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Midwifery - running down the drain

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Beverley Beech looks at the threat to birthing choice in the UK

In 1993 a Parliamentary Report on maternity services, the Winterton Report,1 was published. Those of us who had been campaigning for changes in maternity care jumped for joy (quite literally - the MPs had accepted all but one of the points made in the AIMS' evidence). At last, they produced a Report that highlighted poverty as the major cause of poor birth outcomes and lack of choice. It recognised the social and psychological, as well as physical impact of birth on women and families and called for women to be enabled to make decisions about their care and births, through the provision of less medicalised midwifery care, with midwives taking a leading role in maternity service provision. It recognised that maternity care was overmedicalised, and it concluded that 'there is a strong desire among women for the provision of continuity of care and carer throughout pregnancy and childbirth, and that the majority of them regard midwives as the group best placed and equipped to provide this.'

The Government at the time, however, decided to focus on choice - an issue that is still absolutely central to current maternity care. In 2007, Maternity Matters2 'guaranteed' that by the end of 2009 women would have choice of midwifery care and place of birth. With the end of the year almost upon us these guarantees appear somewhat hollow. The latest National Childbirth Trust survey3 revealed that 95.8% of women do not have real choice between home birth with a midwife, a local midwifery unit (birth centre) or an obstetric unit, and 89% of women live in areas that do not offer the choice of a home birth with a midwife.

Over the years, it has become startlingly obvious that those women who truly are able to exercise choice are mostly those who are cared for by Independent Midwives and midwives working in the community as, for example, in the Albany Practice in Peckham, South London. For those midwives the issue of choice, respecting women's views, and supporting them to birth in surroundings where they feel comfortable are absolutely central. The Albany's stunningly positive outcomes show the impact of careful, continuous, midwifery input which empowers women to make informed decisions. This is also the basis of independent midwifery care and care from midwives who truly respect women and enable them to make decisions. But this ethos appears to be particularly threatening to those working within a system of care that pays lip service to choice and autonomy leading to punitive action being taken against those who do not subscribe to the medically dominated system of care.

While the government appears to be keen to encourage change which will enhance midwifery practice, the forces preventing this from happening, if anything, appear to be even greater. The NHS Information

Centre's latest figures[4] show that national caesarean section statistics have increased yet again to an average of 24.6%, with Imperial College Healthcare Trust achieving the deplorable level of 33.1%. (The World Health Organisation has stated that a caesarean rate over 10% does not improve the health of mothers or babies.)

Trusts are paid for each caesarean section (and £3,626 for one with complications) compared with £1,174 for a vaginal birth. This means that should a Trust vigorously promote normal birth, significantly reduce the numbers of unnecessary caesarean sections, or build more free-standing midwifery units, it would lose substantial amounts of money. Instead of focusing on the relationship between mother and midwife, supporting midwives to provide the skilled midwifery input that has been shown to improve outcomes for women and babies, and increasing the numbers of midwives, the focus has been on improving technological input and team work in an institutional setting.

The King's Fund in 2008[6] reported that an estimated 62,746 safety incidents were recorded in English maternity units between June 2006 and May 2007, with moderate harm in 11% (6,902) of cases; severe harm in 1.5% (941) cases and death in 0.5% (314) cases.[5] At the same time, despite many midwives being unemployed, the maternity services, in England, are 4,000 midwives short, making it impossible for midwives to provide the kind of continuity of care that is needed. This, AIMS believes, is a major element in increased risk and poorer outcomes. Overstretched services, hierarchical structures, and services that do not focus on individual women, cannot provide the safest care possible: instead it provides an environment that encourages and perpetuates bullying of both midwives and women.

