AIMS For a better birth...

The Witch Hunt

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An International Persecution of Quality Midwifery

This is one of the most difficult journals AIMS has had to produce in recent times. The events of the last few months have sounded the death knoll for midwifery and woman centred care not just in the UK but throughout the world. Included in this journal are examples from around the world of the ongoing witch hunt which threatens to wipe out not only choice but safety and normality in pregnancy and birth.

Although this journal is largely filled with stories of midwives and behind the scenes politics its content is deeply relevant for every woman of childbearing age.

A pregnant woman, possibly picking up a copy of the AIMS Journal for the first time, will probably be unaware of the battles that have taken place over the years to try and change the direction of the juggernaught of obstetric dominated maternity care. As the event of this year have shown, it is like building a sandcastle to hold back the tide.

Most women begin their pregnancies wanting a normal birth. During the course of their pregnancies most will read books and leaflets, buy magazines and watch TV programmes. Some will make birth plans and discuss "choices" with their midwives or GPs. Many will feel a rising sense of panic as what appeared to be a normal life event at first, is increasingly treated like a medical emergency.

Although pregnant women, particularly first time mothers, will have read or heard about routine interventions such as induction, acceleration, fetal monitoring, breaking the waters and epidurals it is unlikely that they will be helped to understand the implications of having any of these procedures. Many simply put their faith in their doctor and midwife. What they may not know is that given the precarious state of midwifery in the UK today - this may not be a wise "choice".

In a large centralised obstetric unit a woman probably has less than a one in ten chance of achieving a normal birth ("normal" being a birth which follows the normal physiological process and has none of the routine interventions mentioned above). If a woman does achieve a normal birth in a hospital it may well be because she was cared for by one of the few midwives practising there.

In today's hospitals many women who call themselves midwives are not deserving of the name. In truth they are obstetric nurses, working their shifts and carrying out the doctors' instructions. Within the hospital structure, any midwife who presumes to practise as an independent practitioner in her own

right, being "with women" and facilitating the normal process of birth, will find herself an outcast.

Such a midwife can quickly become disheartened, browbeaten, worn out and thoroughly fed up with a system which provides inappropriate care for the majority of women. She will find herself swimming against the tide of a system which is supported by a media as ill-informed as the women it caters to, and wedded to the idea that more technology means better care.

Over the years, midwives in different countries have been fighting for their professional reputations, the retention of small community based maternity units and continuity of care provided by a known midwife. Those who have given up trying to change the NHS from within practise independently in the face of constant scrutiny. The smallest mistake will be pounced on, often greatly and publicly magnified. For a midwife living in Ireland or some parts of the USA, the fact that you exist at all will make you a target for disciplinary procedures, often instigated by those doctors who are determined to maintain their stranglehold on maternity care and who feel very threatened by midwives (and indeed woman-centred doctors) who continue to have far better outcomes than they.

While AIMS recognises the unfairness of some disciplinary actions it does not mean that all the midwives brought before the UKCC in the UK are necessarily being victimised. The evidence in the case of Caroline Flint showed that she was guilty on three counts of professional misconduct and it is to be hoped she will be changing her practice to dress the charges that were proven against her.

It is right that a midwife whose standards have fallen below professional standards should be criticised. Reassuringly, and contrary to propaganda, midwives have stringent rules and regulations. Indeed, the general public is unaware that midwives can be reported to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting for professional misconduct. The pity, however, is that other professional groups do not come under the same scrutiny, and indeed do not allow themselves to be subjected to such minute examination of their practices.

Doctors, for instance, can only be reported for serious professional misconduct, which means that it is significantly more difficult to reprimand a doctor than it is a midwife or nurse. This perhaps explains why so few doctors ever appear before the General Medical Council. A sad example of this is the many years and the whole string of serious complaints which passed before gynaecologist Rodney Ledward was investigated and struck off by the General Medical Council for his arrogant incompetence which left hundreds of women seriously damaged.

Nevertheless, just because one midwife has been found at fault, it is grossly unfair to attempt to write off the practices of a whole profession as being a danger to women.

In Ireland Ann Kelly, one of the very few independent midwives, has been hounded by the medical profession (see the Anne Kelly Case). Peter Boylan, the Master of the National Maternity Hospital in Dublin, lodged a complaint about the length of time she had allowed a woman to labour before bringing her into hospital (both mother and baby were fine).

As one of the proponents of Active Management of Labour he believes, with no scientific evidence to support his position, that women should not labour for more than 12 hours. What the great Irish public fail to realise is that having closed down most of the small maternity units and having almost eradicated home birth the National Maternity Hospital faced a huge increase in women who had no choice other than to birth in hospital. As the birth rates increased, the length of labour decreased in inverse proportions. In other words, shortening women's labours was related to throughput, not the interests of mothers and babies. This policy was promoted as reducing the caesarean section rate, which it did not, and was enthusiastically taken up all over the world.

