AIMS For a better birth...

MIDWIFERY - Will Higher Level Equal Lower Skill?

by Beverley Beech

AIMS Journal 1999, Vol 11, No 1

AIMS Chair Beverley Beech recently returned from Australia, buoyed up and optimistic about the future of midwifery and maternity care, only to discover that while she was away the powers that be in Whitehall were pursuing a policy which can only lead to a further decline in the quality of maternity care - to the detriment of every mother and baby in the UK.

In 1982 AIMS took to the streets and demonstrated with midwives about the proposal to disband the Central Midwives Board and bring midwives into the nursing fold under the umbrella of the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting). Midwives and consumers protested at the time, because they could see midwifery skills disappearing and midwives' voices being drowned by a union with a much larger profession which had little understanding of midwifery issues.

During the time I served on the UKCC Midwifery Committee I could see the amount of time wasted by overworked midwives who, instead of addressing issues which would take the midwifery profession forward, were constantly having to deal either with issues which the UKCC, in its wisdom, had erroneously assumed had nothing to do with midwifery; or deal with issues where the UXCC had clearly viewed midwifery as a sub-speciality of nursing.

In 1998 the Government appointed a marketing company, JM Consulting, to review the Nurses, Midwives and Health Visitors Act. As usual, comments were invited with a very short deadline and AIMS, together with other consumer groups, dropped everything to submit its views. A joint meeting of midwives and consumer groups met with this marketing company and made it perfecdy clear that if maternity care was to improve midwives had to be autonomous practitioners, in control of their education and training, with a separate midwifery council.

It appeared that JM Consulting had accepted these unanimous views, but then recommended a structure which, although a great improvement on the present UKCC structure, did not wholly meet the needs of midwives. The Government's response which was published on the same day JM Consulting's Report was issued (but those lay representatives who commented on the report were not sent a copy), suggested that instead of a joint midwifery/nursing committee, which JM Consulting had recommended, there would be a tripartite committee in which health visitors would be given equal status, Why they should choose this particular nursing sub speciality, as opposed to any other, is a mystery (The article "Independent Professionals - But for how much longer?" from this journal summerises the proposed

changes).

Not content with marginalising midwifery (again), so that it becomes an even more vulnerable minority, the UKCC is now promoting "Higher Level Practice". While this may be appropriate for nursing it is yet another disaster to be visited on midwives and mothers.

Midwifery was never a hierarchical profession, until it was absorbed into the NHS and, in the last five years, was required to fit into nursing grades. This has been harmful for mothers and babies reinforcing the erroneous notion that childbirth is a medical phenomenon.

The suggestion is that higher level practitioners would have, as a minimum: current first level registration; a degree (or equivalent); practised for a specified period of time in their chosen area of practice; spent the majority of their practice planning, organising, carrying out and evaluating work related to improving health and well being. To register as a higher level practitioner the midwife would have to submit evidence showing how brilliant they are in these largely academic fields and be interviewed. The chosen few would then be able to claim the qualification RM(H).

So, what are the standards by which one decides a midwife is a higher level practitioner? Does she carry her own caseload? Is she expert in topping up an epidural, performing a forceps delivery or skilled at assisting women to birth their babies by the breech? And what about the mothers? What do women decide when choosing a midwife to attend them?

I for one would want a midwife who is a skilled clinician, who would treat me and my baby holistically and would be sufficiently well trained to deal with acomplication, or the unexpected, competently. Who is going to be attended by those practitioners who are not considered to be higher level practitioners, andwhat will be their standards of care? Will they have standards that are carefully controlled and limited? Will we be seeing maternity assistants delivering babies next? Looking at the RM(H) criteria, all experienced midwives should already be working towards meeting these.

When midwives complete their training they should be clinically competent; over the remainder of their career they develop their skills and develop interests in particular areas. Having listened to reports of midwifery initiatives in Canada and New Zealand and Holland, it is clear that the way forward for midwives is the development of direct entry programmes which enable midwives to practise as autonomous practitioners whether in hos- pital or at home. All of these programmes have rejected the militarily based hierarchical structures of nursing, yet, here in the UK the UKCC blindly proceeded in implementing changes which will do nothing to improve standards of maternity care.

Their justification for this action is that having sent out a consultation ques- tionnaire to a variety of bodies, individtj- als and consumer organisations 85% of the midwives who responded (207 out of 243) said yes when asked "Do you agree that nurses, midwives and health visitors who are working at higher level practitioners should have this markedon the register?" The fact that 33,757 midwives did not respond (or were not consulted) does not appear to worry them. The midwifery profession was not asked whether it wanted two levels of practitioner.

Over the last ten years standards in maternity care have degenerated to an unacceptably low level. Less than 10% of first time mothers in the UK succeedin giving birth normally. In some hospitals the caesarean section rates exceed 25%, and if one adds the numbers of women who suffer unnecessary obstetric interventions, such as: artificial rupture of membranes, induction or acceleration of labour, it is little wonder that there are so many complaints. Since 1995 £242,782,343 has been paid out in legal claims for obstetric Damage - a result of the over-medicalisation of birth. Instead of addressing this issue, obstetricians justify this manifestation of sub-standard care by claiming that they are intervening earlier to avoid litigation.

Good midwives have been leaving the profession in droves, and AIMS is receiving increasing levels of complaints about poor standards of care.

When the Central Midwives Board was disbanded the appeasers within the midwifery profession said that they could work with the new structure and that, anyway, after ten years there would be an opportunity to review. The ten years passed and no-one was interested. It is now ten years since the Winterton Report revealed the inappropriateness of obstetrically dominated care. Changing Childbirth came and went and midwives are still struggling to practise real midwifery and fighting amongst themselves, despite an endless stream of reports, pilot schemes and studies all demonstrating the improved care women receive when they are cared for by autonomous midwives who manage their own case loads. Now, more than ever before, childbearing women and midwives must speak out about the unsatisfactory, unacceptable state of ohstetrically dominated maternity care. Failure to do so will condemn thousands of women and babies every year to continued inappropriate, and damaging care - and the litigation bill will continue to increase.