

**Core and developing role of the midwife: Literature Review**  
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## **Introduction**

This is the report of a pragmatic and focussed literature review commissioned to inform the Midwifery 2020 work on the core and developing role of the midwife. It is part of the information and evidence base for the Midwifery 2020 programme report.

The review aimed to:

- Take a practical and systematic approach
- Summarise literature, highlighting any similarities and differences between the four countries of the UK
- Identify relevant examples from the international literature.

Appendix 1 outlines the approach taken to source the literature. Findings are summarised in the following sections which cover:

1. definitions of midwifery and the role of the midwife
2. conceptualizations of midwifery-led care and its benefits
3. role expansion and extension
4. emerging evidence base around midwifery support workers
5. issues related to clinical decision-making and leadership
6. similarities with the challenges midwives face internationally
7. gaps in research
8. emerging issues of relevance to midwifery in the UK
9. policy themes for the future.

### **1. Midwifery – defining the profession and role**

The International Confederation of Midwives 2005 definition of a midwife is frequently cited in the UK and international literature:

*“...The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units” (International Confederation of Midwives 2005).*

In the UK Midwifery is regulated by the Nursing and Midwifery Council (NMC). All midwives practising in the UK must be registered with the NMC and the NMC sets the standards for practice, education and statutory supervision of midwives. The Midwives Rules and Standards (Nursing and Midwifery Council 2004) are currently being reviewed to:

*“...make sure these provide the best possible framework of care to safeguard the health and wellbeing of women, their babies and families. ... The revised rules and standards will provide a contemporary framework for practice, and clarify the role of statutory supervision”* (Nursing and Midwifery Council 2010).

Midwives are expected to be: knowledgeable and highly skilled advocates for the women in their care; accountable for the quality of the care they give and the services they manage; able to measure and articulate the quality of their care; and confident at exercising a high degree of influence within organisations and across networks that provide maternity services (Department of Health 2008). On the point of registration midwives are expected to be equipped to take responsibility and accept accountability for their actions (Fraser 2000) as well as to acknowledge the boundaries of their professional competence (Quality Assurance Agency 2004; Department of Health, Social Services and Public Safety 2010a). In addition, along with all the healthcare regulators, the Nursing and Midwifery Council (NMC) is exploring revalidation in response to the government White Paper on regulation, ‘Trust Assurance and Safety: the Regulation of Healthcare Professionals in the 21st Century’ (Nursing and Midwifery Council 2009).

### **The role of the midwife**

In keeping with International Confederation of Midwives 2005 definition above, the role of the midwife in the policy and professional literature in the UK is considered to span preconception to postnatal care. Throughout the four countries of the UK it is expected that all women should have a midwife involved in their care and there are policy commitments that support midwife-led care and are designed to enable women to access midwives directly rather than having to go through their GP. Some commentators suggest that the public image of midwifery is at variance with the reality of the role. For example, midwives have shown concern about their lack of recognition outside the profession and the insufficient public distinction between midwifery and nursing (Pollard, 2003).

### **2. Midwife-led care**

Midwife-led care is a feature of maternity care policy in the UK. For example announcing comprehensive review of maternity services in Northern Ireland, the Health Minister Michael McGimpsey said *“... Crucial to any of our services is the skill and expertise of staff, particularly clinical staff. It is therefore important that the review takes account of a range of workforce issues in addition to a detailed consideration of the role of midwifery led care”* (Department of Health, Social Services and Public Safety 2010a).

Although it is difficult to divide models of maternity care into exclusive categories, in general a midwifery model of care is underpinned by a philosophy of normality and the natural ability of women to experience birth with minimum or without routine intervention. In midwife-led care the midwife is the lead professional in the planning, organisation and delivery of care from initial booking through to the end of the postnatal period. Some antenatal and/or intrapartum and/or postpartum care may be provided in consultation with medical staff as appropriate but, in partnership with the woman, the midwife is the lead professional. Midwife-led models of care aim to provide care in either community or hospital settings, normally to healthy women with uncomplicated or 'low-risk' pregnancies.

Continuity is an important principle. In some models midwives provide continuity of midwifery care to all women from a defined geographical location, acting as lead professional for women whose pregnancy and birth is uncomplicated, and continuing to provide midwifery care to women who experience medical and obstetric complications in partnership with other professionals. Some models of midwife-led care aim to provide continuity of care to a defined group of women through a team of midwives sharing a caseload. This is often called 'team' midwifery. In team midwifery a woman will receive her care from a number of midwives in the team, the size of which can vary. Another common model, often termed 'caseload midwifery', aims to offer greater relationship continuity, by ensuring that childbearing women receive their antenatal, intrapartum and postnatal care from one midwife or her/his practice partner. There is continuing debate about the risks, benefits, and costs of team and caseload models of midwife-led care (Hatem et al. 2008).

