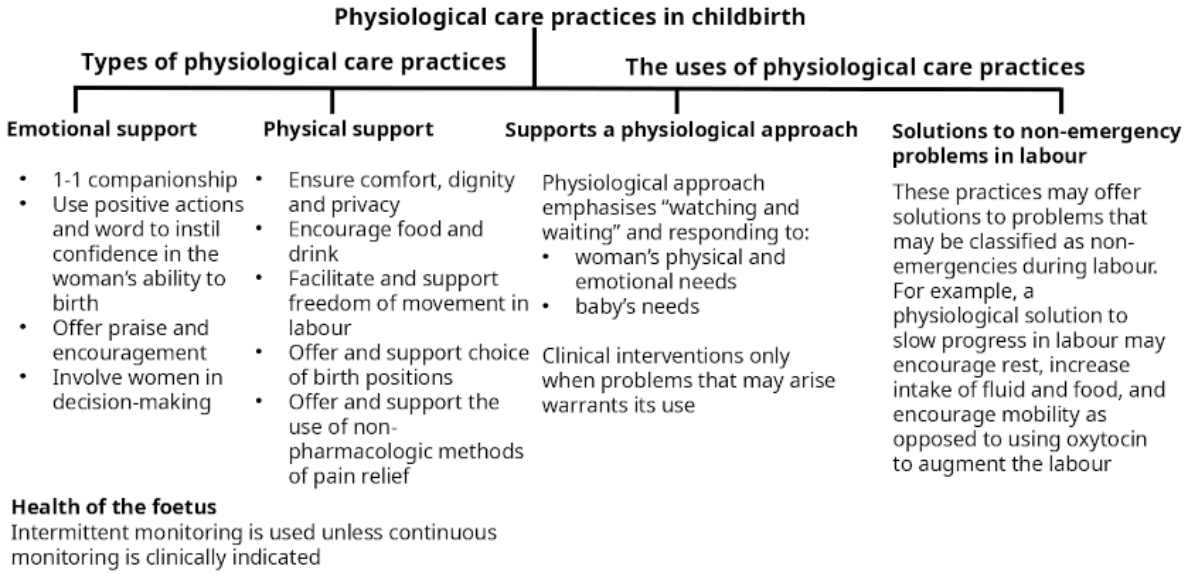
This article describes my PH.D. research that speaks directly to this issue.

The research

The two aims of my research were:

1. To assess midwives' use of and competence in physiological care practices
2. To explore and understand how facilitators and barriers at an organisational leadership, professional group (midwives and obstetricians) and individual (women) level influenced the implementation of a physiological approach.

This research took place in two obstetric units (OUs) at a merged London NHS Trust. The researcher observed twelve labours and undertook familiarisation of guidelines to support decision-making during labour. Interviews included: two consultant midwives and two consultant obstetricians who collaborated to drive implementation of a physiological approach at an organisational level; 16 midwives engaged in implementing physiological care practices; and 12 women and their birth partners about their experience of labour care. Observations also included one mandatory training session for midwives in developing competence in a physiological approach.



Darling, F., McCourt, C and Cartwright M. 2023. Facilitators and barriers to the implementation of a physiological approach (PhD thesis: yet to be published)

This was followed by an analysis of quantitative and qualitative data before integrating and comparing across datasets to generate findings.

Findings

Organisational leadership:

Facilitators

The committed leadership of consultant midwives (CMWs) who collaborated with two consultant obstetricians (COBs) was evident in ongoing work to resource and implement midwife-led models of care, for example: the continuity of carer model; training to develop a skilled autonomous midwifery workforce; and providing opportunities for women to develop personalised care plans. However, their ability to prioritise, resource and upscale this work was described as difficult; and their interactions to implement a physiological approach in practice were met with resistance from midwives and obstetricians.

Barriers

Resourcing decisions that prioritised an obstetric framework of care were described as a barrier.

