THE ASSET MODEL: WHAT MIDWIVES NEED TO SUPPORT ALTERNATIVE PHYSIOLOGICAL BIRTHS (OUTWITH GUIDELINES)

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SUMMARY

This article presents the ASSET model, a pneumonic that highlights what midwives need to support alternative physiological birth choices, with applications to all birth choices and midwifery practice. The model was developed following the data collection and analysis of a large qualitative study that focused on how NHS midwives supported these birth choices in practice. The analysis answered three core research questions: the processes of midwifery care, the midwives' experiences, and the sociocultural-political influences on midwifery practice. This model can be used to inform the skills and support midwives need to drive forward the personalised care agenda.

INTRODUCTION

Full-scope midwifery was defined by the *Lancet* Midwifery Series[1] which includes the optimisation of normal biological, psychological, social and cultural processes whilst respecting women's individual circumstances and views. In the UK, women and birthing people have the legal right to bodily autonomy during pregnancy and childbirth, along with the right to decline care or recommendations.[2] Together, midwives have the professional, ethical and legal obligation to ensure women's birthing choices are supported and respected, including those that sit 'outside of guidelines'.[3] However, realities in practice, where midwives are employed by institutions, can make supporting these choices difficult – issues of hyper-adherence to guidelines, fears of adverse outcomes and potential reprisals or litigation can pose barriers.[4] That said, some employed midwives have successfully supported these birthing decisions, and my research study was designed to capture how the midwives delivered their care, their experiences of doing so and the sociocultural-political influencers on their practice.[5]

In my study, I used the term 'alternative physiological births' to convey birthing decisions that went outside of local or national guidelines where women were in pursuit of a normal physiological birth.[5] I recruited 45 NHS midwives who self-defined as supportive/facilitative of these decisions and collected 65 pieces of data through self-written narratives and interviews. Here, the midwives shared professional stories of practice, using 'real-life' examples of delivering their care. Examples are found in *Table 1*. The data were analysed in several different ways, answering different research questions of the same dataset. Those findings have or will be reported elsewhere. The purpose of this article is to share a model that was developed from across the dataset showing what midwives need to support alternative physiological birth choices, from the personal to system level. Given the Better Births' aims of greater personalised care,[6] this model could help inform the skills and support midwives need to practise within an authentically personalised way.

***Table 1* Examples of birth decisions**

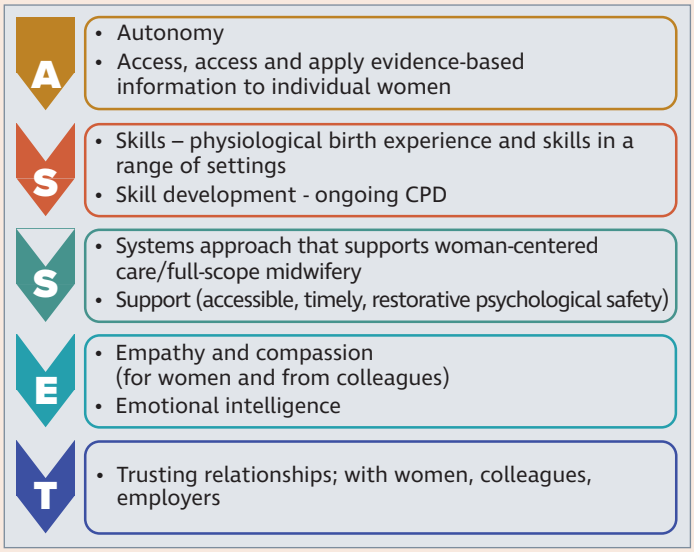
Birth decisions otherwise 'healthy' pregnancy	Birth decisions 'complicated' pregnancy
Declining vaginal examinations during labour	Vaginal birth after caesarean (VBAC) home birth, birth centre or at hospital without usual monitoring
Declining postdates induction of labour (IOL)	VBAC (after 2 or 3 caesareans) home birth/ birth centre
Declining all monitoring during labour and/or freebirth	Waterbirth – VBAC or gestational diabetes or twin pregnancy or breech presentation at home/birth centre or at hospital without usual monitoring
Declining recommended medical interventions (not emergency)	Raised BMI (>35–50) home birth or birth centre
Declining antenatal screening/scans	Breech home birth or birth centre or at hospital without usual monitoring
Declining antibiotics and/or augmentation for GBS+ or PRSOM	Medical conditions such as epilepsy, diabetes, blood clotting disorder, hypothyroidism, blood-borne virus – home birth or birth centre

> *"Together, midwives have the professional, ethical and legal obligation to ensure women's birthing choices are supported and respected, including those that sit 'outside of guidelines'.[3]"*

ASSET

The mnemonic 'ASSET' was developed to highlight a) that midwives are the 'asset' for women getting their needs met and b) situates what midwives need from an individual level across to the organisational level. The model is illustrated in *Figure 1* and an explanation for each section will be provided below.