Midwives are commonly described as being the experts in normal pregnancy. The systematic review carried out by Caird et al (2010) found no evidence of a difference in midwife-led care for low-risk pregnancies when compared with doctor-led care for a range of infant outcomes including foetal loss and neonatal death. Midwife-led care has been shown to improve a number of maternal outcomes including pregnancy-induced hypertension, spontaneous vaginal birth, breastfeeding initiation, and is associated with fewer procedures during labour (instrumental deliveries, episiotomies, use of analgesia and anaesthesia). It also appears to be more effective for reducing antenatal hospitalisation and fetal monitoring in labour, and for increasing women's satisfaction with their care. Midwife-led care does not however appear to make a difference in relation to caesarean section rates, malpresentation, perineal trauma, mean labour length, manual removal of the placenta, antepartum haemorrhage, postpartum haemorrhage, anaemia, postpartum depression, amniotomy, induction of labour, augmentation of labour, or use of intravenous fluids (Caird et al. 2010).

Continuity of carer in midwifery has been considered as making an important contribution to quality (Curtis, Green, & Renfrew 2008) by supporting the development of meaningful and therapeutic relationships (Sheaff et al. 2009); enabling midwives to act as a 'bridge' across services to integrate care (Thomas & While 2007); and resulting in improved outcomes (Estabrooks et al. 2005; Hodnett, Gates, & Hofmeyr 2007).

However there is debate as to whether the most important factor is continuity of care or carer. The evidence tends to suggest that although women appreciate continuity of carer this can be difficult to achieve in practice.

### **3. Developing/expanding the core role of the midwife**

Role development is a key feature of both government and professional policy literature. The core midwifery role is expanding in response to service need and technological developments. For example, what were once seen as extended role skills e.g. cannulation are now viewed as part of core practice and are included in the pre-registration curriculum in many education institutions. Role development is reported in core areas of midwifery practice such as breastfeeding support, in midwives taking on extra skills and/or running new services such as preconception counselling and screening, amniocentesis, ultrasound scanning, ventouse deliveries, arranging for epidurals, oxytocin administration and the management of hyperemesis (Department of Health, Social Services and Public Safety 2006). Some midwives specialise in particular client groups such as teenage mothers and women with particular needs eg those who substance abuse (Macrory & Boyd 2007) and may be formally recognised as consultant or specialist midwives.

Although the role of the midwife has traditionally been centred on the woman there is an increasing policy and professional interest in the midwifery role in relation to fathers. There is growing research interest in the role of fathers in pregnancy, childbirth and in the postnatal period. For example there are a small number of studies exploring the impact of the attitude of fathers on breast feeding rates (Dyson, McCormick, & Renfrew 2005). Little evidence was found on fathers' expectations regarding midwife led care, normal birth, or midwifery.

Policy commitments and structural changes in the organisation and delivery of health services in general are also having an impact on the shape and location of maternity services and therefore on midwifery roles and practice. Role developments also occur in response to policy which is not specifically intended to be for maternity or midwifery. For example in England the Diabetes National Service Framework (Department of Health 2001) led to specialist midwifery roles being developed in some organisations. Across the UK policy in relation to domestic violence has resulted in an expectation that all midwives should ask women about this issue (Barnett 2005; Salmon et al. 2004) and some organisations have invested in specialist and consultant midwives with particular interest and expertise in this area.

Since the early 1990s there have been policy commitments – both maternity specific and more general – about giving women more choice about where they want to give birth and actively promoting midwife-led care for women (Department of Health 2009a; Department of Health 2007; Department of Health & Department for Education and Skills 2001; Welsh Assembly Government 2005; Scottish Government 2008 a&b; Department of Health, Social Services and Public Safety 2010b).

#### **Developing new midwifery roles**

In response to a range of policy, professional and service drivers new midwifery roles have also been developed and the numbers have been growing rapidly. For example in a survey

conducted by McKenna et al in Northern Ireland the majority of respondents indicated that their roles had been created since 2000 (McKenna et al. 2008).

New midwifery roles (specialist, advanced and consultant) have developed in all four countries of the UK although the approach, type, scale and speed of change does vary between countries. For in 2008 example Scotland had 12 consultant midwives (Scottish Government 2008a) whereas there were no consultant midwives reported to be working in Northern Ireland in 2006 (Department of Health, Social Services and Public Safety 2006).

