AIMS For a better birth...

Montrose Midwifery Unit

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Jo Murphy Lawless visited one of the most woman centred facilities in Scotland

An article that appeared in a recent AIMS Journal about the Montrose midwives impelled me to visit the unit. The article, written by a local birth activist and AIMS member,Avril Nicoll, mentions the concerted local campaign to keep the unit from being closed down beginning in 2001, at a time in Ireland when the maternity units in Monaghan and Dundalk hospitals, two smaller towns near the border with Northern Ireland, were being closed with similar sorts of arguments being used to justify closure: cost, effectiveness and safety of small units compared with larger centralised maternity units.

The Scottish context has been intriguing to me; despite the obvious differences between Scotland and the Republic, with the NHS as a bulwark against the establishment of private obstetric practice that distorts the politics of maternity care here, there are similarities to the Republic. Both countries have two distinct population sets, one dispersed over small to mediumsized towns and rural areas, often with poorer road and transpor t networks; the second in large urban areas such as Glasgow, Edinburgh and Dublin. Both countries face all the continuing problems to protect birth as an event best under taken by women and midwives outwith the problems of medicalising control. They also face the argument that centralised high-tech units are the best answer to limited resources even though distances alone guarantee a considerable disruption to women in labour and to their families.

The hospital in Montrose is smaller than Monaghan General Hospital and an elderly building indeed. However, as you go up the stairs to the maternity unit, you come to a turning in the stairwell and a wee alcove with leaflets and information, made homely and which sets a tone at once with the spectacular photographs of newly born babies. Despite the awkwardness of this aging institutional setting, the homeliness is there in abundance when you walk through the door of the unit. There is a team of 13 midwives, working part-time (9.8 whole-time equivalents).

Everyone is so friendly. As I chatted to Phyllis in her office, the door was open and women were coming in for antenatal appointments. Visitors were also coming in to see the two women who had given birth who were in the postnatal space (a space that looks nothing like a typical hospital ward) and were on their way home that day. You can tell at once that women feel easy about being there and about saying what they need and want to say. As she was leaving, one woman said she would have many more questions to ask as her pregnancy went on. We may know that as pregnant women, but actually articulating those questions in a safe and unhurried space is generally not easy. Here midwives greeted the woman's pronouncement with pleasure and smiles.

Phyllis related something of the recent history of Montrose. The Scottish Acute Services Review had already decided that the unit could stay (backed by a concerted campaign at local level to save the unit) but the midwives had some distance to go to transform their practice. The midwives set about proving they could rebuild normality in birth, starting with simple things like enabling women to move off the bed to give birth.

They were working from a baseline of midwife burnout and in that weariness, unsure that changes could work. In 2002, they had reached a nadir of around 40 births, but within a year they had over 100 women from the Montrose area giving birth there rather than going to consultant units in Ninewells in Dundee or to Aberdeen (both these units have high rates of intervention as well as long journeys from the women's homes).

Moving towards a full midwifery-led unit required energy from everyone and a lot of enthusiastic and committed external support. The MSLC Committee was crucial to them. Most GPs in the Montrose area supported the notion that the midwives should be the accepted first port of call when a woman becomes pregnant. The team was increasingly able to articulate their role as securing normality. They were able to speak of that concept to women making initial inquiries. They learned that the same debate on safety and risk and a consultant not being present needed to be gone over in the early stages of building recognition for the unit's work. They would say to a woman 'What does your mum think? Do invite her in to see us and we can show her around.' They identified partners, mums, dads and grandparents as people to be won over and did press work to help publicise the unit.

They also developed a website in conjunction with the other evolving MLU in Arbroath: www.birthinangus.org.uk/ [website no longer available, please see https://www.facebook.com/birthinangus/]

Above all they transformed their own practices, growing in confidence in how they worked with women and sure that they were using evidence to guide their clinical decision-making.

The unit comprises:

- two administrative offices. One of the midwives, Kate, is a computer whiz and helps keep their technology access up to date.

- an antenatal and assessment room with appropriate monitoring technology.
- a small room with a Resuscitaire. The midwives do regular courses updating their skills in resuscitation as well as a raft of other courses now required in the UK (although Phyllis wryly observed that obstetricians and GPs are not as yet subject to the same command structure on up-skilling and re-training)
- a birthing room with a traditional bed. Some women who are used to giving birth this way still prefer it. The room also has a lovely armchair, a birthing stool and other amenities
- a birthing room with a water birth pool (they fundraised locally to have the structural changes) and also a wonderful wide, very firm low bed with a cut-out section that can allow a woman, her partner and the midwife all to be there in various combinations of physical support, depending on what the woman needs and wishes. It could well support a woman squatting for example.
- a postnatal room with I think three beds and cots beside the beds and lovely rocking and easy chairs
- a dining space just beyond there, where women and midwives can have their meals together.

All is made as home-like as possible, despite the constraints of the old building and is a genuinely successful effort.

