ARTICLE

CONTINUITY OF CARER: WHAT DOES IT MEAN AND DOES IT MATTER TO MIDWIVES AND BIRTHING WOMEN?

LA CONTINUITÉ AVEC LES FOURNISSEURS DE SOINS QU'EST-CE QUE CELA SIGNIFIE ET EST-CE IMPORTANT POUR LES SAGES-FEMMES ET LES FEMMES QUI ACCOUCHENT?

Christine McCourt, PhD
Trudy Stevens, PhD

ABSTRACT
This paper discusses key themes from a large-scale, long-term multi-perspective evaluation of caseload midwifery practice in the United Kingdom (UK). Caseload practice was introduced in several UK settings, on a pilot scale, following the publication of *Changing Childbirth* intended to put into practice its core principles of continuity, choice and control for women.[1] A range of new midwifery practices were piloted and evaluated across the UK. Relatively little attention was given to defining and exploring the nature and meanings of the new models of practice, or to midwives in this new practice context. This has led to difficulty in comparing the impact of different models of practice.

We draw on two aspects of our work – an ethnographic study of the experiences of midwives (with and without caseloads) and a study of the women's experiences and responses to care – to explore in greater depth the concepts involved in the caseload model and their meaning for women and for midwives in practice. Interviews were conducted with 40 women and 36 caseload midwives. Other forms of data collection, including questionnaires and observation were used and were analysed thematically using grounded theory principles. Themes emerging included autonomy, confidence, reciprocity and relationship: the idea of knowing and being known. On this basis we have argued that continuity is not an end in itself but an important means towards the end of women-centred care and should be considered in relation to other key themes such as autonomy and environment.[2]

KEY WORDS
midwifery, continuity, maternity care, models of care, pregnancy, childbirth

THIS ARTICLE HAS BEEN PEER-REVIEWED

RÉSUMÉ
Ce travail examine les éléments clés d'une évaluation d'envergure, à long terme et à perspectives multiples de la pratique sage-femme avec charge professionnelle au Royaume-Uni. La pratique avec charge professionnelle fut introduite dans plusieurs milieux au Royaume-Uni, et ce, à l'échelle de projet-pilote suite à la publication de *Changing Childbirth* qui voulait mettre en pratique les principes de bases de continuité, de choix et de contrôle pour la femme.[1] À travers le Royaume-Uni une variété de nouvelles pratiques sages-femmes furent mises sur pieds et évaluées. Il y a

eu relativement peu d'effort fait pour définir et explorer la nature et les significations de ces nouveaux modèles de pratique et peu d'attention fut portée aux sages-femmes dans ce nouveau contexte de pratique. Ceci fait en sorte qu'il est difficile de comparer l'impact de différents modèles de pratique.

Pour explorer en plus grand détail les concepts liés au modèle de charge professionnelle et leur signification pour les femmes et les sages-femmes en pratique, nous faisons appel à deux aspects de notre travail: une étude ethnographique des expériences des sages-femmes (avec et sans charge professionnelle) ainsi qu'une étude portant sur les expériences des femmes et leurs réactions aux soins. Des entrevues ont été menées avec 40 femmes et 36 sages-femmes avec charge professionnelle. D'autres formes de collectes de données, y compris des questionnaires et des observations, furent utilisées et furent analysées par thèmes en se servant de principes théoriques à base empirique. Les thèmes qui sont ressortis comprenaient l'autonomie, la confiance, la réciprocité et la relation: l'idée de connaître et d'être connue. Sur cette base, nous avons fait valoir que la continuité n'est pas une fin en soi, mais plutôt un moyen important qui favorise les soins centrés sur la femme et doit être examinée en relation avec d'autres thèmes clés tels que l'autonomie et l'environnement.[2]

MOTS CLÉS
pratique sage-femme, continuité, soins de maternité, modèles de soins, grossesse, accouchement

INTRODUCTION

This paper discusses key themes from a large-scale, long-term multi-perspective evaluation of caseload midwifery practice in the United Kingdom (UK). Caseload midwifery drew on the model of independent midwifery practice and bears strong relationships to the model advocated by the Canadian Association of Midwives (CAM Vision Statement October 2002).[3] Although midwifery in Canada is organized and regulated on a provincial basis, the principles advocated by each provincial association, of continuity of carer, informed choice for women and respect for their rights and dignity, were echoed in the aims of the caseload scheme.