Institutionalised bullying

All over the UK midwives are struggling to improve care but they are doing so in the face of a complex interaction between the State running down our NHS services,[6] a hierarchical structure, and a conflict between a social and a medical model of birth. Both midwives and doctors are forced into a system which cannot respect individual initiatives but needs people to conform to the organisational norms and established authority in order to cope with lack of resources and understaffing.[7] Such a system allows institutionalised bullying to flourish. Over the years there has been considerable concern about bullying in midwifery within the services and respected senior midwives, such as Mavis Kirkham and Ruth Deery[8] have written extensively on this problem. However, bullying has become embedded in many of the structures within and surrounding the NHS - extending to supervision and the regulatory bodies.

Double standards

Examination of the cases that have been reported to the Nursing and Midwifery Council (NMC) reveals a disproportionate number of independent midwives, although community midwives are also included in the numbers. Those of us who have assisted women in formulating complaints about their care, and who have followed complaints made by women and health practitioners, are struck by the double standards that appear to exist: when women complain about care they received in hospital following untoward incidents, inquiries are likely to remain internal to the hospital and staff involved are most unlikely to be

reported to their regulatory bodies. However, when untoward incidents happen in the community, it is ver y much more likely that the midwife(s) involved will be referred to the NMC. Of course, AIMS would be just as concerned about inappropriate or poor care from an independent or community midwife as one in the hospital, but what we are concerned with is an equal standard of justice for all.

In Wales, Clare Fisher, a skilled and committed midwife, has been battling against the senior midwives in Health Professions Wales (HPW). From the letters between her and the senior midwives, and from the transcripts of the Nursing and Midwifery Council (NMC) cases, there appears to be a concerted effort to remove the only independent midwife in Wales from the midwifery register. Her case is a disgraceful example of persistent bullying and maladministration (reported more fully onpage 6). Despite a critical Ombudsman report, and repeated complaints to the NMC, those involved are still in place and continue their bullying tactics.

In Dorset, midwife Deborah Purdue was struck off the Midwives' Register. While attending a woman at home during a planned home birth, she discovered that the baby was presenting by the breech and advised the woman to transfer to hospital where Debs handed her over to the care of the hospital staff. There is evidence that the baby was fit and healthy upon arrival at the hospital. It died several hours later following an obstetric breech extraction and extensive resuscitation. The subsequent investigation focused only on Debs' practice during the labour rather than into the hospital staff's management of the delivery itself. Given that mother and baby were well on arrival at hospital, this seems particularly perverse (see page 10).

In Scotland, during the Independent Midwife, Beatrice Carla's case, the chair of the NMC Conduct and Competence Committee spent considerable time advising the other members of the panel about relevant appropriate research and correcting their misconceptions about the benefits of medicalised, routinised care, especially about the use of fetal heart monitoring. It was clear that the lay member and the nurse erroneously believed that continuous monitoring of babies' heart beats must be associated with better outcomes, therefore, the more often the fetal heart is listened to, the better.

A major problem with the NMC is that midwives are being judged by hospital nurses, midwives who have little or no experience of community midwifery, (in Deb Purdue's case the 'due regard' midwife was a labour ward manager) and lay people who have even less understanding. Furthermore, the panels are not required to hear expert witnesses. The consequence is that the panel is either without midwifery expertise or, is reliant on the views of one midwife whose experience can be very out of date or inappropriate to the case being heard. In Clare Fisher's case the midwife panelist, Eunice Foster, repeatedly fell asleep.

Midwives who question routine medical practices, and who support women's decisions to avoid these, appear much more likely to receive sanctions. In addition, issues that would normally be dealt with through midwifery supervision at local level, when a midwife is employed by the NHS (such as note keeping and hand over procedures), frequently appear before the NMC when the midwife works independently.

The re-organisation of the NHS in 1974 transferred midwives from local authority employment to the NHS when they were increasingly required to work in hospitals. As a result, many midwives have lost their midwifery skills. While experienced home birth midwives are often expected to 'update' themselves by having a rotation to the consultant unit where they are 'updated' in obstetric interventions, there is no updating the unit's midwives by rotation to the home birth team where they could learn the skills of attending home births. While the NMC considers that all midwives are capable of practising autonomously and independently the reality is that hospitals' hierarchical management impose rules and regulations, protocols, and guidelines that are medically determined yet, at the same time, the midwives are expected to offer choice, one-to-one care, and respect women's decisions.

