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PART I

Emotion Work in Maternity Care
1

Relationship and Reciprocity in Caseload Midwifery

Chris McCourt and Trudy Stevens

Introduction

This chapter explores ways in which the organisation of midwifery care may be seen to affect the emotional work that is central to childbirth. It is drawn from a study of caseload practice that was implemented in the UK, following the publication of the Changing Childbirth report (Department of Health 1993), designed to support woman-centred care.

The traditional, Old English, meaning of the word ‘midwife’ is said to be ‘with woman’. Such meaning and values are clearly held by midwives and the importance of being ‘with woman’ is strongly articulated by midwifery students and practitioners as a defining characteristic of midwifery. However, a number of studies have suggested a considerable gap between such core values and those revealed in much of midwifery practice. For example, ethnographic (Kirkham 1989) and observation-based (Methven 1989) studies have indicated that midwives in practice spend relatively little of their time in work that could fairly be described as directly supporting or working with women.

A key focus of our evaluation was whether the new model of care would actually be woman-centred in practice, and whether it was experienced positively by those who were providing care as well as those receiving it. A structured review (Green et al. 1998) concluded that while there was evidence of women’s satisfaction with new models of care, there was little evidence on midwives’ experiences; they questioned whether the importance of continuity of carer to women justified the possible ‘costs’ to midwives. A large-scale analysis of
midwives’ stress and burnout, however, found that high levels of both were associated with team rather than caseload midwifery (Sandall 1997).

In a study of emotional labour, Hunter (2004) found that midwives viewed the basic work of midwifery as a positive form of such labour, but experienced considerable distress through other, less anticipated, forms. These centred on managing institutional and work-related demands, intra- and inter-professional tensions and conflicts, and hierarchical and horizontal forms of oppression (see also Deery 2005). Such studies echoed the themes of a considerable wider literature on the nature of institutional work, on the experiences and behaviour of oppressed groups and on work-related stress and burnout. The study we draw on here offers a different perspective, indicating that midwives carrying personal caseloads experienced considerable job satisfaction and reward (Stevens and McCourt 2001, 2002a, 2002b, 2002c; Stevens 2003).

During our analyses it was noted that conceptual links could be drawn between the two aspects of the evaluation that examined the experiences of women and those of midwives. The first study explored women’s responses to maternity care through a longitudinal survey and interviews; the second was an ethnographic study of the impact of the change on midwives. This chapter sets the analysis of each alongside the other and highlights ways in which each group’s narratives echoed those of the other, particularly in relation to the emotional aspect of preparing for, and caring for, birth.

The key themes

The key themes identified in each analysis were set alongside each other, as shown in Table 1.1. We discuss these in turn, considering both the women’s and the midwives’ perspectives on each.

Knowing and being known

Knowing each other emerged as an important theme in both analyses and clearly held significance for the well-being of mothers and midwives. The women’s accounts indicated that ‘knowing the midwife’ was more complex than simply having met the person more than once; it was about the midwife knowing them. This was not the same as the intimacy of friendship or kinship, since the relationship was circumscribed by the
experience of maternity; midwives were not seen as friends but were often seen as like friends or like kin:

. . . my midwife and myself got on well. She was like my family there. (Caseload care 116)

When compared with conventional care, the difference in relationship was illustrated by the pronouns used by both women and midwives: ‘my’ rather than ‘the’ midwife, and ‘my’ women.

Such terms could signify some kind of professional territorialism or desire for control and, in attempting to be all things to all women in their care, might create a disempowering sense of dependency. However, their use here appeared to signify a sense of obligation and responsibility primarily to the care of the women on their caseload:

Table 1.1 Women’s and midwives’ perspectives

<table>
<thead>
<tr>
<th>Key theme</th>
<th>Women’s perspectives</th>
<th>Midwives’ perspectives</th>
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<tbody>
<tr>
<td>Knowing and being known</td>
<td>Knowing the midwife; ‘my’ midwife; being known by the midwife.</td>
<td>Relationship with the woman; ‘my’ woman; reciprocity.</td>
</tr>
<tr>
<td>Person-centred care</td>
<td>Care focused on me as a person; someone there for you.</td>
<td>Being a person not a role; personal orientation; being there.</td>
</tr>
<tr>
<td>Social support</td>
<td>Social support.</td>
<td>Support from partnerships and groups.</td>
</tr>
<tr>
<td>Reassurance, confidence and development</td>
<td>Reassurance, sense of confidence.</td>
<td>Confidence and development.</td>
</tr>
<tr>
<td>Informed choice, control and autonomy</td>
<td>Informed choice and decision making; sense of control (locus of control).</td>
<td>Autonomy; decision making; control over own work.</td>
</tr>
<tr>
<td>Holistic and flexible care</td>
<td>Flexible care, not a production line; time to listen and give care; place – hospital to community; medical and social care.</td>
<td>Time orientation; flexibility; place – with the woman; using all skills; integrated.</td>
</tr>
</tbody>
</table>
I’m definitely more in tune with the women that I look after and I certainly respect [the] women – because I know them and I’ll do the best to help them make the choices they want – you know, to help them achieve what they’ve said to me that they’re hoping from the birth. (Caseload midwife 6)

The importance of being known was emphasised by some women for its contrast with a fragmented system where you could not be known, where who you were was forgotten, where your history had to be told over and over, where you did not feel listened to, except in a superficial way. One woman, for example, described wanting to tell midwives about the effect of domestic violence. She had hoped that someone would ask her how things were at home:

. . . and I would probably have broke down and let the whole thing out. But they’ve got a hard job to do as well so I must appreciate that, because there are a lot of women having babies. (Conventional care 370)

However, she found that apart from visits to her GP, she saw different people every time, and was made to feel a nuisance if she tried to talk about how she felt. Nevertheless, the depth of relationship that appeared necessary before some mothers disclosed such intimate situations surprised the caseload midwives:

I was really shocked the other day when a woman reached 34/40 pregnant before she was able to tell me that she had been sexually abused. It would never have come out in the conventional service. As it was I could be sensitive to every nuance. (Focus group of caseload midwives)

The emphasis on the relationship was equally important for the midwives, who felt they gained from the relationship with women in their care, rather than just giving. We suggest that this sense of reciprocity offered an important defence mechanism that helped prevent the ‘burnout’ that could be thought to be a danger of working in this way (Stevens 2003).

The midwives felt known – and valued; they talked about ‘actually being a person again, not just a cog in a wheel’, and highlighted the way women related to them as individuals. The implication was that they had not been considered and valued as people when working in the
hospital service, merely pairs of hands to get the work done. They also
considered that they used many of their personal skills in their daily
work that they had not found utilised in the hospital system. No longer
tied by the routines and immediate workload pressures that dominated
hospital practice, caseload midwives reported being creative in their
practice, responding to the needs of their women in a more imaginative
way than they had experienced working in the ‘confines’ of the hospi-
tal. They were able to practise the ‘art’ as well as the ‘science’ of
midwifery in a manner that drew on their individual skills and
strengths, not just their technical abilities. This feature was facilitated
by their sense of ‘ownership’ of their caseload in accepting responsibil-
ity for care provided.

Also, importantly, they felt that knowing the woman meant they
were not constantly starting over, and they could understand more.
Prior knowledge meant some things were easier – such as supporting the
woman in labour:

It’s very easy to look after women in labour when you know them . . .
Because you’ve got to build up this relationship with them, got to
know them [and they’ve] got to like you. You’ve gone through all
that by the time they go into labour. It’s far easier . . . They are far
more relaxed. (Caseload midwife 62)

Other issues could be more difficult, such as establishing limits to the
care they should offer to a ‘needy’ woman. Nevertheless, this problem
was recognised early by the midwives, who then learnt to define their
role clearly in the early stages of the relationship, and to ‘educate’ their
women, as they termed it. They also built up local knowledge and
contacts, so that they could refer and connect women to other sources
of social support. In many cases, the sense of relationship engendered a
sense of mutual trust and obligation that was important to both the
woman and the midwife:

And they really do tell you things. Very deep things. Very personal
things. But it does make it easier to look after them because you can
actually see why they’re behaving that way or going through it.
(Caseload midwife 23)

