AIMS For a better birth...

The Ann Kelly Case

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The Final Regulation of Irish Midwives

In September 1996, Peter Boylan, Mater of the National Maternity Hospital in Dublin, filed a complaint against midwife Ann Kelly, charging that she allowed a mother to labour for too long. Maire O'Regan discusses the case and its historical context.

Midwifery in Ireland

The Year 1902 brings to mind the Regulation of Midwives Act, but it always reminds me that in October of that year my grandmother had her last child, at home. He was the youngest of a large family all of whom were born at home. They had just moved to the city from a rural area where she had given birth to her other children with the help of a neighbour who was a 'handywoman' or what we might now call a lay midwife or traditional birth attendant.

Her last baby, my father, was (the older members of the family would maintain when teasing him) privileged - a doctor was in attendance at his birth. A family newly arrived from the country, displaced to some extent, finding their way in their new life in a city of more plentiful work and therefore more able to pay a doctor's fee. My grandmother was 46 years old at the time - a not unusual age to have one's last child fn 1902.

The Regulation of Midwives Act was not enacted here in Ireland until 1918, and well into the 1940s 'handywomen' were still working in many parts of the country, in spite of the Act and local attempts to persuade these women to register and attend for some formal and very brief training in the maternity hospitals. Many obviously feared with good reason that they might be put out of business because at that point they were competing with hospital trained community midwives.

By the mid 1950s one third of women who gave birth in Ireland were still doing so at home. The majority were giving birth in a variety of settings ranging from privately run nursing homes, small 'cottage' hospitals with GP cover, to large maternity hospitals (we can boast the three largest in Western Europe, in Dublin). There followed a period when increasing prosperity called into being a number of private maternity hospitals. While one of these was being built in my own parish the word went around that it would have "all the latest machinery and the latest drugs from America", which was one of my first introductions as a child to differing modes in childbirth. Some mothers welcomed the fact that "you went

in, they gave you an injection, and they handed you your baby, like a present", having of course been totally knocked out for the labour and birth.

The 1950s onwards

It is a somewhat similar history to UK maternity developments, with two major differences. From the mid 1950s the trend of attending an obstetrician privately became de rigeur for all middle-class women. (Ireland did not develop a public health service similar to the NHS after World War II. A portion of the obstetrician's fee is covered in our private health insurance; the VHI and BUPA) Secondly, the district provisions were actively dismantled with no community midwives being replaced when they retired. By the early 1970s all districts/catchment areas surrounding hospitals in the large cities were formally closed down. Viewed from the official point of view, all mothers were now giving birth in the safest place for them and their babies, in hospital - everything was nicely tidied up.

It was therefore most unfortunate for officialdom and the obstetric profession that by the mid 1980s a significant number of women did not want to give birth in these large hospitals, which as early as 1968 were "bursting at the seams" in the view of one commentator (Fleetwood, 1983). Many women were now also unwilling to give birth in the locations with maximum painkilling ability, i.e. the private hospital, by now switched to 70-80% epidural cover. Instead they sought the help of midwives who had the depth and range of experience to help them give birth at home as naturally as possible. As no remnant of district support, no Flying Squads, no civilised and harmonious linkage with maternity hospitals remained, it required a calibre of midwife whose experience, commitment and philosophy matched this challenging and often hostile work environment.

It was a hostility which at times deliberately created unsafe practices:

"In one area, where the demand for home births is particularly high, a heath board hospital persisted in its refusal to supply a local independent midwife with Anti-D for a number of years. At the present time, two out of the three Dublin maternity hospitals are refusing to carry out ultrasound scans for women planning to have a home birth." (Independent Domiciliary Midwives, 1998)

In effect a 'greenfield' scenario for home births existed throughout Ireland during this period. In such a market it was frequently the former (disenchanted) clients of consultant obstetricians who sought the care of an independent domiciliary midwife (O'Connor, 1992). The opportunity to establish truly autonomous woman-centred midwifery care, from first principles, uninfluenced by the prevailing straitjacket of Irish labour management protocols, existed for one relatively short window of time.

Ann Kelly's Background

Who was better to exemplify this independence and safety of practice than a midwife who had gained her experience inside the Arctic Circle working with the Inuit people (a community which has just recently gained its independence from Canada), for nine years? A midwife who had not only attended women giving birth, but who had given total health care to the Eskimo/Indian community. This involved

dealing with plane crashes, gunshot wounds and all the eventualities of caring for an isolated community of hunter-gatherers in a terrain without roads. Enter Ann Kelly. (In the context of her case she is referred to as Aine O'Ceallaigh, her Irish name).