***Figure 1* The ASSET model**



A: Autonomy; access, assess and apply evidence-based medicine (EBM)

Autonomy

The King's Fund[7] cites Van den Broeck et al's.[8] robust definition of autonomy; it refers to the need for volition, choice and freedom to organise our experiences for ourselves, and for self-integrity – being able to integrate our behaviour and experiences with our sense of self – for example, as a provider of high-quality and compassionate care. From my study, the midwives had variable workplace experiences. For those who had control and power over their working lives while supported to work in line with their midwifery philosophy and values, flourished. Conversely, those who were not supported or trusted to work autonomously reported negative experiences with huge impacts on their wellbeing. Workplace cultures and politics were key influential factors. Lack of autonomy is a reason for midwives leaving the profession which needs urgently addressing for those who work in suboptimal environments.

Access, assess and apply EBM

Midwives in this study (who worked across Bands 5–8 and across settings community/hospital) were skilled and confident in their research and evidence-based skills. Rather than relying on the local guidelines to be the sole source of information for their practice, the midwives reported extensive wider knowledge bases and sources of information. This included accessing, assessing (critiquing) and applying original research findings to the person in their care. It also entailed accessing wider sources of guidelines including the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and connecting to midwives working at other hospitals. For example, where a midwife participant had restrictive guidelines, say for group B strep (GBS) and water births, they used their wider knowledge and networks to source guidelines from another hospital where those restrictions were not in place. This had a two-fold effect, that they understood that local guidelines vary greatly, are not always based on the latest evidence, so by being aware they sought to understand the underpinning research, anatomy or physiological arguments to support effective care planning. Second, drawing on other guidelines was a tool to advocate for women's decisions. Collectively, the midwives emphasised the research skills required to be an effective practitioner.

S: Skills; skill development

Skills in physiological birth and across all settings

Essential for all the midwives in this study, and indeed central to the role of the midwife was extensive experience in supporting physiological labour and birth. Having expertise in physiological birth created the competence to apply those skills to the more complex alternative birthing decisions or situations. When facing a complex alternative birthing decision such as twins in water, they referred back to their knowledge of anatomy and physiology, applying it to the current situation. Working through a range of possible scenarios, and sometimes practical simulations, the midwives demonstrated careful planning and contingency planning based on enhancing the physiology. Such expertise was gained from actively seeking opportunities either as a student or once qualified – this may have been asking for specific mentoring, requesting to work at a birth centre or joining a home birth or caseloading team. For others, they happened to be placed in certain areas with enabling environments for physiological birth (hospital or areas with high home birth rates or proactively used birth centres) which informed their skill development. For some, it was by chance they worked with a particular mentor who had these skills and supported the midwife participants to gain knowledge, skills, confidence and passion for supporting physiological labour and birth.

Skill development/CPD

This point relates to the role of the organisation to help midwives access opportunities for ongoing skill development in physiological birth. Hospitals must ensure these training needs and development are met for all midwives, working in all areas of clinical practice. Of particular importance now, as the continuity models are increasingly rolled out, all midwives must have physiological birth skill development.

S: Systems approach; support

A systems approach that supports full-scope midwifery

Where some of the participants worked in hostile environments, unsupportive of midwifery and women's autonomy, this created poor working relationships with negative impacts on the midwives' mental, emotional, physical and financial wellbeing. Working as a 'lone ranger'[5] when delivering authentic woman-centred care is unsustainable, leads to distress and burnout, and for some is a leading factor in leaving the profession (which mirrors the numerous studies about why midwives

leave).[9,10] Conversely, some participants worked in supportive environments whereby the organisational values and culture created the optimal environment for midwives to deliver woman-centred care where women's (alternative) choices were 'normalised'. These positive cultures went beyond individual midwives, teams, or areas of midwifery practice. As such, the burden of delivering woman-centred care was not placed upon one individual or team, rather, it was a shared vision and a collective responsibility across the organisation. Central to this was the valuing of women's autonomy over organisational needs, and trust in the midwives to deliver such care.

Support

Midwives need support that is accessible, timely and restorative. From my study, sometimes this was as simple as calling a senior or consultant midwife for reassurance that the care plan was appropriate, or to brainstorm the situation which may have become unexpectedly complex. For others, debriefing through challenging episodes of care were required. In other circumstances, support for women and birthing people's decisions were cultivated through formalised care pathways, care planning proformas or guidelines – viewed as supportive mechanisms. Overall, midwives need to know they have the support of the organisation, from managers to heads of midwifery, to reduce the potential for burnout outlined above and to enhance the psychological safety for midwives.