The midwives also gained a sense of professional and personal satis-
faction from feeling that they had seen a particular relationship
through – the accepted conclusion being the end of postnatal care and
the settling of the woman into new parenthood. Occasionally this proved longer-term as individual relationships were renewed in subsequent pregnancies, something warmly welcomed even when a child-bearing experience had proved difficult. Recounting her experience of caring for a mother after a previous stillbirth, one midwife noted:

She had two others since then and she's as happy as anything – because I went through that traumatic time with her and it helped her to grieve and it helped her to accept the other two pregnancies much more easily. Because I knew [what she had gone through] we could talk about it much more easily. (Caseload midwife 21)

Such relationships may hold psychological benefits for both the woman experiencing such traumas and the midwife supporting her.

**Person-centred care**

For both women and midwives, the organisation of care appeared more person-centred. This was reflected in the orientation of the midwives' work and sense of responsibility, which appeared to shift from accountability to the institution towards accountability to the client and to the profession of midwifery. Autonomy of practice and expectation of continuity gave them space and time to get to know the particular circumstances of each mother; by recognising the individuality of each case the women became special because they were different and they demanded different responses. Emotions were engaged, but were ‘worked through’ by midwife and mother, not denied behind a professional ‘mask’.

Person-centred care was highlighted by the importance attached to the phrases ‘having someone there for me’ and ‘being there’:

. . . knowing that I could like pick the phone up and talk to someone on a one-to-one basis sort of, like really relaxed me and gave me the confidence to carry on. (Caseload care 717)

In practice, knowing that the midwife was ‘there for you’ did not engender greater dependency; the women reported that they rarely called as they had the confidence of knowing they could, if they really needed to.

For the midwives the ‘being there’ was an idea that was closely linked to the expectation of continuity and the autonomy the midwives experienced. Their work with an individual held a greater significance
because they knew they would be following through a case and had the power to influence the situation.

During the booking visit you are investing time for the future. (Caseload midwife 8)

Providing continuity and having responsibility were seen to be categorical in the midwives being able to ‘invest in’ and ‘build on’ care provision for the future event of childbirth and subsequent motherhood. The disappointment they reported if they had not been present at the birth reflected the personal satisfaction this investment could give them. Comments made at such times were particularly illuminating:

You are with them for all that time and then miss out at the end – you’ve missed the bloody party! That’s what I feel. (Caseload midwife 18)

It’s like revising for an examination and then missing the result. You have put all the hard work in . . . and then you don’t know if what you have done has been appropriate. (Caseload midwife 34)

Caseload practice entailed the midwives becoming more deeply involved with their work than conventional midwifery practice permitted. Such form of engagement could go beyond an ‘investment’ of their professional skills to ensure a meaningful outcome. It also encompassed something of their individuality that they gave and something that they received in return. The midwives valued the reciprocal relationships established, experiencing enjoyment in the communication and receiving acknowledgement of their personal interests. They valued occasions when their individuality was considered, for example the coffee specially prepared for their visit, or the chats. And they talked of mothers who delayed phoning them because they were aware of some activity in the midwife’s personal life, or ‘waited’ to go into labour until the midwife returned from a weekend off or from holiday.

On a deeper level, the midwives appeared to gain some sense of approbation of their work and being, of why they were a midwife. In defining it as ‘real midwifery’, they were affirming what they believed midwifery to be, and in being able to practise it in a way that made sense to them, they were able to achieve a sense of self-actualisation (Herzberg et al. 1967; Maslow 1970). No longer acting as the ‘caring
robots’ of conventional service, caseload midwives clearly valued the opportunity to express themselves through their work:

... doing a job that matters. Making a difference by your decisions, not just carrying out care that someone else tells you. (Caseload midwife 20)

You can portray your life and your personality in your work. (Caseload midwife 16)

For them, the organisational features of caseload midwifery facilitated a realisation of themselves in their work, a situation they had not found possible when working in the conventional services.