We use qualitative data drawn from two aspects of our work – an ethnographic study of the experiences of midwives and a study of the women's experiences and responses to care – to explore in greater depth the concepts involved in the caseload model and their meaning for women and for midwives in practice.[4-10] We feel this work has particular relevance for Canadian midwifery at a time of debate about the model of care and the need to broaden access to midwifery as a profession and as a maternity service. In particular, we draw on our analysis to help address the question of whether continuity of carer needs to be seen as an essential part of the Canadian model, or, if not essential, does it have value and relevance for Canadian midwifery? We also aim to illuminate the important features of midwifery perceived as positive by women and the aspects of the model that support these.

BACKGROUND

The history of midwifery and childbirth in Britain in the 20th Century was one of steadily developing regulation and formalization of midwifery and medicalization of care. The place of birth moved from the domestic arena to the public or institutional spaces of hospitals. Throughout this process, care for mothers became increasingly fragmented. Although midwifery was not replaced, as in Canada, its role was diminished and constrained. With the advent of the National Health Service (NHS) in Britain and then a policy of hospital beds for all, strongly influenced by modernist theories of health, the domiciliary midwifery system declined and most midwives became employees of large institutions.[11] The domiciliary midwifery system had provided free, midwife-managed home-based care since the 1930s. Within the new, hospital-based system of maternity care, midwives found their work (like all hospital work) modeled on the factory production line, essentially industrial-type workers, overseen by a small number of managers. The nature of production – and reproduction – had changed.[12]

Women's groups criticized care over a long period but before the advent of free maternity care and maternity rights, their criticism focused on rights to receive care

and addressing inequality.[13] From the 1950s, women began to protest about the medicalization of care, lack of personal care or regard for their wishes and needs.[14]

By the early 1990s, a parliamentary health select committee heard evidence from a range of groups, including midwives and consumers, and reported that birth needed to change.[15] An Expert Maternity Group was convened, which recommended more women-centred care. Three core principles – choice, continuity and control for women – were proposed as crucial to support this.[1] Midwifery was retained in Britain. However, the struggle to regain the more woman-centred values of traditional midwifery paralleled that of Canadian struggles for recognition and restoration of midwifery in many ways.[16]

Our study evaluated a caseload midwifery scheme, which aimed to implement *Changing Childbirth* principles.[2,17] The midwives carried a personal caseload of 40 women giving birth per year, working with a partner and within a group practice of six midwives. They mainly saw women on their own caseload; however, they also got to know their partner's caseload. They shared arrangements for availability for births or emergencies.

The details of practice varied among midwives, since each partnership or group was able to organize practice in the ways that suited them best. All shared basic principles of working around the needs and wishes of the women on their caseloads. The groups managed their own bookings, aiming to ensure that each had a balanced caseload. They avoided births due around the time of their planned holidays or study leave. They offered midwife-led care to 'low risk' women, and midwifery care to 'high risk' women in consultation with obstetricians and other professionals.

Conventional care in the UK for low risk women normally means 'shared care' between the general practitioner (family physician) and the hospital, by obstetric consultant. In practice much, if not most care, is actually given by midwives. The role of midwives differs greatly from that in Canada, since all women will routinely expect to receive most of their care from a midwife. Midwives do not, on the whole, practice autonomously.

A number of schemes for different models of practice were piloted in the UK during the 1990s and some were evaluated formally. However, few studies analysed the nature of the practice, or the underlying concepts and their meaning for women and midwives. Many were simply dubbed 'continuity of care' schemes, to meet the *Changing Childbirth* targets for women having a 'named midwife' and for 'knowing the midwife' present at birth. Studies attempted to measure targets and outcomes, often without looking carefully at the nature of the practice producing those outcomes. Some compared different models of practice as though they were the same. They tended to overlook important issues of context and environment.[18] This was reflected in a structured review of studies, which highlighted the lack of detailed description and analysis of features of the different models they were attempting to compare.[19] Nonetheless, the authors compared a number of models as though their characteristics were essentially similar, with little reference to the context of each.

