AIMS For a better birth...

An interview with James Bourton

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Interview by Anne Glover

Thank you for agreeing to be interviewed by AIMS, James. To begin, can you tell us what first attracted you to being a midwife, how it came about?

Midwifery is something that is part of who I am, it isn't necessarily just what I do for a living. This is a way of life for me and it sits alongside the other aspects of my daily living. I remember as a child dreaming about being in the birthing space of women even before I knew how babies were born. However I didn't immediately associate those early dreams with becoming a midwife. Of course, being a man, I didn't believe midwifery would be an option for me. When I was in my late teens, I remember travelling past the local maternity unit, looking at the building and just intuitively knowing I had to be in there. So I went in and spoke to some of the maternity staff expressing my interest in midwifery and I ended up leaving with a week's work experience. That is the beginning of my long journey into midwifery.

Can you tell us a bit about your journey and how you got to where you are today?

During my week of work experience in the late 1990's, I remember going out with a community midwife on her visits and spending some time on the postnatal ward. It was all very conventional for the time but I remember loving the experience and knowing that's what I wanted to be doing.

I became a health care assistant (HCA) in the same maternity unit. I did shifts in all areas of maternity including the labour ward. I was so lucky to be able to witness a vaginal birth and a caesarean birth on my first ever shift. It just fuelled my desire to become a midwife. Of course, looking back, I would never practise now in the way that I observed then, but prior to that, the only births I had seen were on TV drama shows, so it was exciting for me to witness birth in real life.

After about a year I was considering how to apply for a midwifery course. The Trust I was working for had sponsorship opportunities for people to apply for adult nursing and continue to be paid their HCA wage throughout the training, but not for midwifery. I ended up being accepted for sponsorship to train as an adult nurse and although this wasn't my chosen path, it was a means to an end. So, in September 2001, my nursing diploma training began. It was a long and difficult 3 years for me. Several times I nearly left nursing because my heart wasn't in it. I knew it wasn't where I wanted to be. I completed my training and luckily got a job on a women's health ward specialising in early pregnancy, gynaecology, and breast surgery.

Finally in 2006 Oxford Brookes University were offering places for nurses to enter midwifery on a 20 month BSc degree programme. I jumped at the chance and luckily I was accepted. My midwifery training began in September 2007 and I loved every minute of it. My first clinical placement was with a small team of community midwives based just outside Oxford and their base was a free-standing midwifery-led unit, (MLU). They were hot on promoting home birth and the first 3 births I witnessed as a student midwife were home births. Suddenly everything clicked into place. I had found my passion; I had finally answered my calling.

I qualified in 2009 and I spent the first six months working on a very high-risk labour ward where I had trained in Oxford. However, I found it so traumatic that it nearly ended my career due to what I was witnessing.

I eventually got a job closer to home in the same unit where I had been a HCA all those years before, so some of the staff remembered me. At that time they had no MLU so I began working a rotational post between antenatal, postnatal and labour wards. I remember being unaligned with the culture there. My views on birth differed greatly to the majority but they did respect me as a practitioner and everyone knew if they came in my room the bed would be pushed out of the way and women birthed instinctively with my very 'hands off' approach.

After a few years the Trust opened an alongside MLU and I was lucky to become one of the first midwives to work there. I felt so elated to be able to now work with women and their families within the scope of physiological birth and the unit soon became a victim of its own success. Very quickly more midwives were needed to support the numbers of women using the facility.

However, I knew I needed to have a change when I began to burn out by literally just catching babies. Birth was becoming less 'special' because I was catching nearly 100 babies a year and not developing relationships with families either before or after. Something had to change.

Community midwifery was my next goal so off I went feeling like I could change the world and promote home birth and improve the local home birth rates that sat at around 2-3% at that time. I soon realised this was not going to happen. With a caseload of around 100 and only seeing women through a GP clinic for 15 minute appointments, trying to build any kind of relationship was near impossible and I would hardly ever see them postnatally. Being on call just twice a month also meant I would hardly ever be exposed to home birth and the few women in my caseload that did choose this option would be very unlikely to have me on call when they went into labour.

So I put myself on call more often and that increased my exposure to home birth. But it wasn't enough. I looked into becoming an Independent Midwife (IM) and undertook a course with the amazing Liz Nightingale. I knew this was my path and that I wanted to provide full continuity of carer. Then came the blow that IM's couldn't practise intrapartum care without insurance and there was no insurance package available. I was devastated!

Just when I thought all hope had been lost, an ex-colleague who had moved to Wales to live and work, had come back for a visit. She found me, sat me down and explained about their model of care and knowing my ethos, encouraged me to look at moving and applying for a job in the same health board. When I read the health boards job description and their ethos, it was a no-brainer.

So in 2015 I moved my whole life from Wiltshire, England to Powys, Wales and that is where I remain working and living.

What are you most proud of in your career to date?