E: Empathy and compassion; emotional intelligence

The midwife participants demonstrated high levels of empathy and compassion for the women in their care. Empathic concern was expressed by midwives who were moved by the women's accounts, usually distressing, which 'compelled them to act' to support the decisions. Such compulsion seemed to create a mother-midwife allegiance that mitigated against potential obstacles such as workplace cultures or constraints. Such emotional attunement results in empathic responses to serve the women's needs that can be viewed as 'compassionate midwifery care'.[11] As such, emotional intelligence skills need to be embedded within the university and hospital organisations to ensure safe, respectful and dignified care is provided. Moreover, that these midwives had variable workplace contexts, midwives delivering this care must be afforded the same respect and dignity within their workplaces. This includes empathy and compassion from their colleagues and managers to foster greater relational inter and intra working. Within an empathetic and compassionate model of working, resistance to 'blame cultures'[12,13] is more easily attained. In turn, this enhances a 'transparency culture' that is well evidenced as a safer culture for all.[14]

T: Trusting relationships

While much attention is given to the trust benefits within the mother-midwife relationship from the women's perspective, this study extends this vital component of care. Trust was seen as the 'glue' within the mother-midwife relationships; the midwives recognised they needed to be deemed trustworthy by the women and made great efforts to convey and be trustworthy – echoing other research. Unique to this research is that trust was seen as reciprocal, and where midwives trusted the women, they were more confident and willing to support the birthing decisions. Moreover, the other findings highlighted how important trust was within the midwives' working relationships. The absence of trust was a precursor to challenging experiences, vulnerability and negative experiences. Moreover, trust from the employers links to an enabling (or not) workplace environment, influencing the extent to which midwives were able to practise autonomously. Therefore, trust as the glue for all relationships means organisations must work to create trusting environments for and between all professional groups so as to maximise women's experiences of respectful maternity care.

URGENT RECOMMENDATIONS AT AN ORGANISATIONAL LEVEL

Frontline midwives need to be supported within non-punitive, open and learning cultures where their autonomy is respected. A supportive work environment is an enabling factor for providing true woman-centred care and creating the space for full-scope midwifery. The benefits to women are well documented, therefore, could be used to enhance women's psychological and physiological birth outcomes. Ideas for implementation are provided below aimed at senior midwives, managers, and Trust boards:

- Organisation-wide education regarding women's childbirth legal rights (to include senior medics, midwives, Trust board directors, legal department etc.).
- Consider formalised documentation that reflects women's human rights in childbirth, with the responsibilities of all maternity staff to ensure dignity and respect for women's autonomy clearly identified. Such documentation could include guidance with common scenarios, to ensure that staff are reminded that, whatever their views about the decisions made, if the woman is properly informed (and not pressured with biased or repeated information) her decision should always override that of her attendants unless she has, in a legal sense, lost competence, which is very rare indeed.
- To stimulate positive change that enhances women's access to meaningful choices could include the development of a co-created toolkit (informed by all maternity staff, representation from all practice settings, and birthing people) that has the support of senior management.

- And/or an 'alternative birth choice bundle' could be developed, a toolkit designed to help support women, midwives and hospitals to provide safe, woman-centred care where choices are outside of guidelines.
- Identify a lead midwife (in the absence of a consultant midwife) who could be the liaison between maternity staff, the multidisciplinary team, legal and managerial teams.
- Set up supportive learning sessions for multidisciplinary teams to discuss what has worked well when supporting/facilitating women's alternative birthing choices.
- Establish 'open door' sessions for junior/inexperienced staff to discuss ongoing cases with senior/experienced midwives. These can be used to provide support, and/or identify gaps in knowledge or skill sets. This could generate a co-created action plan for staff skill development, where both the individual midwife and the hospital are obligated to fulfil training needs.
- Offer debriefing sessions to all/any staff automatically after challenging experiences – not just related to adverse outcomes, but issues of relationships with women or their families breaking down, issues of poor communication between staff, inappropriate care etc.
- Provide ongoing feedback from women who have requested alternative birth choices. Inviting women after their birth to share their stories with staff could provide beneficial learning opportunities and validation of the service provision.

CONCLUSION

This model was developed during the latter stage of my PhD in 2018 but has since been echoed by two key reports. First, the General Medical Council November 2019 *Caring for doctors, caring for patients*[15] report highlighted the need for GPs to have autonomy and control over their working lives and practice; a sense of belonging through positive team working and cultures, and competence that includes access to ongoing professional development. Second, King's Fund in September 2020 *The courage of compassion: supporting nurses and midwives to deliver high-quality care*[7] highlighted the need for autonomy, belonging and contribution. The latter relates to the need to feel effective as though we are contributing something of value. Collectively, the reports and this model acknowledge and detail what is needed for health professionals to flourish within their work. Enabling environments that support health professionals will only have a positive impact on service user experiences and outcomes. Furthermore, it is in line with the personalised care agenda, as this model provides an overview of what midwives need to deliver such care. While extra challenging due to the pandemic, we must not lose sight of these necessities to recruit and importantly, retain our staff. I urge organisations to review their workplace cultures and move toward an enabling environment where midwives are supported and trusted to do the job they are trained to do. **TPM**

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