Our study included quantitative and qualitative research and looked at processes as well as outcomes to try to understand the nature of the practice, and what might (or might not) be important about it.

More in-depth work on the nature of midwife-woman relationships has been conducted in Canada and in New Zealand, where the models of midwifery share key principles with those of caseload midwifery. Pairman and Guilliland set out the New Zealand model of midwifery as essentially one of partnership.[20] Pairman's in-depth study of this relationship identified that both the midwife and the woman contribute equally to the relationship and value what each brings to it. Being available and getting to know women over time allowed the relationship to develop and seemed to be of mutual benefit to both women and midwives.[21] Such findings were echoed in the theme of reciprocity, highlighted in Fleming's study of New Zealand and Scottish midwives. This theme emerged as central to Stevens' ethnographic study, on which we draw here.[8,22]

In a phenomenological study of midwife-woman

relationships in Canada, James focused on the lived experience of 'being with woman as midwife' and giving 'attention to this woman in all her relations'.[23] Similarly, Sharpe argues that such relationships nurture the midwife as well as the woman.[24] She notes that the primary care base of midwifery in Canada, rooted in its history of lay midwifery before regulation, has facilitated midwives keeping their primary focus on the woman. Similar themes were raised in Brodie's study of an innovative model of team midwifery in Australia, which seemed to shift midwives' primary orientation and relationship from the institution to the woman.[25]

In the late 1990s, with only limited progress in England in relation to *Changing Childbirth,* a number of writers began to question the value or feasibility of developing models of care that incorporated continuity of carer. They advocated instead continuity of care, as in team-based models with a shared philosophy or approach to care.[26]

Few studies looked in-depth at the experiences of midwives themselves, or at what women valued and their experiences of maternity. Similarly, few looked at structural, organizational or socio-cultural aspects of care. Notable exceptions were the work of Sandall who, in a study of midwives' 'burnout' found higher stress levels in team midwives than in those carrying a personal caseload.[27] Kirkham and colleagues looked at the culture of midwifery care, offering critical insight into the continuing power of institutional organization and practices, hierarchy and oppression.[28,29]

METHODS

Midwives' study

An ethnographic study of the midwives' and other professionals' experiences was conducted over a four-year period from the initial implementation of the caseload midwifery scheme. Data collection methods included unstructured and semi-structured interviews, participant observation of a number of areas of practice, review of documents and summary questionnaires. This analysis draws, particularly, on the interviews with caseload midwives. These included in-depth unstructured interviews (in some cases several) with all the midwives who joined the caseload pilot scheme during the study period (n=36 midwives).

Focus group discussions were also held with caseload midwives in two groups: those originally appointed at the outset of the scheme, and those who joined subsequently.

The 20 midwives initially appointed to the scheme had applied for caseload practice from within the existing maternity service. Of these, three had been working as 'community' midwives and the others were hospital-based. The 16 who subsequently joined were recruited mainly from within the existing service. Some tried caseload practice initially by providing maternity leave cover for caseload midwives.

Women's study

Following a large-scale longitudinal survey of experiences of all women receiving caseload or conventional care in our wider study, in-depth qualitative interviews were conducted with two samples of women (total n= 40).

The first sample was drawn from women who returned survey questionnaires, with the aim of providing more in-depth insight into the women's views, structured by the women's concerns rather than by those of researchers. All women who returned their final postnatal questionnaire in a particular month were contacted consecutively to seek their permission to be interviewed. The month was chosen for convenience and to allow time for the new service being evaluated to 'settle in'. This process continued until interviews had been conducted with 10 women who received caseload midwifery care and 10 who received conventional maternity care.