There is some evidence that consultant midwives have had a positive impact on developing and improving existing midwifery-led services and in particular on increasing midwifery-led low-risk births, decreasing medical interventions and increasing breast-feeding rates (Guest et al. 2004). 'Front line care, the report of the Prime Minister's Commission for the future of nursing and midwifery in England' recommended that regulation of Advanced Midwifery Practice be considered (Prime Minister's Commission 2010).

The career frameworks in all four countries identify a range of levels of practice and emphasize the need to develop new and existing career pathways.

#### **4. Midwifery Support Workers**

Sandall et al (2007) found that there is great potential for support workers to contribute to improving the quality of maternity care and facilitating women's choices. Several studies have explored support workers contribution to post-natal care with contradictory results (Morrell et al. 2000). Furthermore nationally there is a lack of clarity and consistency regarding title, task and training, accountability and governance which leaves women, managers and midwives with uncertainty around the scope of practice and competence (Sandall et al. 2007). The Royal College of Midwives has recently launched learning and development guidance for Midwifery Support Workers (Royal College of Midwives 2010b; Royal College of Midwives 2010a).

#### **5. Decision-making**

All levels of midwifery practice require high quality clinical decision-making. However decision-making in midwifery is under-researched. Areas which have been identified as requiring particular focus include: the complexity of decision-making during intrapartum care; the clinical reasoning skills of midwives; midwives' relationship with women; the impact of the organisational context and the employment status of the midwife; and the role of the woman as decision-maker in her own care during birth (Jefford, Fahy, & Sundin 2010). Although there is limited research into the development and impact of clinical protocols in midwifery, it appears that they may be useful in supporting midwife-led care (Bick, Rycroft-Malone, & Fontenla 2009; Rycroft Malone et al. 2007).

## **Leadership**

Leadership is a major theme in the policy and professional literature (Department of Health 2009b; Department of Health 2009c; Department of Health, Social Services and Public Safety 2010a; Scottish Executive 2006; Scottish Government 2008a; Scottish Government 2009). Government commitments include improving the overall quality of leadership in general, developing strong clinical leadership in particular (Department of Health 2009b) and building leadership capacity in the service as a whole (Welsh Assembly Government 2006; Welsh Assembly Government 2005). Clinical leadership is considered to be important in promoting woman centred services with midwives providing the first point of access and acting as the co-ordinators of care.

Heads of Midwifery (HoMs) are recognised as providing key strategic and organisational leadership and investment in HoMs, and their ongoing development, is advocated as a means of contributing to improved services and staff development (Department of Health 2007; Department of Health 2008c; Prime Minister's Commission 2010). The HoM role has the potential to increase midwives' influence on boards and in the commissioning process (Department of Health 2009a). Consultant midwives are also promoted as having an important clinical leadership role (Department of Health 2007).

The types of leadership likely to be required are articulated in some of the policy documents. For example the Scottish Government highlights the importance of leaders being able to lead across partnerships and networks (Scottish Government 2009).

## **6. International perspectives**

Literature from the UK, Europe (publications in English language journals), New Zealand, Australia, Canada and the USA was identified. Many common concerns emerged such as encroachment of the midwifery role and increasingly medicalised maternity services.

In spite of the differences in provision of midwifery and models of care in the countries reviewed there are some common issues internationally . These include concerns about an increasingly diminished role for midwives in the face of increased obstetrician involvement and approaches to childbirth.

Issues with particular resonance for midwives and midwifery in the UK are summarised in the table below.

**Table 1: Issues from international literature**

Country	Issues	Sources
<u>Australia</u>	<ul style="list-style-type: none"> <li>• Lack of opportunity to practice across the full spectrum of midwifery care</li> <li>• Invisibility of midwifery in regulation and practice</li> <li>• Medical dominance</li> <li>• Workforce shortages</li> <li>• Impact of institutional system of maternity care</li> <li>• Lack of a clear image of what midwifery is within the wider community</li> </ul>	(Homer et al, 2009)
<u>Canada</u>	<ul style="list-style-type: none"> <li>• Midwifery has only relatively recently become regulated and emerged as a profession distinct from nursing</li> <li>• Legislative changes to mainstream health system funding have increased access to midwifery for more women</li> </ul>	(Chalmers, Dzakpasu, & Heaman 2008)
<u>New Zealand</u>	<ul style="list-style-type: none"> <li>• Variety of different service models – midwife-led, medical-led and shared care models</li> <li>• A gap in the respective roles of midwives and obstetricians in the care of the critically ill obstetric patient has been identified</li> <li>• Developing roles for midwives in neonatal care</li> </ul>	(Hatem, Sandall, Devane, Soltani, & Gates 2008) (Simpson & Barker 2010)
<u>Sweden</u>	<ul style="list-style-type: none"> <li>• Strong professional identity yet midwives’ professional role in childbirth has decreased in favour of other professionals</li> <li>• Midwives’ particular skills and clinical experience have become less valued due to increased medical technology</li> <li>• Lack of trust in the normal birth process among women has affected midwifery</li> <li>• Risk of litigation influences practice.</li> </ul>	(Larsson & Aldegarmann 2009)