**Social support**

Their relationship also provided an important practical and emotional aspect of social support for both the women and the midwives, something which conventional midwifery care did not appear to facilitate:

I was just having a horrible time and I just didn’t feel there was anybody there for me to talk to. I literally just didn’t know what was going on and I went to my classes but it’s that emotional side, there was no support at all. I didn’t know what I was doing, I just learnt and I still don’t even believe I am a mum. Do you know what I mean? That care could have made that little bit of difference. (Conventional care 370)

In contrast, the caseload midwives were able to plan their work to provide more social support to those who needed it most:

The midwife came to my home to give me the injection. I was very worried at this time as my husband was [in home country] ... she gave me nice words, reassuring, it was very important, she was friendly and didn’t want to rush you. (Caseload care 48 – refugee separated from husband by visa problems in a ‘high risk’ multiple pregnancy)

Adjusting to a different style of practice, the midwives soon developed boundaries that clarified the limits of the support they should provide. This discouraged the potential to encourage dependency – the
need to be needed – or to encourage women to look to them for all their support, which could also prove unsustainable for the midwife, rather than to facilitate them in finding the other sources of support they needed.

The midwives also developed strong networks of peer support through the partnerships and group practices, something not experienced in conventional practice. Some of the midwives noted how they had developed lasting friendships with their colleagues. However, the satisfaction gained was not confined to working with friends but, more importantly, with like-minded midwives, forming an enduring feature of the caseload model. Although encompassing a wide diversity of personalities and experiences, the midwives shared a similar ethos of practice:

It’s like going to heaven being with midwives that work the same way, who are enthusiastic. I felt this big cloud has lifted! (Caseload midwives’ focus group)

The development of such a degree of support and caring formed an important feature of caseload practice and denies the perception that caseload midwifery encourages an individualistic and isolated approach to work. Such potential may be present but was identified by the midwives as compromising the sustainability and safety of working this way. Elements of their practice that helped to sustain this included working within the group practice for mutual support and back-up but also conducting peer review and discussing their practice during regular meetings and an annual ‘awayday’. Clearly, having ‘volunteered’ to try working with a caseload meant that some element of shared philosophy was present, but the organisation of the practices helped to develop and maintain this, and to prevent individual midwives working in an isolated, unsupported fashion.

**Reassurance, confidence and development**

Comments from both women and caseload midwives suggested that this organisation of care facilitates the development of confidence and growth for both parties. For some women, the midwife support they received helped them to grow in confidence through the pregnancy and birth, which can be a crucial time of change and adjustment (McCourt 2006). This was especially the case for the younger mothers and those from socially disadvantaged groups. One young woman, for example,
had an unplanned pregnancy in her teens, but the midwife helped her to make her own positive choice about it. She felt that she had personally grown through the experience and was now a confident mother, planning further study:

... reassurance and that, 'cos I was still two minded [about the pregnancy]. It was really nice the way she handled the situation. She kept me going and made me finally decide. (Caseload care 411)

Another discussed how knowing that she could call her midwife at any time if worried gave her more confidence and made her feel less anxious. Women’s confidence in the midwife grew through the pregnancy, helping them to prepare for and then cope with the birth:

well I could talk to her about anything and say to her everything, that's how much confidence I had in her. (Caseload care 116)

For the midwives, following through care meant they were able to see the outcomes and assess decisions that were made. Continuity made an important ‘feedback loop’ for learning and evaluation of care provided, which included a significant safety aspect:

It makes you appreciate the value of today's activity on tomorrow's care. You can see the results of what you do today. If you miss something in hospital it is not so important [inferring the expectation that someone else will pick it up]. (Caseload midwives’ focus group)

One midwife described how the ability to follow up and constantly assess the impact of advice given enabled her to change advice to meet individuals’ needs, and that she could learn from this and build confidence in her practice; for example: having observed the subsequent healing of a perineum she had sutured, she noted with confidence, ‘I now know it will not fall apart’.