Ironically, Ann Kelly's birth statistics are far better than those of comparable women who birthed in the National Maternity Hospital, but their statistics cannot easily be examined. Last year, Peter Boylan and his colleagues put their statistics under copyright regulation and thereby ensured that they cannot be obtained without the hospital's permission. One wonders what they have to hide?

Time and again examination of statistics reveal that midwives have better outcomes than doctors, yet this does not stop national newspapers claiming that women would be better of cared for by doctors. The most recent Confidential Enquiry into Stillbirths and Deaths in Infancy revealed that obstetricians were responsible for 49% of avoidable mistakes compared with 18% hospital midwives and 6% community midwives.

At one time there were 140 independent midwives practising in the UK, these figures have now fallen to 40. It has long been recognised that independent midwives offer a quality of midwifery care to which all midwives should aspire. We often hear NHS midwives say that because of the rigidity of NHS staffing arrangements they are not able to offer similar quality care.

In recent weeks the English National Board revealed that there is a serious shortage of midwives. What the press has not realised is that this shortage is far worse than the shortage of doctors. Most pregnant women can manage very well indeed without a doctor around, very few will do better without a midwife. The World Health Organisation has recognised the importance of midwives to good quality maternity care when they introduced a campaign to improve infant and maternal mortality rates all over the world by introducing schemes to promote midwifery care. While this has been vigorously taken up in Third World countries it has largely been ignored in the developed world.

Yet developed countries need midwives too. Unfortunately the majority of countries in the developed world have maternity care dominated by doctors and as a result have seen an epidemic of caesarean sections and operative deliveries with no corresponding improvement in outcomes. Indeed, judging from our case files the outcomes are far worse, but while maternal morbidity is largely ignored and unreported it will continue to be nearly impossible to change this domination.

No longer can women expect to be cared for by a midwife they know throughout their labour, instead they are attached to fetal heart monitors or epidurals and left, with their partners, to get on with it. Many midwives are in despair about the sub-standard care they are forced to offer. So many midwifery units

have reduced their numbers of midwives, and deliberately removed the more senior, more skilled (and more expensive) midwives and in favour of newly qualified midwives.

Women are unaware that many of the interventions to which they are routinely subjected are often undertaken because the staff cannot cope with a woman who is slowly and gently labouring at her own pace. Such a woman could well take 36 hours to produce her baby but the propaganda machine has ensured that women believe that a labour should not last longer than 12 hours, and therefore increasingly expect someone to "do something about it" if they fail to produce their long awaited baby within this time limit.

They need not worry. If the woman in hospital does not conform to the timetable she will have a forceps, ventouse or caesarean section and then be further conned into believing that it was all for the best because her body did not function properly and could even have presented a danger to her baby. Some interventions can be lifesavers for the few women and babies who really need them, ironically, those women who most need obstetric care occasionally do not get it because the medical staff are busy involving themselves in labours of women who had no problems until they arrived at the obstetric unit.

Repeated studies have revealed women's needs. They want to have a normal birth with an attendant they know who has looked after them during their pregnancy and who will help them birth their babies and look after them postnatally. Instead, they are offered fragmented "care", teams of anything up to ten midwives and precious little postnatal care.

So where does that leave Mrs Smith who begins her pregnancy wanting a normal pregnancy and birth and has not the slightest idea of why such a simple request should so enrage her doctor and her obstetric nurse, why she finds such a pregnancy and birth so difficult to achieve and what she should be doing to maximise her chances?

It leaves her as a silent individual who has no idea that her experiences are mirrored by thousands of women all over the UK. Silent until she puts pen to paper and complains to the Trusts, the purchasing authorities and the Department of Health (and Frank Dobson in particular).

Unless women complain about care, unless they make choices based on evidence instead of emotional blackmail, and based on their own individual needs and not on "fitting in", "not making a fuss" and being "a good girl" those in control will continue to delude themselves and believe that introducing Higher Level Practice - a new proposal for the reorganisation of midwifery care and standards of 'professionalism' (see AIMS Journal Spring 1999, 11(1): 1-2) - and more centralised obstetric units will solve their problems. In truth the new era of Super Midwives will produce a race of automatons who will know all everything there is to know administration, but who will posses little, if any genuine midwifery skills.

In America women are so desperate to get away from this type of "care" that an unprecedented, and very vocal, unassisted birth movement has sprung up. At this point in time it may be relevant to ask how long before British women begin to do the same, and expose themselves to the risks of such a regime?

True midwifery is a precious gift to pregnant and birthing women. It ensures the safety and well being of the mother and her baby in a way which no technology, however well intentioned, will ever be able to match. As we enter the next millennium, mothers and midwives must accept the single most important truth about midwifery - If we don't use it, we will lose it.