In a truly enlightened society Ann Kelly's skills and highly developed instincts would have been cherished. Her invaluable experience would have been recognised, respected, and treated as a resource. But a rival and conflicting paradigm of obstetric-based methodology had been evolving in Ireland while Ann was inhabiting the icy stretches of Northern Canada.

To begin with she had not even trained in Ireland, but in the UK in community midwifery, so her midwifery practice had never been influenced or coloured by the dictates of 'active management of labour', the very dominant (though largely unevaluated) model of labour management which evolved in the National Maternity Hospital, Dublin during the exceptionally high volume birth years in the sixties and seventies (O'Driscoll & Meagher, 1986 /93).

The Ann Kelly Case

Ann Kelly's long legal 'labour' began in late September of 1996 when a complaint was made by a consultant at the National Maternity Hospital. He alleged that a mother in a prolonged first labour had been brought to hospital too late, after an alleged three-day labour. The baby was delivered unharmed and both mother and baby are well, though experts dispute the three-day labour scenario. The baby's mother actually wrote to the Board complaining in the strongest possible terms against the use of her case in what she called a 'witchhunt' against her midwife. A second complaint was made by the same consultant, but this case was not Ann Kelly's. Two other complaints came from another large Dublin maternity hospital.

These cases were identical to the first one in that there were no ill-effects to either the mothers or the babies, and the complaints were made expressly against the wishes of the parents involved. The mothers went so far as to swear affidavits to the High Court that, should they become pregnant again, they wished to retain Ann Kelly as their midwife.

Ann has stated: "I practise natural childbirth and I offer a very personalised service. I only take on four mothers a month because it is a 24-hour a day job. I have always had to be very professional with all my cases but I have had to be ten times stronger to stand up to what has been said about me. My service is about giving women choice and respecting their rights, but it is also extremely safe. I wouldn't do it if it wasn't."

In August of the following year An Bord Altranais (Nursing Board) successfully applied for an interlocutory injunction against Ann Kelly which suspended her from practice. This injunction was modified on a number of occasions, but it remained in force until the l8th of May this year, when Ann won back her right to practise again in the High Court.

Sixty pregnant couples had applied to have the injunction varied. As the court hearing on the case was in

progress, the 47th 'injunction' baby, whose mother had applied to the court for permission to retain Ann Kelly as her midwife, was born safely under her care, at home. This was the l7th High Court order made in the case.

In his judgement, the President of the High Court, Justice Frederick Morris, said that he had no doubt that the original order taken out by the Board should not be continued. The original order was made under Section 44 of the Nurses' Act, but in his ruling he advised that it was incumbent on the Board*'to reconsider the evidence available to it at present, and not to rest on its oars'.* Only by reviewing its position, he said, could the Board be satisfied that it was in the public interest to restrain Ann Kelly from practising.

In what appears to the outsider as a game of legal leapfrog Ann Kelly's trials have been proceeding in the High Court, the Supreme Court and in the Fitness to Practise Committee of An Bord Altranais (FTPC). But this is an inaccurate perception. The two forums are separate legal tracks which at times have converged when the courts have overruled or upheld the decisions of the Board.

Expert Witnesses

One very significant ruling occurred in December `98 when the Supreme Court ruled that Ann Kelly could have her expert witnesses present at the FTPC hearings. An earlier attempt in the High Court in May '98 had failed. The expert witnesses involved are Ms. Mary Cronk (MBE), Ms. Marie T. O'Connor, Research Sociologist and Prof. Lesley Page (Queen Charlotte's Professor of Clinical Midwifery, Thames Valley University), Dr. Richard Porter (Director of Maternity Services, Bath and West Wiltshire) is also appearing as a witness on her behalf.

The fact that a midwife had to go to a higher court for her expert witnesses to be allowed to attend during all of the hearings should illustrate the mAnnr and degree of working obstacles which are in place. This legal precedent illustrates just one of the archaic mechanisms of the FTPC which desperately needs overhauling, another being the fact that all hearings are held 'in- camera', incompatible at this point with the vast majority of European countries. There is some acknowledgement of these deficiencies in the Report of the Commission for Nursing:

"There is a need to give the Board a more clearly defined professional focus and distinct identity. There is also the need to give nurses and midwives a greater sense of ownership and inclusion in its decision making process and activities...The Commission recommends that the profession take greater control over its own destiny through ownership of the Board." (Government of Ireland 1998).