Although caseload midwives initially encountered some difficulties and even hostility from their colleagues working in other parts of the maternity service, as time passed in many instances this changed and more positive attitudes developed, with the midwives feeling more acknowledged and respected. The recognition they gained from medical colleagues was highly valued and proved another source of professional satisfaction:
Recognition for professionalism – I found I got that in the caseload project but not in the hospital . . . the doctors may say ‘good on you, that was a good decision’. (Caseload midwife 8)

Not only were the midwives gaining confidence with their clinical skills, their interpersonal and inter-professional communication skills were honed in a manner not facilitated by the conventional service, where conflicts tended to be ignored rather than resolved. The midwives developed skills to work through rather than avoid any of the disputes that inevitably arose, and to be assertive rather than either confrontational or ‘avoidant’; this was recognised by senior staff, both medical and managerial, who described them as having ‘matured’ and developed in ways not generally noted in those working within the conventional service.

**Informed choice, control and autonomy**

The women tended to feel more fully informed with ‘their own’ midwife, and in our wider survey, they showed higher expectations of personal control and ability to make decisions about their birth as well as higher satisfaction with the information they were given (Beake et al. 2001). In contrast, women in conventional care, particularly in the hospital setting where care was highly fragmented, often described situations in which lack of information or being given ‘empty’ information failed to provide the reassurance they needed:

I think that mothers have the right to ask questions and get proper answers and the doctors and nurses need to have more patience with the member of the public really. (Conventional care 312 – when asked what could be improved about care)

Instead, they often attempted to gain information indirectly, for example by ‘reading’ professionals’ faces, or reading the monitor.

Being informed and feeling they had some control and say in what happened to them was important to how the women felt about their experience, whether they had a straightforward or complicated pregnancy and birth, and appeared to reduce fears and anxieties, whereas lack of information could compound them. This was recognised by the midwives, who commented on how their prior knowledge and discussions with the woman influenced the way they could support them:
You discuss so much before they actually go into labour that when they’re in labour it makes it far more easy and you can discuss things better, e.g. fetal monitors. It’s all been discussed and then they can see all your reasons why you would do it, why you wouldn’t do it. They just come in and they do so much better. Even when they end up with a Caesarean section or whatever they seem to do better afterwards – seem to recover better and psychologically they’re better. (Caseload midwife 23)

In assuming a sense of responsibility for their women, and with a greater understanding of an individual’s situation, the midwives became more flexible in applying the unit’s guidelines concerning labour. Providing they could justify their care plan to the obstetrician’s satisfaction, if questioned, the midwives’ decisions were usually respected. Where they were not, usually by a less confident registrar who did not know the caseload midwife and imposed intervention routinely, the midwives reported later proactively following up such unsatisfactory management with the delivery unit consultant. In becoming confident to practise and to question medical behaviour in an evidence-based way, the midwives had to be very sure of their own management. This also reflected a growing confidence with their body of midwifery knowledge:

Caseload practice keeps you up there [on top of things], you don’t have time to vegetate. If anything came up that you didn’t understand you immediately looked it up. (Caseload midwife 8)

The caseload midwives saw care provision within the conventional service as being limited, in terms of responsibility and decision making, by the lack of continuity:

In the hospital setting if there is something that you’re not sure about you pass the buck to either the doctor or whoever’s around and often, because you are so busy in the hospital setting, you don’t get the chance to follow through to see the outcome, to have it properly explained to you. You pass the buck. Full stop. You’ve done your responsibility. You’ve handed it over and you get on with something else; whereas with a caseload it doesn’t stop. You have to follow it through. You have to make those decisions and you have to find out for yourself. (Caseload midwife 6)
The midwives did, nonetheless, learn the value of working with others – when it is appropriate to refer or seek advice – but this did not imply a simple handing over of responsibility, so much as a sharing, since they maintained their role and contact, even when complications arose.

The caseload midwives also described ways in which they could exercise choice and the degree to which autonomy made the system of care and the personal flexibility it demanded possible for them. The midwives managed their own caseloads in partnerships within the group practices. They worked out their own arrangements for providing cover to women, without fixed requirements to work in a particular way. They were primarily answerable to their employers via their caseload. Similarly, they were expected to account for what they did rather than for their time or presence, such as by completing timesheets or clocking in for shifts. It was the unpredictability of birth and women’s needs rather than the demands of shifts or rotas that created challenges for them. This was an important feature, since lack of control over their work pattern, such as team midwives being expected to cover for staff shortages on labour wards while maintaining care for a caseload of women, has been highlighted as a major problem in some studies (Green et al. 1998; McCourt et al. 2006).