The second sample was drawn from women who did not return any questionnaires, but who had not refused consent to participate. The aim was the inclusion of the voices of women who are less likely to respond to written postal questionnaires. Since survey responses tend to be more skewed to ethnic majority, middle class women, this sample was targeted to ethnic minority women. All women in our survey database classified in hospital records as of minority ethnic origin were selected and were contacted consecutively, until interviews had been

conducted with 10 women who received caseload midwifery care and 10 who received conventional maternity care.

Interviews were conducted using a narrative approach. This provided more in-depth responses, in the women's own words and led by their own interests. Women were asked to 'tell the story' of their pregnancy, birth and postnatal experience. They were then asked to try to sum up, for each stage, what they found helpful about maternity care and what they would like to see changed. Prompts were used if needed. They were conducted in a place chosen by the woman, usually her own home, and were audio-taped.

DATA ANALYSIS

The data were transcribed fully and were analysed using grounded theory techniques to identify themes.[30] The CAQDAS software Textbase Alpha was used to organize each of the women's interviews into broad narrative stages, and files of text produced for each. Two researchers coded each file independently. The initial codes were then discussed by the team, and grouped into key themes. The midwives' interviews were analysed by the researcher (TS) using open codes, and progressive focusing was used, so that later interview transcripts were read and re-read, and scrutinized by the researcher to check for agreement, or discordance, with the themes identified from earlier interviews. The themes were validated with the second researcher (CM) who read a sample of transcripts and discussed them in detail. In both cases, constant comparison was employed, moving between codes, themes and the original transcripts. This gave them context and retained the narrative integrity of each story.

FINDINGS AND DISCUSSION

During the analysis process we were struck by the ways in which the women's and the midwives' accounts echoed each other. The theme of the midwife-mother relationship was highlighted. Autonomy and related themes of confidence and personal development also emerged very strongly. Continuity was also a major 'linking' theme, since it connected all the other important themes. It appears as an important underpinning or facilitative feature of caseload midwifery and woman-centred care. The main themes are discussed below.

Autonomy

A major component of the theme of autonomy was the sense of control for the woman and midwife. Women described feeling a greater personal sense of control. They felt more able to make choices during their maternity experience. This was partly accounted for by enhanced information sharing:

"if there was any small problem bothering you, you go to the hospital or the GP, you think oh, should I tell her? This is what was bothering me, whereas a midwife comes to you, you are friendly and you talk to them, you have no fears or anything you can say to them, 'look there is something bothering me', how small it is." (caseload 116)

In our wider survey, women receiving caseload care showed higher expectations of personal control and ability to make decisions about their birth and higher satisfaction with the information they were given.[9] In contrast, women in conventional care, particularly in the hospital setting, felt that information was often inadequate, and found it difficult to ask questions:

"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 312)

They also described situations in which 'empty' information failed to provide the reassurance or sense of control they needed.

Midwives described feeling more control over how they work. They reported more opportunities to make decisions and to work with other professionals as a team, rather than deferring to them. This supported a strong sense of professional and personal identity in which they became…

"…a person again, not just a cog in a wheel...you come out of a role

"You can portray your life and your personality in your work" (clm16.2)

Choices and self-management were crucial to the caseload model and the ability to do the work in practice. This was an important point, since a number of evaluations of team or group practice schemes in

the UK have shown that if midwives lack autonomy, they are likely to become stressed and find the demands of the job too great. Since flexibility was required of the midwives to manage their caseload around the needs of the women, and to be available for births, it was essential that they were given flexibility to enable them to make the job work for them.[31]

In the Hart et al study, in contrast, the midwives were not able to manage their own caseloads and booking system. They were expected to run regular GP clinics and were at times called in to cover staff shortages in hospital. This scheme was not found to bring significant benefit to women or midwives.[32] Similar issues were raised in the Allen et al study of midwifery teams and group practices.[18]

The level of autonomy the midwives experienced suggests a degree of professionalism that is not present in conventional midwifery care in the UK.[33] Although midwives are educated and regulated for this, throughout the 20th Century midwives' roles have became increasingly like those of nurses. The sense of autonomy and professional identity engendered in caseload practice was an important source of satisfaction. The midwives talked about feeling like "a real midwife" and being able to practice *"real midwifery"*. In practice, their autonomy was limited by structural factors including the medical and hierarchical ethos of the unit that employed them.