Although the Commission recommends, there is no guarantee that these aspirations will become a reality, or enable the midwifery profession to regulate itself fully. Furthermore, they are unlikely to become a reality while Ann Kelly's case is before the Board's FTPC.

In effect, the professional development of the midwifery profession is greatly handicapped due to the combining of the nursing and midwifery professions in administrative and regulatory aspects. The Central Midwives Board had extended its powers to Ireland in 1918 and continued its regulation in the

new Republic until An Bord Altranais was set up in 1952. Not only were nurses and midwives then combined as an amalgam 'nursing' profession under this new body, but they continued to be dominated by a Board with a majority of medical men, a gender characteristic which persisted for many years.

"Nowhere are the consequences of the lack of representation of midwives more clearly seen than in the Fitness to Practice procedures operated by the Board. Its FTPC enjoys quasi- judicial powers, one of which is the power to deprive a midwife of her livelihood. Midwives who appear before the FTPC are denied the right to be judged by their peers.

"Of the 12 current members appointed to that Committee, only 3 are midwives. Given the separate, autonomous nature of midwifery as a profession, natural justice demands that midwives be judged by members of their own profession." (Independent Domiciliary Midwives, 1998)

These factors strew the path of genuine midwifery with sufficient stumbling blocks. When coupled with the fact that to the Irish obstetric mind any labour which exceeds the 8-12 hour time limit which 'active management of labour' has attempted to establish as being 'safe', is 'dangerous', and any midwife who practises in this mAnnr requires official 'regulation', then you will come near to understanding the tightening vice-grip which independent domiciliary midwives are experiencing at present. We have just a dozen, a very significant dozen - scattered throughout the country.

Domiciliary Pilot Schemes

Ann Kelly's case is being conducted against a backdrop of three domiciliary pilot schemes; one in Dublin, Cork and Galway. They each have a separate approach:

- a Community Midwife approach,
- a Hospital Out-Reach approach
- The "Domino" approach

They are planned to be operational for 2 years, be closely audited, and assessed for viability in the six months following completion of the pilot phase. It is now evident that if home births are to continue they should be conducted very definitely with 'active management' principles in mind. Particular criteria has been laid down by the National Maternity Hospital, during their Domino pilot scheme for transfer during labour.

Not surprisingly, any woman whose labour does not proceed at a cervical dilatation rate of 1 cm per hour should be transferred to hospital. One of the most disquieting aspects of the criteria is that the membranes can be ruptured by a midwife at home, a practice with well defined iatrogenic hazards. If meconium staining (of any grade) is detected this should always be a reason to transfer the mother to hospital.

These criteria are clearly an extension of hospital based practices - 'active management of labour' in the home, and obviously no other template for practice is being considered.

The latest report to be issued on the subject of home births in Ireland is a report to the Chief Executive Officers of each Health Board by an "Expert Group" in May. The group is comprised of an assortment of medical and health board personnel and does not have either a domiciliary midwife or consumer representative who had given birth at home represented on the this national committee.

The only domiciliary midwife involved worked on the design of one of the three proposed pilot scheme in the Western Health Board. This was despite the stated request of the Home Birth Association to the Director of Public Health that they should be involved in "communication, consultation and representation on any task force related to home birth" since they were deeply involved with women who wanted to give birth at home and were therefore deeply knowledgeable of the issues (Home Birth Association of Ireland, 1997).

We in AIMS had also made the same request and added that the author of the only work of evaluation in relation to home births performed in Ireland, Marie T. O'Connor, should be included in this committee (AIMS 1997). Our pleas fell on very deaf ears and the Department of Health have also failed to publish Ms. O'Connor's study (which they commissioned), although they have been asked to do so many times.