> "Organisational priorities were orientated towards allocating resources to obstetric specialisms and research aimed at reducing stillbirths, pre-term births, [and] admission to neonatal units. They do not recognise that a social model of midwifery could also achieve

these outcomes" (Consultant Midwife)

In practice, learning in risk management was more widely resourced than learning in a physiological approach. Time allocated by the consultant midwives to provide clinical support in practice to develop competence in a physiological approach was limited by their responsibilities at organisational leadership level.

Consultant obstetricians described engaging in role modelling a physiological approach; and were supportive of implementing continuity of carer models. However, one described midwifery units (MUs) as creating a divide:

> "We need to move away from obstetricians do high risk and the midwives do physiological birth. We do need to get rid of midwifery units and change the way we think about birth – we should be able to have one unit where women can come in without this divide" (Consultant Obstetrician).

Consultants described a preference for collaborative working and caring for all women on the OUs. However, one stated that obstetricians were, "the experts in intrapartum care;" and the other stated that a centralised approach to risk surveillance was necessary to ensure safe care. Their views suggest a supervisory rather than a collaborative model. In contrast, based on their experiences of interactions to implement a physiological approach, the consultant midwives emphasised that midwifery units and care in the community were needed to remove women from the 'obstetric gaze,' with obstetric care accessed only when deviations from the norm occurred.

Both consultant midwives described implementation in the OU as varied:

> "Depending on the leadership in those areas, midwives who want to make change, support different behaviours or practices can either feel empowered or disempowered. The leadership changes on a day to day basis and depending on who your Labour Ward (L/W) coordinator is you either feel empowered or disabled" (Consultant Midwife).

Most labour ward coordinators were observed and described as embedding an interventionist approach:

> "You are newly qualified, and you are asking for advice and even then they do not nurture you to make your own decisions – they make the decisions for you and that is the decision that is made" (Midwife)

> "I wouldn't imagine any of them, if they were looking after a woman, using a birth stool or upright positions. That will help you to imagine how it's hard for us as new midwives to come and say, 'let's do this and this and this'" (Midwife)

Observations showed a lack of implementation and competence in several physiological care practices,

for example, provision of labour support, protecting the labour space from unnecessary intrusion, use of upright positions, optimal cord clamping and facilitating skin to skin, advocating on women's behalf and discussing informed consent for clinical intervention use. Centralised surveillance increased the routine involvement of OU coordinators and obstetricians in the care of all women. What was observed was an approach where midwives routinely escalated the woman's progress in labour, even when there were no concerns, to the team in charge of the OUs, and implemented decisions the team made, rather than working autonomously as lead carers of women.

Professional Groups (Midwives and Obstetricians):

Facilitators

Midwives described opportunities to work in birth settings apart from the OUs as useful in developing their competence. Midwives who chose to work rotationally across all birth settings were observed to use a higher number of physiological care practices and were rated as more competent in using these practices.

Barriers

Despite the facilitating influences of rotational working, the preference amongst most midwives was to practise in one birth setting. The consultant midwives described having "to win hearts and minds" to encourage midwives to adopt different ways of working.

In OUs, midwives described hierarchical decision-making and use of centralised surveillance as institutionalising them in an interventionist approach.

> "You come into work, women are on the bed, on epidurals and doctors give you a plan, rather than you make your own plan. If you spend 99% of your working life here it's extremely easy to become a part of that culture." (Midwife)

> "Practices are deeply ingrained, they are just habitual – you end up doing things – how often do you have women on intermittent auscultation on L/W? – hardly ever, you do it automatically, put them on a CTG." (Midwife)

> "They [L/W coordinator and obstetrician] were watching the CTG outside and wanted to do a ventouse. She was beginning to push well but once they were in the room it was too late. I felt they could have given her more time but once they were in the room, there was little I could do." (Midwife)

The implementation of an interventionist approach was engendered by daily dilemmas of managing large workloads; risk preoccupations; and a lack of skills amongst L/W coordinators to support a physiological approach. However, this norm was also observed and experienced by most midwives as a preference; some described it as a "more efficient" way of working.