"Working this way is very, very rewarding. This is midwifery." (exit interview)

Confidence

Caseload practice both encouraged and supported midwives' ability to make decisions. This included greater confidence in making clinical judgements, in consulting with or referring to other professionals and in working outside the hospital. Women described a calm, confident, encouraging approach to birth and parenting from their midwives. This influenced their own feelings, offering greater reassurance and confidence. For example:

"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 717)

This also increased the women's confidence in midwives, in such a way that the growing confidence of women and midwives seemed to work iteratively each supporting the other. For example:

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

Women described parallel growth in confidence that sometimes extended to general self-image. For example, a teenage mother who had been unsure about whether to continue her pregnancy found the relationship with her midwife valuable for being able to make up her mind positively and, looking back, felt she had grown through the whole experience.

"reassurement and that, cause I was still two minded. It was really nice the way she handled the situation. She kept me going and made me finally decide" (caseload 411)

This is particularly important in the contemporary Western setting where there is evidence of increasing levels of worry about birth.[34-36]

Development

The midwives described how continuity throughout care facilitated their learning from experience. They were required to be highly self-managing in terms of time, management of their caseload and workload, defining boundaries and place of work. They recounted a period of rapid professional and personal development, which had not been experienced while working in hospital or in traditional community midwifery.

"it was when I learnt to be a midwife. In the hospital I didn't know how, it was only when I went into the homes." (focus group)

"This way of working teaches you what you know and what you don't know very quickly. It gives you the ability to consolidate your practice. You feel you are a midwife." (focus group)

As described above, some women also talked of personal development through pregnancy and birth supported by their midwife.

Relationship and reciprocity

This theme captures an aspect of the midwife-woman relationship, which emerged as a central characteristic of caseload practice. The relationship was valued highly by the women and the midwives. It was more reciprocal than generally found in traditional professional/client relations.

Communication between the woman and midwife was characterised more by dialogue than one-way information. With continuity of carer, the midwives could build a picture of the woman, her background, her knowledge, her needs and wishes. This could extend over a long period, as subsequent children are born and the relationship becomes very much one with the family. They could learn a great deal from her, as well as offer things to her. The sense of great reward and satisfaction with work they described appeared to reflect the feelings of reciprocity.

"Knowing women who I provide care for makes the job fulfilling and meaningful" (questionnaire)

The relationships with women gave them something back. Providing support to women was experienced as supportive for themselves. The midwives also developed strong networks of support, through the partnerships and group practices, which they had not perceived before. It was important for the midwives to tackle issues of developing different sorts of boundaries, offering support without encouraging dependency, or over-estimating the extent of their role.[5,7]

In his theory of 'moderated love', Campbell describes this kind of relationship as being one of professional-friend.[37] It is also reflected in the New Zealand midwifery model of partnership.[21] It was evident in the women's comments and the language they used to describe midwives – personal names and possessive or first person, rather than third person, pronouns:

"my midwife and myself got on well. She was like my family there. I mean there was no difference between me and her, if I had to say to her, I can say anything and everything" (caseload 116)

A number of the women in conventional care, and especially those who were more socially disadvantaged said that they would have liked to see only one, or a few, midwives.[10] The system of care was such that they felt lost within it, and not cared for. This woman, who experienced ante- and postnatal depression, having left an abusive partner, did not reveal her problems until speaking to the researcher. She described wanting to see the same midwife so that she could talk to her:

"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 370)

Knowing and being known

The discussion of relationship suggests that the idea of knowing the midwife is more complex than has been evident in much of the published research to date. It is not simply a matter of having met someone before, even though most women would prefer a 'familiar face' at birth if possible. The discussions also do not take account of the potential value of knowing the woman for the midwife herself. As we have suggested above, knowing the woman was perceived as valuable for learning and professional development, and providing reciprocal rewards from the relationships with women.