Bullying and suspending midwives

The institutionalisation of midwives and the hierarchichal system tolerates bullying and perpetuates the lack of understanding or acceptance of midwifery knowledge because this poses a serious threat to the medicalised service which encourages a fear and dislike of innovative midwives, 'tall poppies', who have to be cut down to size.

The latest example of undermining midwifery and midwives, and institutionalised bullying involves the midwives at the Albany Midwifery Practice, in Peckham, London. King's College Hospital initially, and without warning, suspended the home birth and home labour assessment services in October, and subsequently suspended from duty a long standing, highly experienced, Albany midwife and reported her to the NMC (the NMC has since thrown out the case.) King's then took the unprecedented action of suddenly terminating the contract with the Albany Midwifery Practice, amid huge protests from the community it serves (see page 21). As the perinatal mortality rate among babies looked after by the Albany Practice midwives is 4.9 per 1000, compared with 11.4 per 1000 for the locality and 7.7 nationally; and as the caesarean section rate is below 14.4 % compared with a caesarean section rate of 24.1% at King's (2008 figures), and while the breastfeeding rates among Albany mothers is consistently around 80% at 28 days - way above the local and national rates, the decision to withdraw the service is truly baffling.

Thorough investigations

When a mother or baby dies, or is seriously injured, it is right that there should be a thorough investigation to determine whether or not this was caused by incompetence, misadventure or was an unavoidable tragedy where everyone did the best that they could, but it appears that far too many of

these 'investigations' are primarily designed to criticise a practitioner, invariably the midwife, and then use it as an opportunity to report her, or him, to the NMC. There appears to be an assumption that if the baby dies in hospital the staff will have done everything possible to prevent it, having carried out lots of interventions (many of which may have caused the problem in the first place); but when a baby dies at home the mother, midwife, or both, must be to blame.

Any enquiry is stressful for everyone concerned. Too often we have seen little or no support for the individual midwife involved in a difficult incident (as in Clare's case) and, not infrequently, we have learned that senior midwifery and medical colleagues make comments to the parents designed to alienate them from their midwife(s).

Length of time

Perhaps, one of the greatest injustices is the length of time these investigations and referrals take, and the failure of both the NMC and the Local Supervising Authorities to follow their own rules and regulations. The strain on the individuals and their families constitutes a breach of human rights.

In Deborah Purdue's case she was not suspended and continued to work for four years whilst awaiting her NMC hearing, only then to be struck off the register. Clearly, the local managers after their initial investigation did not consider her to be a risk to women and babies which makes the Conduct and Competence Committee's decision even more questionable.

Clare Fishers case took the NMC nine hearings from January 2006 to May 2008, covering 19 days overall, to come to their questionable decision and impose a five year caution. (see page 6)

AIMS would support any Trust that suspended or disciplined an incompetent midwife or doctor who is a danger to the public, but it appears that too many hardworking, conscientious and competent midwives are being subjected to months, and even years, of uncertainty and further bullying while waiting for their cases to be heard.

British society generally accepts as authoritative the obstetric management of childbirth and midwives. There is an illusion that obstetricians understand normal childbirth, that women can choose the kind of care they want, and that midwives and doctors practice informed consent.[9] Few practitioners, however, understand that the other side of informed consent is the principle of informed refusal. Woe betide the woman who chooses to reject the medical model, who refuses to go into hospital and whose midwife is not willing to bully her into complying. Those midwives, whether working in the community or in hospital, too often find that really supporting women, enabling them to give birth without unnecessary interventions, and practising good midwifery care, is not supported and, should there be a less than optimal outcome, they will find themselves criticised and subjected to intense scrutiny that their hospital-based colleagues, who conform rarely, face.

This injustice will continue while the present system of birth practices, supervision and NMC hearings fail to address the tensions between holistic midwifery care and obstetric management.

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