Most midwives were observed to acquiesce, citing fear of blame if things went wrong; not wanting to feel isolated and not receiving clinical support; and being respectful of labour ward coordinators. Rationalisation by midwives to manage cognitive dissonance[5] that arose from having to implement an interventionist approach that they disagreed with included, for example, wanting to work in a collegial manner, "we do not wait on the OU, we need to be seen to be progressing labour," and describing practices like lithotomy positions as useful in hastening birth. Time and resourcing for learning activities in classrooms and clinical practice was limited; and group appraisals to reflect on practices were absent.

Women and Partners:

Facilitators

All 12 women described plans to experience a physiological labour and birth. During labour, their actions demonstrated their resolve with the support of their partners to achieve a physiological birth.

For example, in one labour I observed a birth partner negotiating a longer wait when contractions slowed after an epidural insertion, rather than agreeing to immediate intravenous syntocinon. This was despite opposition from the obstetrician.

> Obstetrician: "What are you expecting in 2 hours? Do you want an infection?"
>
> Partner- standing his ground: "I do not think we will lose anything by waiting two hours."
>
> Obstetrician: Bleep sounds - she leaves the room.
>
> Partner (head in his hand): "I am so against interfering in a normal process." He worries about what will happen if nothing happens in 2 hours.

In another example a woman told me that the only thing she did not want was an episiotomy. In my observations, during her labour, the obstetrician stood at the end of the bed, gloved up with a ventouse trolley by his side. The woman was pushing in a recumbent position. The midwife held a pair of scissors, baby's heartbeat was slowing down (baby's head was at the perineum and advancing):

> Midwife: "I am sorry, but I need to do a small cut."
>
> Woman: "No! No! No!" And during her interview recounting the experience she said, "I was like - no way. I will push my baby out."

Women were not observed to present barriers but rather to be facing them at organisational and

professional group levels.

Barriers at organisational and professional group level to women's experiences of care

Women and their partners described not having time to discuss their plans for birth with midwives in antenatal clinics. Antenatal education was described as, "being talked at." Most women developed their plans through conversations with friends, relatives and research on the internet.

The women said they understood why MUs were recommended for their birth, but the main reason given for choosing the OUs was:

> "Lots of the people we know have had complications. It would be better for us to be on the labour ward in case there were problems. The level of care should be the same wherever you go, instead of 'why are you here? You should be going to the birth centre'." (Woman)

Midwives were observed to continue to encourage women in labour and during its progress to move to the MUs. However, those who opted to stay in the OUs were not always supported to use a physiological approach, for example pharmacological pain relief options were routinely offered instead of options like the use of water that was available on the OUs. One woman said:

> "I did not want the epidural, and it seemed I had no choice. I could only use the OU if I used the epidural." (Woman)

Midwives made assumptions that most women who used OUs were open to clinical interventions. Noting that most women will want an epidural at some point during their labour, one midwife said:

> "Quite often, if women do not want an epidural, they will tell you if they want to stand up and be walking around. But I don't think she [woman whose labour was observed] would have done that."

This was also given as a reason for not moving the bed away from the CTG monitor to create space and encourage mobility because women on epidurals will need to be continuously monitored. However, only two out of the 12 women wanted to use an epidural.

Other aspects of care, for example, support in labour, were described as the partner's responsibility and most midwives were mainly observed to engage in technical tasks.

> "They forget how reassuring it can be, especially for someone who is doing it for the first time to have someone there, instead [you have] someone who is focused on admin work, leaving you on your own" (Birth partner)

> "In terms of supporting the woman's needs in labour, this was not there. If I had not

> received support [from my husband] I would have gone for the epidural or something" (Woman)

These women's involvement in decision-making was also observed to be limited by centralised surveillance because discussions about their care frequently took place outside their room next to the white board and centralised CTG monitors:

> "The midwife kept leaving the room to talk to doctors. They had updates happening outside the room. They should come to the room to discuss our care" (Partner)

Women expressed surprise at the involvement of other professionals in their labour and when informed of decisions to intervene.