The midwives talked about the value of understanding the woman, her background, situation, personality, hopes, and fears. They talked about learning throughout the midwife-client relationship and about the depth of midwifery knowledge gained as a result.

Knowing the woman meant they were not constantly having to start to build a relationship. They could focus on support and care provision appropriate for each individual. Such work was found to be much less difficult, frequently involving watchful inaction as opposed to the action demanded by conventional practice:

"It's knowing these women and having a really good relationship with them so that you just don't have to be with – you have to be there, but not as someone telling them what to do when they're in labour. I mean, I can stand back in the room, … and just let them get on with it and they'll just ask me what they want. You know, whereas when you don't know them you continue to say well how about this then, what about that or have you thought about pain relief? Bit inappropriate time to be discussing these sort of things." (clm23)

Knowing the woman allowed the midwives to learn to trust them, and to gain confidence in their abilities both to call when needed and, more fundamentally, to birth normally and without undue assistance. They reported that at times their greatest action was in deciding when not to act, particularly during labour, but remain quietly aside, 'allowing' the woman to continue as she wanted. Through this the midwives learned to trust the value of 'being' rather than 'doing'. They reflected on presence as an important constituent of good midwifery care.[22,38] In providing and protecting the space for women to labour 'normally' these midwives also learned from the women, coming to recognize what was, and was not, normal behaviour during birth.

The midwives also found continuity of relationship gave them time to access evidence or advice, so that they could inform themselves and the woman appropriately. This provided opportunities to work with others, including community workers and organizations. They also felt more able to offer advocacy for women. The sense of relationship engendered a sense of mutual trust and obligation that was important to both. The midwives also gained professional and personal satisfaction from feeling that they had seen a particular relationship through.

For both women and midwives, the organization of care was more person-centred. This was further reflected in the orientation of the midwives' work and sense of responsibility or accountability. This appeared to shift from accountability to the institution towards accountability to the client and to the profession of midwifery.[25,28]

From the woman's viewpoint, being known was about feeling someone understands you and what you want. For some women, particularly those from minority groups or younger mothers, it also meant not feeling alienated within the system. Women did not have to repeat their history, over and over, a systems problem that has been discussed in the maternity literature.[39] Women felt able to confide in and trust their midwives.

Being there

In some midwifery models of care in the UK, there is a measure of continuity, but not necessarily for birth. For example, a woman may see the same few community midwives at an antenatal clinic at her GP surgery or local health centre. Except in a few cases, (including home births), the community midwives do not attend the birth. A larger community team provides postnatal care. A number of writers have questioned whether being there for the birth is sufficiently important to warrant reorganization of care.[26]

Our studies suggested that midwives and women valued 'being there' very highly and that being with the woman is about more than a physical presence. Women *did* highly value *'their'* midwife being there for birth but this wasn't the main issue. It was about feeling the midwife was 'there for you' in a wider sense. This woman, for example, distinguished this birth experience from her previous ones:

"well they do know me, they recognize me, but my midwife, she was part of it, part of the birth, the baby". (caseload 391)

Midwives felt a sense of getting something back from the women, on a personal and professional level, including learning from continuity of experience.

"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." (corridor chat, clm18)

"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." (focus group)

There was a suggestion that being present at the birth held as much, if not more, significance for midwives than mothers. As one midwife noted when she found she had missed a birth she felt…

"…very down, fed up, upset. It's us that minds. We like to think they want us and are upset if we are not there, but it isn't true. Now it is us that wants to be there, that's why you put yourself on call so much, you don't want to miss the end – it's the icing on the cake" (corridor chat, clm11)

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The traditional, old English meaning of the word 'midwife' is said to be 'with woman'. Such meaning and

values are clearly held by midwives. However, a number of studies have suggested a considerable gap between such core values and those revealed in midwifery practice.[28,40-42]

In this study of caseload practice, midwives described growing confidence in themselves, in midwifery, in women and in birth. Women described a parallel growth in confidence and tended to see the services as 'about me and for me' rather than for an institution.