Midwives from the unit also do extensive childbirth education classes and work with par tners to insure that they see what role they want to have and feel confident about that role. Phyllis commented that husbands have been especially important in helping women ride through the last minutes of first stage labour, supporting and encouraging women who are without an epidural.

Approximately half the births are now in the birthing pool and the midwives have become very confident and skilled in using the pool.

Other notable aspects were:

- women do not need to book but can come in at any point; even if they have already booked for one of the consultant units as long as they fulfil the criteria they can still come along to Montrose at any point
- any family member can come along with the woman, her partner, mother, sibling, children. Very rarely midwives have had to say 'too many people in the room'; for the most part a rhythm and an understanding by the women of who and what they need establish themselves. Visiting hours are entirely open and that too has worked well
- a visitors' book in the dining space is open for all to sign and comment as they wish. I read some of the comments and they were amazing. Phyllis said that if the midwives have a down day, just reading those pages bucks up their spirits no end.

I watched a friend of one of the two young women in the postnatal room who had come in to see her new baby signing the book while I as there. The visitor was a very young woman,THAT is what changes hearts and minds, seeing what birth can be, having that reinforced with such positive images of a woman and her

baby after a successful birthing.

The episiotomy rate thus far this year is zero and the midwives do not routinely use vaginal examination (VE) during labour.

Theirs has been a cumulative learning process, building the team's work base while dealing with the usual raft of external complexities.

An obstetrician comes from Ninewells once a fortnight to see some women as part of their antenatal care. The current obstetrician is a woman from Northern Ireland. There has been a delicate shift in balance here as she has had to come to trust midwives to under take their role as autonomous practitioners. Much is still being learned as to what constitutes normality and the differing perspectives between midwives and obstetrics.

I thought again how many times over the years I have heard of acquiring skilled midwifery being an 'unlearning' of much previously taught while midwives learn to become more reflexive with women and more autonomous from obstetric thinking. This is an intriguing process (if frustrating, what a waste to have to undergo an 'unlearning' as distinct from a cumulative learning from the outset). I wonder how the few obstetricians who go through such transformative experiences deal with their 'unlearning', how they express that. We hear very little from them at all and it would be important to know something of that, just as we now have research and insight about midwives and women as they come to identify what comprises good midwifery and good birthing.

The one great pity but understandable, given all the time constraints under which the midwives work, is that there was no research done from the outset tracing this evolving project of change. Phyllis says she hopes they can now initiate some research on women's decisionmaking, how they come to choose Montrose.

The awareness and sensitivity of the unit were underscored in the best possible way while I was there. Soon after I had arrived, a tall woman, quite pregnant, came in and stood by Phyllis's door. She said that she was feeling very ner vous and anxious, that she hadn't gone into labour and she really wanted to avoid a scheduled induction in Aberdeen for the following day. She hoped somehow that she would go into labour before the morning. She accompanied one of the midwives down the corridor to the assessment room. Phyllis explained that the woman had been diagnosed with Group B strep and was scheduled to go to Aberdeen for an induction the following day. This suggested intervention does not concur with the current evidence in relation to the woman's profile, Phyllis explained. Phyllis then excused herself and went down the corridor after the woman and soon returned. The woman herself left the unit a short time later.

Just as we were finishing up lunch, the telephone rang and it was this woman to say she was in labour. Phyllis and the other midwife had decided to sweep her cervix, an intervention to be sure, but if it avoided the induction and the accompanying displacement of a woman to Aberdeen, with three children at home, much to be preferred. One of the midwives happily went off to fill the birthing pool and a bit

later, a relieved and happy woman with real energy about her was coming through the door with her husband. They went in to the birth pool room. And a bit later still, all proceeding with perfect calm, we were seated in the little corridor tucked into an alcove about twenty-five feet from the door to the birthing pool, having tea, it being now mid-afternoon.

Occasionally the husband would come out of the room and call to one of the midwives who would go back in with him. Otherwise they were getting on with labour entirely undisturbed. From that entirely undisturbed space, a midwife went in to them one final time and just after four, we heard the cries of a newborn baby and not a murmur of pain from the mother. The midwives cheered and clapped when informed that the baby was a girl and both mother and baby were well.

That atmosphere of calm and tranquillity are vital for good birth and so seldom realised. Working with Nadine Edwards in Edinburgh a day later, I described this event. Nadine said that in her experience, now including many dozens of women, giving birth while she attended as birth companion, the less a woman is disturbed in labour, the better.

Nadine described how in her own daughter's home birth in a birthing pool, her daughter laboured away in that tranquillity, and would reach down to feel the baby's head as she pushed down in the pool. Without a word from her, so quiet was the atmosphere, the baby's head slipped out and when next asked could she feel the baby's head, she said, 'The head is born.' Those first photographs of the baby show an alert and relaxed little fellow safe in his little world.

How many times in ordinary hospital practice are women encouraged to reach down to feel the baby's head, to give them encouragement that their hard pushing work is bearing fruit? How often can they labour in peace and tranquillity? How often does the newly born baby actually experience tranquillity and safety?