AIMS For a better birth...

Alongside midwifery units

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Andrea Nove looks at the evidence supporting out-of-hospital models of care

The Birthplace in England study 1 found that, for healthy women with 'low-risk' pregnancies, midwifery-led units (MLUs) had better outcomes for women and equally good outcomes for babies, at a lower cost than obstetric units (OUs). That study also found that freestanding midwifery units (FMUs) had slightly better outcomes than alongside midwifery units (AMUs). Both AMUs and FMUs provide midwifery-led care for women with 'low-risk' pregnancies as defined in national clinical guidelines,2 but AMUs are located close to (usually within the same building as) OUs whereas FMUs are on a separate site.

Despite the evidence of better outcomes in FMUs than in AMUs, a recent study3 found that both service providers and service users tend to assume that AMUs are safer due to their proximity to emergency care should it be needed. For this reason, and because it is easier and cheaper for the NHS to provide AMUs, the recent increase in the number of MLUs in England4 may not translate to an increase in the number of FMUs.

To help understand why outcomes are poorer in AMUs than in FMUs, this study aimed to explore the organisation, staffing and management of AMUs and to examine the perceptions of AMUs among women and their partners, and among those working in maternity care, and then to make recommendations about how to maximise quality of care within this environment, given financial and organisational constraints. The researchers interviewed 136 women, partners, managers, commissioners and health workers at four NHS AMUs from different parts of the country and different types of location such as city centre and suburban. They also observed key aspects of the service, such as staff handover meetings.

Two of the four AMUs had an 'opt in' system (women had to request to birth in the AMU), and the other two an 'opt out' system (in other words it was assumed that all women with 'low-risk' pregnancies would birth in the AMU unless they requested otherwise). In theory, an 'opt out' system should result in equality of opportunity to experience midwifery-led care. Some of the medical professionals interviewed for this study felt that the AMU philosophy is designed by and for affluent, white women and has less relevance for those from other social and ethnic groups. However, the women in this study were from a wide range of backgrounds, and without exception they appreciated the experience. The only noticeable difference was that women from poorer backgrounds tended to feel more surprised to have access to what they perceived as luxurious surroundings.

Whether the system was 'opt in' or 'opt out', there were occasional problems with the provision of clear,

unbiased information to women when they chose their preferred place of birth. The differences between the options were not always clearly explained, so many women could not be said to have made an informed decision. Some AMUs were working towards integrating the work of AMU midwives and midwives working in the community (for example at GP surgeries) so that all midwives were able to provide accurate information about the options available to women.

The fact that the study focused mainly on women who had opted for AMU care means that it did not provide much information about why women would opt out of AMU care. The study's authors question why such a small propor tion of 'low-risk' women used the AMU ratherthan the OU, and more interviews with women who had chosen an OU birth with a 'low-risk' pregnancy may have helped to understand this. The study did find that lack of space in the AMU may be a factor, yet it did not find any evidence of plans to expand AMU capacity at the study sites, which does not bode well for women, who may be unable to opt for AMU care even if they want it.

Most of the health professionals interviewed felt that strict criteria should be used to determine whether or not a woman should be offered an AMU birth. They felt that any bending of the rules presented risks to both the women and the AMU midwives, and also to future choice for women. For example, if a woman with known risk factors gave birth in an AMU and experienced problems, then not only would the woman and/or baby suffer, but the attending midwives may be subject to an investigation and the whole future of midwife-led care could be jeopardised. On the other hand, some AMU midwives thought that there should be more flexibility, and that the focus should be on strict guidelines for when to transfer to the OU rather than whether or not to admit to the AMU. Interestingly, when OUs were busy, they sometimes asked AMUs to admit women who did not meet the AMU admission criteria. Likewise, sometimes women with 'high-risk' pregnancies asked for an AMU birth because they did not want an OU birth. The study authors recommend careful documentation of birth plans and advice given by health professionals, so that women's decisions can be respected without putting the NHS or health professionals at risk of being sued. These situations raise important questions about how to maximise safety whilst not denying women the option to make their own decisions, and about the extent to which fear of legal action unnecessarily limits the range of options presented to women.

Despite the history of professional tensions between midwives and obstetricians in the UK,[5] the study found that obstetricians were generally supportive of AMUs, because this model means that they can focus on caring for women with complications. There was, however, professional tension between AMU midwives and OU midwives. When women transferred from AMU to OU, sometimes the AMU midwives felt that the OU midwives judged them to have 'failed', and sometimes the labouring women noticed the resultant tension. Perhaps of more concern was that this can lead to AMU midwives being reluctant to recommend transfer to the OU even when this would be the most appropriate option. Similarly, if the OU was busy, there were examples of the OU refusing to accept a transfer from the AMU for nonemergencies, such as a request for an epidural. Such cases were not viewed as priorities, which was distressing for the labouring women and the AMU midwives. Sometimes, if there were staffing shortages in the OU, the AMU midwives would get 'pulled' to work in the OU. This caused tension because fewer

midwives in the AMU could lead to it being closed due to staff shortages, thus limiting women's options.

The issue of women being sent home if they arrive at an OU in early labour, and the distress that this can cause, is well-documented. 6 This study found similar issues at AMUs, which regularly sent women home due partly to a belief that home is the best place when in early labour and partly to lack of space. This policy of not admitting women who wish to be admitted is at odds with the philosophy of woman-centred care that AMUs are designed to promote, and the study authors suggest that the policy should be reviewed at the same time as improving information and support for women to minimise the number who come to hospital in early labour. [Editor's note: AIMS would like to see more midwifery support for women in early labour at home regardless of where they are planning to give birth.]

The development of MLUs presents an important opportunity to provide women with a broader range of birthplace options and a model of care that reduces the number of unnecessary interventions and avoids some of the risks associated with OU birth. To make the most of this opportunity, the health service must show strong leadership, make evidence-based decisions and rise to the management challenges identified by this study. The study noted that the existence of the current set of AMUs was not due to any commitment to this model of care among health service managers; they were simply a pragmatic response to a set of circumstances such as a perceived need to centralise all services on a single site. This suggests that the expansion of access to midwife-led care will require targeted advocacy work with health service management.

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