RISK SELECTION OR
THE PERSONAL CARE PLAN

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Risk selection is a central issue in midwifery care. It limits the tasks that we as professional midwives can do and in this lies the safety of normal birth and home birth. A birth is safe only as long as the birth process is progressing within the physiological rhythms and boundaries . So midwifery care is safe only as long as the midwife moves inside the boundaries of her profession, using her specific tools to promote health (salutogenesis).
The goal of selection is to understand until what point a woman is healthy and when she does need medical care.

Let's start with some question:
What is the role of protocols?
Who makes the choices about intervention?
What kind of tools can a midwife use to restore health in borderline situations?
What happens by focusing on risk factors?
What happens by focusing on signs of health and resources?
How can we include informed choice in risk selection?

THE DIFFERENCE BETWEEN AN APPROACH BASED ON THE MEDICAL MODEL OF CARE AND AN APPROACH BASED ON THE MIDWIFERY MODEL OF CARE

The education of midwives is based on the medical model of care. So many midwives are in conflict between their education and practice and their inner female model of birth.
Illustrated below are the main differences in the focus of the two approaches:

MEDICAL MODEL:
Focus is on pathology (diagnosis and intervention)

⇩

Caregiver and technology are at the centre of care

⇩

Security is in taking control over women

⇩

Professionals make the decisions -------> disempowerment of women

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MIDWIFERY MODEL:

Focus is on health (health promotion, salutogenesis)

⇩

The woman, the baby and her family are at the centre of care

⇩

Security is in a woman, who is in control

⇩

The woman, together with her partner and midwife, makes the decisions-------> empowerment and shared responsibility

This changes completely the approach to care for the midwife and the tools she employs.

MODEL OF MIDWIFERY CARE BASED ON HEALTH (SALUTOGENESIS)

Physiological adaptation:

- Education to genesis of health
- Use of the biological resources of woman and baby
- Use of the physiological systems of adaptation: Reactivity, adaptation and the reactive systems
- Roots in the physical perceptions and intuition
- Hormones - emotions
- Physiological rhythms: Polarities and rhythms of the physiological systems
- Circular observation
- Communication between the physiological systems: The internal communication between hormones, autonomic nerve system, immune system and behaviour, outside environment
- Biological attachment
- Mother baby as a unit from conception to the first months
- The foetus-placenta unity and autonomy

Midwifery model of care: the 4 C's

- Woman centred care: *Focus on endogenous resources*
- Choice: *Unity of person and environment, body and mind*
- Continuity of care: *Professional, symmetric, therapeutic relationship*
- Control of woman: *Development of coping capacities*

Social adaptation

- Cultural de-conditioning, positive communication
- Social, psychic and cultural resources
- Social systems of adaptation (Antonowsky)
- Orientation, knowledge
- Behaviours, life style
- Modulation of behavioural rhythms
- Communication between mental and social system
- Social and psychic attachment
- Mother and baby as individuals

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In a midwife-specific model of care the focus is on signs of health, endogenous resources, and on women's choice.
Thus we need a different model of observation and a personalized approach to care, as every woman is different and exists in a different context.

The normal model of risk selection in the medical model of care is linear:
From the symptom----------> to diagnosis based on pathology ----------> to medical care

In midwifery care the approach is circular, a process of reasoning and problem solving:
From the symptom -
----------> to searching for signs of health in the woman's physiological and mental systems,
---------> to seeking a balance between signs of health and signs of disease
----------> to the activation of the woman's inner resources, if there is enough time
----------> to promoting women's choice
----------> assessment
----------> either health is regained or, if the woman's inner resources are not sufficient,
----------> integration with medical care follows.

TOOLS FOR A CIRCULAR EVALUATION, OBSERVATION AND INTERVENTION

All observation of symptoms and signs of health are done on **three levels**:
1) CLINICAL LEVEL: Body, physiology, baby, womb

2) ENVIRONMENTAL AND BEHAVIOURAL LEVEL: Human, social and public health environment, behavioural rhythms

3) EMOTIONAL AND RELATIONAL LEVEL: Personal and social experiences and conditioning, relationships with others and the baby

Usually one of these levels emerges more than others: for example the mother arrives with a physical complain (first level), or she appears stressed and anxious (second level) or she bursts out in tears after the first exchange of words (third level). Although they are all linked together, we can start with intervention at the more acute level.
The following observation chart gives you an example of how to organize your observations and illustrates how to become conscious about the level of every sign that you capture, often in an instinctive way.

OBSERVATION CHART

OBSERVATIONS	SYMPTOMS OF GOOD HEALTH	SYMPTOMS OF POOR HEALTH	NEEDS AND RESOURCES
CLINICAL ASPECTS Hormonal system Autonomic nervous system Placenta-foetal system (baby) Primary adaptation system Health condition Other			
ENVIRONMENTAL AND BEHAVIOURAL ASPECTS Kind of support and supportive people available Rhythm of life Behavioural rhythm Capacity of coping, adaptation, flexibility reactivity Other			
EMOTIONAL AND RELATIONAL ASPECTS Bonding with the baby Bonding with the partner Bonding with the family Reactions to changes Emotional opening/closing			

Now that you have an idea about the circular or holistic approach toward salutogenesis (origin of health), we can move a step forward and look to the traditional medical model of risk selection and to the salutogenic, physiological model of risk selection from the midwifery model of care.