**Holistic and flexible care**

It was clear that care provision within the caseload model was more individualised for both women and midwives, meeting their emotional needs and expectations in a more holistic and flexible way than experienced within the conventional service. The hospital setting was seen as being impersonal and rushed, ‘like a cattle market’, with long waits for hurried visits that were routinised rather than responsive to the women’s needs. This environment, stressful for midwives too, often had a negative impact on the care they could provide:

> . . . she worried me unintentionally and she was abrupt. She didn’t have any time for me, there was obviously too many people there. (Conventional care 370)

The women described valuing care that paid attention to both their medical and their social or psychological needs. They spoke about being understood, being ‘cared about’ as well as ‘cared for’ and caseload midwives paying attention to their ordinary needs:
. . . you have no fears or anything you can say to them, look there is something bothering me, how small it is. They don’t make you feel as if you are wasting their time. (Caseload care 116)

In the hospital they found it difficult to ask for or obtain such help. Women with medical problems or complications tended to praise the high standard of medical care they had been given but they described the lack of midwifery input and care for their ordinary needs. For example, following a previous stillbirth one woman reported excellent medical care throughout the birth but felt that her emotional needs were entirely forgotten and her difficulties overlooked once this baby had been born alive; another recognised the good medical care received during an emergency Caesarean but felt entirely abandoned in the postnatal ward. In contrast, ‘high risk’ women who had a caseload midwife were not transferred from one form of care to another – their midwife maintained the midwifery role, working with the consultant and other professionals as needed, to ensure all-round care was provided.

The midwives particularly valued being able to combine clinical and psychosocial care and saw this as facilitating appropriate care for individual women across this boundary. They discussed their initial fears and then their growing confidence in what they saw as holistic care and using all the skills of midwifery. This included care for women at all levels or types of risk, both medical and psychosocial care and care for all stages and aspects of pregnancy, childbirth and early parenthood. They described this as an important source of personal and professional satisfaction, and associated it with their own, tacit, concept of ‘real’ midwifery:

You feel you are a midwife – after a while of working this way there will be very little that you don’t know about’. (Caseload midwives’ focus group)

The majority of this care was provided at a time that suited both mother and midwife; practising autonomously meant the caseload midwives were completely flexible, working as and when they found appropriate. Thus they could both ‘make the job work for them’ and work within women’s individual time constraints, arranging their schedules in a manner that suited themselves and their partners. The midwives did not have total control over their time as they had to be available to respond to the needs of their women. Nevertheless, once they had developed their personal time management skills and learnt to
advise women appropriately, they reported that interruptions at night were minimal and usually confined to labour and emergencies:

At night? It’s not very often. I would say on average a month I would get three. You can’t put [a number on it]. Or you may be contacted three times in one night! (Caseload midwife 6)

Such reporting was verified in a study of caseload midwives’ work diaries (McCourt 1998). Knowing the women who contacted them enabled the midwives to respond appropriately, not necessarily having to visit or ask the women to attend hospital but giving advice or making an appointment for the following day. Similarly, the women were reported as not wanting to disturb their midwife unless it was urgent. This symbiotic relationship was seen as an enduring feature of caseload practice, where care and concern was reciprocated and the emotional needs of both women and midwives could be fulfilled.

Conclusions: Should woman-centred care mean midwife unfriendly care?

I felt this went beyond a job. I felt that she enjoyed her job. Some people that do it . . . don’t actually enjoy it, that comes across; but she was so caring. (Caseload care 391 – about ‘her’ midwife)

The above quote captures what some women felt about the care provided by caseload midwives, but it also captures some of the concerns and debates aired among midwives about different models of practice. A major question and concern has been whether ‘caring work’, particularly when offering continuity of carer, is a source of stress and burnout to midwives, making this form of practice ultimately unsustainable for all but an exceptional or dedicated minority. Caring work is clearly demanding, and the woman’s comment is suggestive that dedicated midwives may go ‘beyond’ their job, perhaps beyond what is reasonably demanded of them. However, the picture that emerged from these linked studies gives a very different perspective on the demands and the emotional labour of midwifery work.