The key themes that emerged in analyses of both women's and midwives' responses to caseload care can all be linked to the core theme of continuity of carer. This did not mean that one midwife should provide all the care, or always be present. Continuity of carer was inherent in the way these midwives worked and underpinned the qualities of the role the midwives valued. In the conventional service, these themes were present in what the women hoped for, and in the midwives' ideals, but not in their usual experience.

We suggest that if the goal of practice is women- and midwife-centred care, then the aim of the model of care is not the achievement of continuity of carer in itself, but rather the development of conditions of practice that enable the core themes we have highlighted to be present. The development and satisfaction the midwives experienced were centred on the nature of relationships they were able to develop with women. The learning and satisfaction this engendered and the autonomy that allowed them to practice in this way was also important. Autonomy was a necessary condition for caseload practice to work in a manner acceptable to midwives; it was also an outcome of this style of practice.

In the ethnographic study, an iterative process of midwives' development was observed over an extended period. The midwives' level of control and decision-making changed. This has not been a feature of many midwifery team developments, including some developments described as caseload practice.[19] Some introduced new forms of fragmentation to ensure a 'known face' was present for labour and birth. Many attempted to introduce continuity without autonomy, often in organizationally elaborate schemes, thus introducing new stresses for midwives who were expected to act flexibly without any real flexibility in their working lives. They were expected to support women's choices without having any real choices themselves.[27]

Simply 'knowing a face', while helpful and friendly, does not support women's autonomy and choice in labour and birth in the same way. There has been a tendency in the UK to see caseload midwifery as an elite service, a luxury or one only really wanted by 'pushy' middle class women, who don't need care so much. In Canada, where such a model has been established as a 'standard and cornerstone' for midwifery practice, similar concerns may be raised that midwifery is only available to a minority of women able to articulate and advocate for their wishes.

In our interview analysis and our observations of the midwives we found that minority, young and disadvantaged women valued continuity of carer particularly highly. This group of women has a sense of alienation from hospital-oriented health services, where they often felt isolated, overlooked, anxious, not listened to, and frightened.[9] Developments in midwifery in Canada are increasingly focused on inclusion of minority and socially disadvantaged women.[43]

Our research showed that continuity of carer facilitates other important values, particularly in a fragmented, hospital-based health system. Continuity of care without continuity of carer is very difficult to achieve in such a system. It does not support autonomy in the same way. Conversely, it may be that in different practice environments that can support autonomy and personal care more effectively, such as small, midwife-led birth centres, continuity of carer is less important.[44,45]

In the current Canadian context, midwives practice according to a model that is rooted in the history of community-based, lay midwifery. The values we have discussed in this article may appear to simply be those of the 'midwifery model', or a more social model of birth. However, the UK experience shows that the institutionally-based midwifery that was ushered in with the dominance of hospital births, within a hierarchical healthcare system, may eventually conform to a medical model and a fragmented system of care in which it is difficult for the midwife to be

'with woman'. We suggest that the themes highlighted in this analysis describe principles that are important for Canadian midwifery to foster and maintain. Continuity of carer was found to be a core theme.

Continuity of care or carer is not an end in itself but an important means towards the end of women-centred care.[2] It has arisen as an issue in the historical and political context of extreme fragmentation of care and diminishment of midwifery practice brought about by medicalization and hospitalization of birth. It's importance or relevance cannot, therefore, be considered outside of its context. What continuity of care, or of carer, actually means to women and midwives needs to be examined carefully.

AUTHOR BIOGRAPHIES

Dr. Christine McCourt is a Reader with Maternity, Health and Social Sciences, Thames Valley University in London, England.

Dr. Trudy Stevens is a Senior Lecturer in Midwifery at Anglia Polytechnic University.

Address correspondence to: Dr. Christine McCourt, Centre for Research in Midwifery and Childbirth, (CeMaC), Faculty of Health and Human Sciences, Thames Valley University, 32 Uxbridge Road, London W5 2BS, England. Phone: 44-208-280-5287 (admin: Lisa Rodrigues 280-5312); fax: 44-208-280-5125; e-mail: Chris.mccourt@tvu.ac.uk.

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