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# Believing in Normal

AIMS Journal, 2008, Vol 20 No 4

*Lee Seekings Norman looks at some of the issues surrounding supportive midwifery*

This edition focuses on some of the dilemmas and issues involved in providing good midwifery care, whether NHS or independent.

The big picture into which autonomous midwifery fits is what concerns all of us: How important it is to have a social and cultural understanding that the health of a mother and baby and family are best protected when childbirth is enabled to be undisturbed. AIMS has always supported and campaigned for midwives to be part of that process and continues to do so. In these politically uncertain times midwifery is straining under the pressure of increasing birth rates, under-staffing (highlighted in the recent Healthcare Commission Report) low morale and burn-out. The continuing presence of midwives who can practice in accordance with the Midwives Rules and Standards, as autonomous practitioners, is extremely important for all midwives and the families they serve. We must continue to support midwives who work tirelessly within and outside the NHS, against so many odds, to keep promoting normal birth. Keeping independent midwifery not just alive but part of the NHS, as a real option for any woman, is another way of supporting all midwives and birthing women. Annie Francis's article, on page 10, looks at the ongoing uncertainty regarding independent midwifery.

Keeping belief in normal birth strong and mainstream is imperative. We may be losing this belief culturally, but by promoting and supporting the care we know has the best rates for normal birth (which includes independent midwifery, home birth, birth centres and midwife-led units) we have the best chance of reviving that belief. There is a public perception that the care on offer must be the best because there is a fundamental belief that healthcare in the UK is amongst the best in the world and that, therefore, it is childbirth and women's bodies which fail. This was illustrated profoundly to me by comments from a student midwife who accused me of promoting 'fairytale' birth. She had started her training 'believing' but after her first experiences on a labour ward her ideal had been shattered. Thankfully, her later experiences, often at home births, reinstated her belief in normal birth.

In this issue pioneering midwives are lauded in the review of the Passionate Midwifery Conference, on page 15, which was an exemplar of women and midwives with common vision sharing skills, knowledge and acknowledging each other's contribution to keeping the art and soul of midwifery (as well as 'clinical' skills) alive. The conference was called in honour of Tricia Anderson, who died in 2007, and who is missed by so many. Tricia coined the midwifery term "drinking tea intelligently" to capture the intensity of midwives' watchfulness when they might appear to be doing little.

Just as there are differing personal needs among women there are differing personal needs among midwives, and if woman-centred care is to have a real chance then we need varying models of care to meet this diversity. If we are to continue to learn about physiological birth then we need midwifery which confidently facilitates pregnancy, labour, birth, breastfeeding and the growth of a confident parent to unfold in their own time without disruption or disturbance of the mother's integrity; midwifery which recognises this period in a woman's life as a rite of passage. This is important for research, the future of childbirth and midwifery, but most importantly, for the long-term wellbeing of women, babies, families and ultimately, populations.

This kind of midwifery is difficult to provide in institutions, even enlightened ones where NHS midwives and managers strive for it. However, most independent midwives work this way as a matter of course and, therefore, facilitate and witness undisturbed birth more often, giving invaluable data on normal birth. A review of the second edition of Soo Downe's book on Normal birth is on page 26.

It is difficult for anyone not behind the scenes in maternity care to appreciate fully the deeply complex issues in providing maternity services. Denis Walsh's article (on page 4) illustrates how institutionalised and medicalised maternity care creates barriers between women and midwives, breeding fear and blame. As Mavis Kirkham's and Ruth Deery's work shows us, midwives' coping strategies in the NHS include being task focused rather than woman focused as one of the only options left besides leaving the profession. The culture of maternity services maintains institutions not individuals. But, unless we create a maternity care system which nurtures our midwives, how can they be expected to nurture women? If women are not nurtured how can they nurture children more fully? Rolla's story, on page 7, touches on this.

Of course, culture changes slowly and if it is to change to meet the needs of its members better, then passionate and proactive leadership in lay groups, government, professional bodies and the NHS, is needed. This leadership must recognise childbirth as the profoundly life altering event that it is and, therefore, the potentially powerful agent for social change that it is. Such leadership has also to recognise the diversity as well as the commonality of humanity, it has to be humane and both politically and sociologically aware. The 'politics of optimism' as coined by Pat Brodie at the Passionate Midwifery Conference also springs to mind.

Increasing public faith in normal birth and providing a maternity care system that supports this is imperative. We can do this by embracing and building on those ways of working which are already

proven to be successful.