Core themes that were identified from the work included aspects of social relationship such as knowing and being known, reciprocity, knowledge and confidence (in self and others). We argue that this model of midwifery care facilitated emotional support for women, and
did so without creating additional emotional labour for midwives. Caseload midwives gained satisfaction and reward from their relationships with women. A high level of autonomy in their practice, and the ability to form supportive relationships with women and with colleagues was important to their ability to cope well with the demands of their role. Nevertheless this could easily and often be undermined by tensions with colleagues working in different models of care and in the interface with the service-providing institution.

It was clear from the women’s narratives that they viewed the care given in the caseload system as more woman-centred (or indeed family-centred). This applied particularly to women who were socially disadvantaged, young or from minority ethnic groups. Was this provided at the expense of woman-centred work for midwives, conforming to a caring ideal that makes unreasonable demands on their time and energy? The evidence we gathered did not support this conclusion. The flexibility required of the midwives to provide continuity of carer was also balanced by the greater control they experienced over their patterns of work, allowing them to gain some flexibility in their lives. A key sustainability issue, alongside that of relationship and reciprocity, was the level of autonomy this organisation of practice facilitated.

The midwives described their own development in terms of confidence and decision making. This included greater confidence in making clinical judgements, greater confidence and assertiveness in referring women when they felt more specialist advice or care was needed, and greater confidence in working outside the hospital. The midwives were required (and learned) to be highly self-managing in terms of time, management of their caseload and workload, defining appropriate boundaries and their place of work but were also able to work effectively with their peers. These changes were underpinned by greater autonomy, decision making and locus of responsibility and control. However, the structural position of midwives had not changed to facilitate this, as reflected in the many tensions the midwives encountered at interfaces between different parts of the service.

Caseload midwives were able to achieve a sense of self-actualisation that they had not found in the conventional service, as exemplified in the movement from ‘role’ of midwife to ‘being’ a midwife; this was an important constituent of the job satisfaction they expressed. It has been suggested that workers not fulfilling such a need could result in a sense of alienation, disconnection and associated loss of meaning about their work (Herzberg et al. 1967). Marxist notions of alienation hold strong resonance with conventional maternity services – involving a separation
of worker from the product of their labour, a fragmentation of the work process so it becomes task orientated and eventually meaningless, and domination by market forces rather than relationships (Martin 1987; Robinson 1990). It might also explain the concern raised by Jean Robinson of AIMS (Association for Improvements in the Maternity Services) (Robinson 2000: 143) who, following receipt of a number of complaints from mothers, questioned: ‘Why are midwives turning nasty?’ The relationship, once the fulcrum of a midwife’s work, now holds minimal significance to midwives working in conventional services.

The findings of our research suggest that caseload midwifery, if it is supported by appropriate structural and organisational changes, can redress this imbalance. This is achieved through the development of a reciprocal relationship that the prolonged contact facilitates. Mothers have the opportunity to address any sense of indebtedness they may feel towards the care provider, the midwife, enhancing their sense of control. Perhaps more significantly, midwives benefit from the reciprocal relationship by its contribution towards high levels of job satisfaction and less stress, thus reducing the potential for ‘burnout’. These midwives gained great satisfaction and a sense of reward from their relationships with the women, something which sustained their practice and may provide a key to its sustainability.

Reflective questions

1 Given the findings of our research detailed in this chapter, how far do you consider it is possible that the ability to offer continuity of carer can benefit midwives even more than women? In what ways may this occur?

2 In providing continuity of care the caseload midwives highlighted how this enabled them to learn from ‘their’ women. How do you learn from the women you care for? How might this be influenced by the organisation of midwifery services in your area and how might it differ from caseload practice?

3 The relationships that caseload midwives were able to form with their women proved important for their own emotional well-being and was central to the sustainability of this model of practice. In your practice what do you find to be most stressful and what factors help to maintain your motivation?
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