This is a difficult question but I think I am most proud of the fact that I haven't allowed myself to become medicalised and I have tried to stick to my true calling, which is ultimately to be 'with woman' during pregnancy, birth and beyond. I will always put the needs of my clients before anything else and I am not afraid to be a strong advocate for them when the need arises.

I have ensured that I am an 'expert' in physiological pregnancy and birth by constantly updating my knowledge and understanding of what that entails. Sadly physiological birth is no longer the 'norm', so I see it as the midwives' responsibility to remain competent in the skills of facilitating physiology so that women and birthing people can still have choice and that midwives do not fear physiological birth.

I fear that true, authentic midwifery is almost a lost art. The midwife of the future is now trained in a highly medicalised model where midwifery AND women's autonomy have been overridden by the mainly obstetric-led system we find ourselves in. Dare I say it, but, in my opinion, midwives are now being moulded into obstetric nurses.

James, you currently practise in an NHS continuity of carer midwifery model, covering a vast rural area in Wales. Can you tell us about your role and what you enjoy about working in this way?

So, we are a midwifery–led service covering rural mid Wales, which spans around 2,000 sq miles. We have 6 free standing birth centres across the patch and in each birth centre there is a small team of between 4- 6 midwives.

Within each team there is a band 7[1] team leader, who also has a small caseload of women, then the remainder of the team are band 6 midwives and occasionally we have newly qualified band 5 midwives. Each midwife in the team covers a certain geographical area that their birth centre caters for and those women become your caseload.

Caseloads tend to be around 35 women at any one time for a full time midwife, and less for midwives working part time. The caseload is of a mixed complexity so we provide care for women who also receive obstetric input.

As a service, we feed into around 8 different district general hospitals. Each team will normally feed into 2 different units.

We continue to work closely with our clients who receive obstetric care to ensure they are being given the correct information, based on current evidence so that they can make truly informed decisions. We remind them that they are in control of their care and what their legal rights are when it comes to pregnancy and birth choices. If women choose to birth with us 'outside of guidance,' then we ensure we support them by giving them the evidence and the 'actual risks' not 'relative risks' so that their care is individualised to enable them to make informed choices. We then put in place a robust plan, outlining our discussions including the evidence we have used to support our conversations. This plan is given to all midwives so that if their named midwife is not available when they go into labour, the woman doesn't have to endure the same conversation.

When it comes to labour care, some women decide to use their nearest obstetric unit and will contact them directly for advice. However most units are around 30-40 miles from us, so some of these women (particularly multip's) don't make the hour's car journey and we end up catching the baby.

For women who are undecided or know they want a local birth, we will firstly 'home-assess'. This isn't a case of going in and performing observations and vaginal examinations, it's about sitting with the women, watching and waiting and making an assessment from what's going on externally. Of course, we will gently, over time, offer to perform the clinical observations to ensure fetal and maternal wellbeing. Also,

most of the time the woman is seeing a known midwife, and often it's their named midwife, so we are aware of their pregnancy journey and their wishes, which means we don't have to question and disturb them while they are in labour.

It's at this point we will ask the woman where she wants to give birth, and she decides if she wants to remain at home or to move to the local birth centre. If a home birth isn't planned but she decides on the day that's where she is staying, then we are fully kitted out to be able to facilitate that choice there and then.

Postnatal care is again carried out by the named midwife or their 'buddy'. We see the women in their homes and provide an individualised approach. There is flexibility in when we offer certain screening for the new-born, so often the named midwife can work the postnatal care into their own diaries and around their own pre-planned antenatal appointments.

Midwives are encouraged to work as autonomously as they can. Planning their working hours around the needs of their caseloads and to some extent their own personal lives. Hours can be worked flexibly if that's preferred and we keep a running total of our hours in our own diaries so if we go over then we take time back or if we go under then we make the hours up when the caseload becomes busier again.

Working in this model of care is where I want to be. It's still not perfect, but close. I have covered the same patch now for 8 years so I am now the 'village midwife' and I have gotten to know many of the families in the area. I have seen many of them through 2 or 3 pregnancies and that includes the births, which gives me the most amazing job satisfaction.

I am the team leader for my team and although this gives me added responsibility, it also enables me to empower those midwives to remain autonomous and support their families in a way that is individualised and evidence based.

So tell us James, what are the practicalities of working in a continuity of carer team and how do you make it work successfully?

To work in this model of care, you have to be able to work flexibly. It really isn't a 9-5 job. Also being able to commit to 2-3 on calls per week is sometimes challenging.

It Is essential to have ownership of your own work and diary. There needs to be a trusting relationship between the management team and the staff working on the ground floor. Our management team is very supportive of our model of care and actively encourages us to work in this way.

There can also be challenges working in a small team, so communication is a must. We have monthly team meetings where we have protected time together to discuss issues about our caseloads. I provide some revision on an element of physiology of pregnancy or birth, and we also run a scenario on a specific obstetric emergency.