In its interim report in October 1997 the "Expert Group" stated that "their findings were a cause of major concern". They also stated that they were "unable to find any evidence of good practice" in relation to the handling of enquiries and official management and supervision of home births by the various health boards. In the same report they recommended:

- a standardisation of existing procedures to an agreed format
- a named officer with responsibility for domiciliary midwifery services in each health board area
- the establishment of an audit group at health board level for maternity services, with a sub- group to oversee the operation of the home birth service in each region

The issue of supervision is a contentious one, and although the Independent Midwives have stated very clearly that: "a clinical midwife advisor should be appointed who would be responsible to the health board for providing on-call information, guidance, and support on a 24-hour basis", the indications are that such a clinical midwife would be outranked and supervised by a Superintendent Public Health Nurse. (This would be just the same as the Chief Health Visitor in any area in the UK supervising domiciliary midwives)

So it remains to be seen if what has happened in other locations will also be our lot. The stated bias from our Dept. of Health against home births has been evident in all women's health publications over the last decade and although submissions and representation had been invited, it is painfully obvious that much of it is purely a cosmetic exercise. Will the "Expert Group" repeat the same unevaluated prejudice against home births, deciding that hospitals are safest?

The grudging exercise of these three pilots came about following the Report of the Maternity and Infant Care Scheme Review Group (1994/1997), and is receiving very minimal funding from the Department of Health. The rationale for allowing three years to elapse before this review was published, a review with definite intentions for the future of home births, perhaps can now be clearly understood. In any form of warfare surprise is a great advantage.

What happens when the allotted time span given the pilot schemes is up, will the funding continue? Will the transfer rate to hospital be so high (due to midwives being unable to make autonomous decisions) that again it can be stated that the "safest place to give birth is in hospital", and that home births are not viable?

There is already evidence of a high rate of hospital births during the Domino pilot based at the National Maternity Hospital. The pilot was proposed to operate only within a five mile radius of the hospital and they have recruited midwives from France and Scotland to fill the vacancies. One Scottish midwife stated that: "In Holles St. there is 'active management of labour' which is different to the systems I previously worked in. Also, the maternity hospitals I worked in had nothing like the 8,000 or so births they have here." But this midwife is prepared to adapt and work within the protocols of 'active management'. (Irish Independent, 20 May 1999)

Have we enjoyed an all too brief renaissance of authentic midwifery here in Ireland? Time will tell. In our submission to the Scope of Practice Project of An Bord Altranais we stated very clearly that 'active management of labour' creates:

- an environment where midwives are prohibited from working as autonomous practitioners
- succeeds in obscuring and confining the scope of authentic midwifery (AIMS, 1998)

Presently, a turf war is in progress for who controls and operates home births. Obviously, from an obstetric viewpoint the home birth option is at a crucial switch point and obstetricians want to determine very definitely its future direction. In addition, it is obvious that they are intent upon retaining credibility in their protocols and securing the final regulation of midwives.

The fact that a national survey carried out by the Economic and Social Research Institute shows that in Ireland, the demand for home birth is a high as 17% must indeed have accelerated (pardon the pun) the urgency to regulate midwives (ESRI, 1996). Obstetricians are increasingly forced to compete with independent domiciliary midwives for private clients.

Ann Kelly vs. the Policy Makers

Ann Kelly's mode of practice gives the lie to relatively long labours always being unsafe, a positive anathema to our hospital based and hospital-minded policy makers. At present the mettle of the independent midwifery profession is being tested in the person of Ann Kelly. But she has many supporters who flock to the various hearings with their babies and their bAnnrs, remaining for hours outside the 'in-camera' hearings, presenting her with flowers, returning the support and love she has given to hundreds of women in labour.

A small frail woman with grey hair, Ann is personifying a struggle which is not only centuries old, but vital in the opinion of many observers to the survival of the autonomy of Irish midwifery in general. There is a growing interest in research based practices and a 'direct entry' midwifery course is being instituted in one of the Dublin universities.

After a week of FTPC hearings which started on the 2lst of June adjournment until the end of September. There is no knowing when this case will finish. It is obvious that a legal partogram is not being employed, but conversely a prolonging of the time span between each legal 'intervention'.

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Note: Ann Kelly welcomes and needs your support. You may visit the website atwww.iol.ie/~raydj/Ann (e-mail annmidwife@tinet.ie) and if you can spare a donation (a prolonged legal labour is costly!) please send it to: The Ann Kelly Fund, Trustee Savings Bank, Princes St., Cork. Acct. no. 990703-30222501.

See also:

Ann Kelly wins supreme court victory - AIMS Journal, Summer 2000 Vol 12 No 2

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