> "Up until now you have not taken me seriously [referring to the little support she received on coming to the labour ward], and now I have all these wires and bits hanging off me. You have got a ventouse out and you are cutting me [episiotomy]." (Woman)

> "It was OK until the doctors came. Wow! How serious is this? Then more people came, whether they were required or not I do not know but that was the last stage of labour, were they there for support? I don't know." (Partner)

Frequently, women were informed by professionals that, "you need help" or "your baby needs help," as explanations for clinical interventions. Options were not fully explored with women and there was an observed lack of involvement and advocacy from midwives. In only 2 out of 9 labours where decisions to intervene were made, was informed consent obtained.

Conclusions

Despite a committed leadership, the resourcing and scaling up of midwife-led models of care to progress the implementation of a physiological approach is tenuous. Consultant midwives were of the view that resourcing decisions prioritised an obstetric framework of care. This is despite evidence that in midwife-led models of care, clinical interventions are reduced; care is safe and cost-effective; and in continuity of carer models, outcomes also show a reduction in stillbirths and premature births. While practice in midwife-led models of care offered midwives opportunities to develop competence in a physiological approach, in the obstetric units, an interventionist approach was progressed through hierarchical decision-making and centralised surveillance. Most midwives did not regard themselves as autonomous decision-makers and sought permission to implement a physiological approach. They were predominantly observed not to challenge routine clinical intervention use. In the current context of care, MUs and practice in other models of midwife-led care, for example, the continuity of carer models, provide an important opportunity for midwives to be supported to work autonomously, and to develop competence in using physiological care practices.

Women were of the view that they should be supported to experience physiological labour and birth in all birth settings. However, most women and their birth partners were poorly involved in decision-making, and explanations for clinical interventions used were cursory.

Midwives' lack of advocacy of women, and their lack of challenge of routine clinical intervention use, posed significant barriers to women in sustaining a physiological experience through to birth.

Author bio: Florence is a semi-retired midwife and PhD Student. She has a BSc in Midwifery (First), an MSc in Public Health and an MSc in Clinical Research Methods. Her PhD research was supervised by Professor Christine McCourt and Dr. Martin Cartwright and was funded by The Worshipful Company of Saddlers, City University of London.

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1 Iatrogenic harm is harm caused by medical treatment

2 Miller, S., Prof, Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., BIS, Diaz, V., Geller, S., Hanson, C., Langer, A., Manuelli, V., Millar, K., Morhason-Bello, I., Castro, C.P., Pileggi, V.N., Robinson, N., Skaer, M., Souza, J.P., Vogel, J.P and Althabe, F. (2016) 'Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide',*Lancet*, 388 (10056), doi: 10.1016/S0140-6736(16)31472-6.

3 Macfarlane, A.J., Blondel, B., Mohangoo, A.D., Cuttini, M., Nijhuis, J., Novak, Z., Ólafsdóttir, H.S and Zeitlin, J. (2015) 'Wide differences in mode of delivery within Europe: risk-stratified analyses of aggregated routine data from the Euro-Peristat study,'*British Journal of Gynaecology*, 123 (4). doi:10.1111/1471-0528.13284

4 De Jonge, A., Dahlen, H. and Downe, S. (2021). "Watchful attendance" during labour and birth,'*Sexual & Reproductive Healthcare*, 28, p.100617. doi: 10.1016/j.srhc.2021.100617.

5Festinger's (1957) cognitive dissonance theory suggests that we have an inner drive to hold all our attitudes and behaviour in harmony and avoid disharmony (or dissonance). This is known as the principle of cognitive consistency. When there is an inconsistency between attitudes or behaviours (dissonance), something must change to eliminate the dissonance.