If we are the midwife on-call, we try to only work in the morning to ensure we have a rest break before

the on-call begins. However, occasionally we can't do that if our caseload needs us. So being able to support each other is essential. In this situation, often one of the other team members will offer to triage the calls for a few hours to ensure the on-call person gets some protected time to rest.

What do you see as the advantages of the continuity of carer model of care for your clients?

Our clients are receiving a good standard of care, compared to many other areas of the UK. I think this is evidenced by the feedback we receive, which is often very positive.

All women have a named midwife and have access to a team of midwives 24/7 for advice when needed. This ensures women have confidence in us and that is important when it comes to their birth.

Seeing women in their own homes and having the same midwife for each of their pregnancies, builds a robust and trusting relationship. We know this improves outcomes in maternity care and it is so rewarding for the women and the midwives.

We achieve high levels of home and MLU births, compared to the rest of the UK. Over a quarter will start their labour in our care with just under a quarter birthing with us either at home or in their local MLU. Our transfer rates are low compared to national averages and the outcomes for women and babies are not compromised by this.

We know through evidence that the CofCer[2] model improves health outcomes for both mums and babies and it leads to better birth experiences for women.[3],[4] This is important, especially as suicide is a leading cause of maternal death.[5]

We know that women who plan birth at home but then transfer to hospital are still more likely to come through birth having had a much better experience and feeling empowered and part of the decision making process.[6]

One theme of this Journal issue is place of birth. Can you share some of your experiences of this?

I class myself as a home birth midwife, even though some births are facilitated within our free standing MLU. The MLU is no closer to an obstetric unit than the woman's home, and we have nothing extra in an MLU than we have in our home birth kits, other than a fixed birthing pool, so it is basically like a home birth. Many women decide on the MLU in order to use the pool, and for no other reason.

Home is where physiological birth happens, and I am lucky to witness this time and time again. It is where I feel most comfortable in providing care to women in labour and it is where I feel most confident in my skills as a midwife providing intrapartum care.

Homebirth is calm, it is raw, it is empowering. It is where women have birthed their babies for thousands of years, up until our recent history. Birth in the home works pretty well most of the time and with skilled home birth midwives, the rare deviations can be dealt with swiftly and safely in the majority of cases.

I witness the primal instinct of birthing women at every home birth I attend, and when I arrive at the

homes of women who are very close to giving birth, I know exactly where they will be. In the smallest, darkest room of the house, tucked up in the corner, kneeling or forward leaning. This is physiological birth!

I have attended many births where children have either been present for the birth or they have been in another room blissfully asleep and unaware of the events that are unfolding. In my experience those children who are asleep, tend to remain asleep and often wake as the baby is born. Those children who witness a birth are never traumatised, they are instead, mesmerised and in awe of what has just unfolded before them.

The children who witness birth in this way will be empowered in the understanding that this is not a process to fear, but to embrace and see as a normal, physiological process.

AIMS continues to campaign for continuity of carer and physiology-informed maternity services in the UK. Any thoughts on how AIMS can best focus our limited resources, to help ensure improved maternity services for all?

These are challenging times for maternity services. We are deeply embedded in a culture of fear and we no longer trust birth.

The terms 'normal birth' and 'physiological birth' are now seen as threatening to some groups of people and there is a big push from government level to stamp out the perceived 'ideology of normal / physiological birth'.

We have almost lost the truly autonomous midwife; many people grow up fearing birth due to the media and television programmes depicting it as a painful, dangerous process.

AIMS has a massive challenge to combat this. My suggestion would be starting at the beginning. We need to educate our children from school age about birth and what it means to understand this as a physiological process and not fear it as something dangerous.

I fear it is too late now to turn the tide on the current maternity system, instead we need the birthing people of the future to stand up for their rights as human beings and insist on being heard.

If women and birthing people want to continue to have the option of physiological birth then they are going to need to stand up and fight for it, and equally midwives are going to need to stand up and fight for their rights to remain truly autonomous practitioners.

James Bourton is a Midwifery Team lead and clinical midwife who specialises in home birth.

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[1] Editor's note: Bands are related to years of experience and level of responsibility. It is explained here:

www.reed.com/articles/midwife-bands-salary-uk

[2] CofCer, the abbreviation of Continuity of Carer

[3] NHS England. Continuity of carer www.england.nhs.uk/mat-transformation/implementing-better-births/continuity-of-carer

[4] Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5 www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full

[5] MBRRACE Report (2022) Saving Lives, Improving Mothers' Care www.npeu.ox.ac.uk/news/2188-new-report-highlights-persistent-inequalities-and-continued-inequitable-care-for-pregnant-women

[6] NPEU The Birthplace cohort study: key findings. www.npeu.ox.ac.uk/birthplace/results