The linear, medical model of selections follows an outline like the following:

Flow diagram for determining responsibility for care during pregnancy, birth and puerperium, as used in drawing up the revised indication list

relevant condition? □ □	no □	**A**		
Yes □				
Specific policy? □ □	no □	**A**		
Yes □				
Increased risk? □ □	no □	**A**		transport risk? □ no □**A**
□ □	possible □	↑ consultation **B**		□
Yes □		□		Yes □
□	□	**C**		**D**

A. Primary obstetric care. The responsibility for obstetric care in the situation described is with the primary level obstetric care provider, midwife or GP

B. Consultation situation. This involves evaluation involving both primary and secondary level care. The individual situation of the pregnant woman is evaluated and agreements are made about the responsibility for obstetric care based upon the above mentioned five questions. Consultation will take place unless structural agreements have already been made at a local level. The section on obstetric co-operation provides information about such agreements.

C. Secondary obstetric care. This is a situation requiring obstetric care by an obstetrician at secondary level for as long as the disorder continues to exist.

D. Transferred primary obstetric care. Obstetric responsibility remains with the primary care provider (midwife/GP), but in this situation it is necessary that birth takes place in a hospital in order to avoid possible transport risk during birth.

This way of selection is very rigid and creates a high transfer rate to medical care without any use and true benefit.

CIRCULAR RISK SELECTION OR **PERSONALIZED CARE PLAN**

In woman centred, personalized midwifery care, the rigid concept of selection can be substitute by the flexible concept of a personalized care plan, who searches in every moment to find the best solutions for the current situation with the woman's active participation. This flexible way requires however to think about every case and find different solutions every time.
Together with the circular evaluation women have much more possibilities to stay healthy and to activate their own resources and forces.
The following outline can help in taking appropriate decisions together with the woman, respecting her choices and her needs. It offers criterias for searching for the best individual solution.

OUTLINES FOR DECISIONS

THE QUESTIONS	THE CARE GIVER	DECISION INFORMATION	INTERVENTION THE TOOLS WOMAN'S CHOICE
What are the risk factors for this woman? ✓ *On a personal level* ✓ *From a medical point of view*	*Who is the caregiver with the most effective tools?*	*What does the care giver know* *What does the woman know: intuitions, perceptions, resources*	*Which tools are needed? What is the level of professional experience? What is the best approach?*
Is it possible to prevent these risks? Yes ---------->> No ! ! V	Who has the most effective tools? The midwife?------> --------- The doctor? --------> Other?	What is known from Physiology? What is known from EBM? What are the resources? What is the woman's/midwife's perception/intuition? --------- →	What kind of tools? - **Clinical**, hands-on, treatments - **Social**: setting, context, rhythms, lifestyle - **Emotional**: professional and affective relationship, support --------- - Diagnosis and therapy --------- What is the woman's choice?
It is possible to diagnose these risks early on? Yes ---------->> No ! ! ! V	Who has the most effective tools? The midwife?------> --------- The doctor? --------> Other?	What is known from Physiology? What is known from EBM? What are the resources? What is the woman's/midwife's perception/intuition? --------- →	What kind of tools? - **Clinical**, hands-on, treatments - **Social**: setting, context, rhythms, lifestyle - **Emotional**: professional and affective relationship, support --------- - Diagnosis and therapy --------- What is the woman's choice?
It is possible to afford these risk, should the pathology manifest itself? Yes ---------->> No ! ! ! V The woman remains with midwifery care	Who has the most effective tools? The midwife?------> --------- The doctor? --------> Other?	What is known from Physiology? What is known from EBM? What are the resources? What is the woman's/midwife's perception/intuition? --------- →	What kind of tools? - **Clinical**, hands-on, treatments - **Social**: setting, context, rhythms, lifestyle - **Emotional**: professional and affective relationship, support --------- - Diagnosis and therapy --------- What is the woman's choice?

DESCRIPTION

Point 1) Definition of the risk:
You need to understand the symptoms and analyze the true risks for this woman. To make the right diagnosis, you need to know physiology very well. Using the observation chart and circular evaluation can help.

Point 2) Who is the caregiver with the most effective tools:
Here you have to look at both medical and non-medical tools.Usually doctors have medical tools and midwives have more manual and relational tools, such as counselling, active listening, problem solving, manual treatments like massage, anti-stress treatments, body work, relaxation and others. Also evaluate your education and experience, the tools you own. A more experienced midwife will have more tools then a less experienced, and will have less need to refer to medical care. But, if you don't have the tools, medical care may be safer for the woman.

Point 3) Decisions and information:
Here you need the tools of Informed Choice. You bring together objective and subjective elements. The scientific knowledge is integrated with a glance to the resources and the subjective elements like intuition and perception. A woman in control, who is listening to her body and is not distressed, is able to feel very well how her baby and herself are. A midwife who is in a good relationship with the woman, is similarly capable to feel what is going on.
Bringing all these elements together, you have a good ground for taking informed decisions that you are confident about.

Point 4) Tools and woman's choice:
Here you can use the observation chart again, looking at needs and resources. The first intervention will be done on the most evident level between the three, where the symptom appears. Then you integrate the others.
Very often there are two possible approaches to the problem: the medical approach and the salutogenic, midwifery approach. You can propose both to the woman and enable her to make her choice.
Sometimes medical care has priority; in that case you will integrate medical care into the other levels.

(The schedules and concepts are pubblished in my last book Schmid V. (2007) "Salute e nascita, la salutogenesi in gravidanza, Apogeo ed., Milano – *Health and childbirth – Salutogenesisi in pregnancy and motherhood*)