Country	Issues	Sources
<u>Holland</u>	<ul style="list-style-type: none"> <li>• Role division between midwives and obstetricians has been formalised in the "List of Obstetric Indications"(LOI).</li> <li>• LOI designates the most appropriate care provider for women with defined medical or obstetric conditions.</li> <li>• Nature and the content of many indications have changed, as has the assignment to the most appropriate care provider.</li> <li>• For women considered to be at low risk of complications, midwifery care and home birth are clear options although the chances of obstetric involvement in birth has increased from 24.7% in 1964 to 59.4% in 2002</li> </ul>	(Amelink-Verburg & Buitendijk 2010)

## **7. Gaps in the research**

Policy and practice are where innovation occurs. To continue to support and inform such innovation there is a need for more research on:

- key concepts such as: accountability, and autonomy
- different service models
- areas of practice such as clinical decision-making; and
- outcome measures that all stakeholders and particularly new mothers and midwives can identify with and value.

Multidisciplinary research is also needed to more effectively determine a woman's risk status and optimal type of care and care provider, taking into account the risk of both under- and over-intervention (National Collaborating Centre for Women's and Children's Health 2007; Amelink-Verburg & Buitendijk 2010).

Key questions include:

- What are the outcomes of different models of midwifery on women, babies and healthcare professionals?
- What are the outcomes that parents and professionals think should be measured to take account of physical, emotional and psychological well-being, cost-effectiveness and short and longer term perspectives?

## **8. Emerging issues**

Considering the literature reviewed in relation to the current socio-political context the following issues seem likely to have an impact on the core and developing role of the midwife:

- increased emphasis on health promotion and public health
- data collection to inform evidence based practice and metrics.
- the use of technology
- concerns about productivity.
- skill shifting and workforce re-design
- the need to view the midwifery role in the context of the clinical maternity team
- increasing diversity of service providers and employers
- developing clinical leadership capacity
- changing organisational structures
- engaging the public in discussions about midwifery

## **9. Policy themes for future**

Choice is likely to remain a major focus in health policy. The four UK governments have made commitments to choice in: how to access maternity care; type of antenatal care; place of birth; and place of postnatal care.

There is also likely to be a continuing interest from policy makers in the core and developing role of the midwife.

It is intended that midwives should increasingly be the first point of contact and the lead professional and co-ordinator of care. Enabling midwifery to maximise its potential will involve the profession, the public and policy makers seeing and seizing the possibilities.

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## Appendix 1: Search strategy

Bibliographic databases (Athens), catalogues of the RCN and King's Fund libraries were searched. This was supplemented by searches of 'specialist websites' including:

- Midwifery 2020 <http://www.midwifery2020.org/>;
- Cochrane database of systematic reviews  
<http://www.thecochranelibrary.com/view/0/index.html>;
- Prime Minister's Commission on the Future of Nursing and Midwifery  
<http://webarchive.nationalarchives.gov.uk/20100331110400/http://cnm.independent.gov.uk/>;
- OECD library  
<http://oberon.sourceoecd.org/vl=15414789/cl=16/nw=1/rpsv/home.htm>;
- Scottish Maternity <http://www.scottishmaternity.org/>

Online searches were carried out using the key terms presented in table 1 below. Finally each publication's own reference list was searched. This produced 497 sources for in-depth consideration. Although not a systematic review the evidence presented has been systematically sourced and compiled.

Table 1 Search terms used

Term	Notes
Midwife	Also picks up midwifery
Role	Singly and in combination with student, new, specialist, advanced and consultant
Decision-making	In combination with Midwife/Midwives
Critical-thinking	In combination with Midwife/Midwives
Autonomy/autonomous	In combination with Midwife/Midwives
Lead	Singly and in combination with professional
Accountable/accountability	In combination with Midwife/Midwives
Level	Of practice
Image	In combination with Midwife/Midwives/Midwifery