AIMS For a better birth...

# Remaining radical

AIMS Journal, 2010, Vol 22 No 4

*Charlotte Williamson looks at the 90s and the article that she felt most defined AIMS*

Twenty years ago, Nancy Stewart wrote that the aims of AIMS were to provide information and support for individual women and to try to influence the system. Then, as now, AIMS provided information and inspiration through the Journal's articles, reviews of books, reports on what is happening, critiques of research, analyses of official policies and pronouncements, and women's vivid accounts of good and bad maternity care, as they judged it.

Then, as now, AIMS equipped women to think about and to act in the interests of their babies, themselves and their families, as they define those interests. (In 1965, alerted by AIMS, I asked to have my husband present at the birth of our baby and was the first woman who wasn't a doctor's wife to succeed, so letting in all other non-doctors' wives.) Then, as now, AIMS equipped women to sit on local and national professional, ethics, advisory and governance bodies. Without that inspiration and information, the background support that we take for granted, we would be ill-equipped to take part in discussions and debates about maternity care.

These personal and political activities are connected to each other. It is what women tell AIMS about their experiences of maternity care, linked to AIMS' members' knowledge and experience, that makes AIMS an effective patient organisation. An effective organisation and its voice are ever more necessary as obstetric and midwifery practice change in ways that should sometimes be challenged, sometimes supported by us; as some midwives seem unable to distinguish between interventionist and non-interventionist childbirth; as financial constraints increase; and as other interest groups and interests become more numerous and sometimes more oppressive.

AIMS' strength lies in its members' passion and in the expertise they build up. AIMS benefits from a mix of long-term members' dedication and short-term members' freshness of approach. (Some voluntary organisations limit members' terms, so fail to build up expertise and a coherent set of beliefs and objectives. Others allow a few long-serving members to dominate the organisation.) AIMS also probably benefits from its lack of paid staff. Paid staff have their careers to think about and necessarily have different interests from those of the voluntary members. Some staff may be less keen than volunteers to rock the boat. Many organisations that started out as radical challengers to the status quo fade into conformity with it, as they appoint professional staff, paid to do what volunteers did from moral conviction. AIMS also benefits by refusing to ask for money from the government or drug companies. Nothing can harm a voluntary organisation's reputation more than accepting money from suspect

sources, however hard it is to work without adequate funds.

In avoiding these traps, AIMS has remained the same radical organisation that it started from, tackling new issues and persevering with old ones, undeterred by disappointment and opposition. Nancy Stewart's definition of the aims of AIMS is as true today as it was when she wrote it. We have not yet achieved those aims: our work is as important as ever.

## AIMS Journal 1990 Vol 2 No 3




## AIMS Journal 1994 Vol 6 No 4




## AIMS Journal 1991 Vol 3 No 1

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Association for Improvements in the Maternity Services

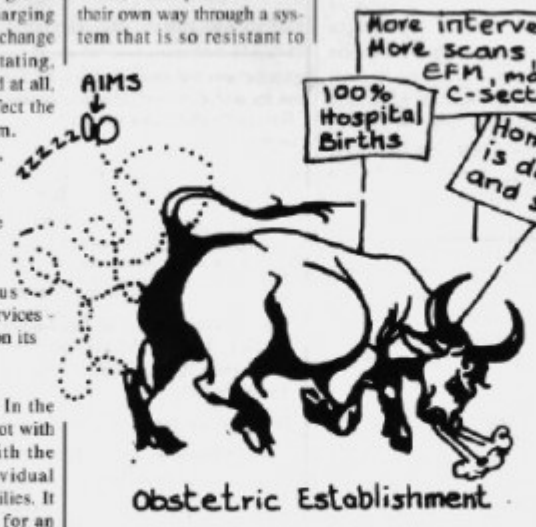
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# What are we AIMing for?

Editorial

The work of AIMS sometimes seems like the efforts of a flea, nibbling the hindquarters of a charging bull in an attempt to change his direction — irritating, perhaps, if it's noticed at all, but hardly able to affect the enormous momentum. So AIMS comments, complains, suggests, and informs, but year after year we see the obstetric establishment - which is almost synonymous with the maternity services - continue undaunted on its path.

Why do we bother? In the end, our concern is not with institutions, but with the experiences of individual women and their families. It is still just possible for an individual woman to obtain the type of care she wants - given that she is sufficiently informed, assertive, and has a modicum of luck. So why do we not concentrate solely on the educative side of our work, to help women find their own way through a system that is so resistant to change?




There are several answers to this. First, the possibility of a woman choosing other than mainstream obstetric care is always under threat, and a lack of vigilance could mean losing what few options remain. Amanda Ellingworth's personal account (p. 6) shows how difficult it can be to gain information about choices, and what "choice" really means in some hospitals.

We must continue to draw attention to the principles of a woman's right to make choices and to hold ultimate responsibility for those choices. We have not yet reached the point in Britain where, as in America, doctors resort to the courts to force women to undergo caesareans they judge to be necessary (often wrongly, as the cases of normal birth after such proceedings testify). But the same assumption that obstetricians can define the limits of a woman's choice apply here on many levels. A doctor- such as Pauline Bousquet

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Liz

# EDITORIAL

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who based her practice on women as individuals and resisted the tide of obstetric technology more than a decade ago, was hounded out of her position with the initial claim that she was "incompetent" - a clear case of the obstetric establishment defining the choices they would make available to women.

Even the draft Midwifery Act, as Marjorie Tew points out in her letter in this Journal (p. 3) can be seen as perpetuating the present system whereby women's choices are strictly limited. Making attendance by anyone other than a registered midwife or doctor illegal maintains a monopoly for an obstetric-based system which currently holds firm control over what is judged to be acceptable, and therefore made available to women. Certainly the competence of care-givers is a concern, but must the medical definition of competence circumscribe women's rights to choose? A second reason we must go beyond helping to equip individual women with the tools to negotiate the maternity care they want is that being successful in the current system can be an enormous task. We are expecting women, over a period usually less than nine months, to become expert in the pros and cons of obstetric techniques, to their own satisfaction if not to the doctors'; be able to weigh up the complexities of scientific research and its implications (which can tax even the most dedicated followers, such as in the Bristol trial of third stage—see p. 4); learn their legal rights and how to ensure they are fulfilled; become confidently assertive; and at the same time put aside probably a life-long respect for authority and learn to give greater credence to their own instincts about what is best for them.

It's a tall order, and though some women may manage it all, for many others it will only be learned the hard way after one or more unhappy or damaging experiences of becoming a mother, while many more will accept what is on offer and just be glad to put their experiences behind them afterwards. This is not good enough, and it is only by continuing to question, and whenever possible foster alternative visions of, maternity care that AIMS can hope to affect the situation for the majority of women. Our work is important on both levels—in providing information and support for individual women, and in influencing the system which affects so profoundly the kind of choices that most women see as open to them.

**Nancy Stewart**

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## NOTHING CHANGES

In 1865 James Edmunds, M.D., wrote to the 'Times' about his researches into mortality in childbirth in London during the previous five years. He concluded that women attended solely by midwives were far less likely to die from 'puerperal causes' than those who could afford to call in 'educated and skilled medical men'.

His concluding paragraph shows how little progress has been made in the intervening 125 years: "The remedy is to separate the general practice of midwifery from that of medicine and surgery, and this can be done best by encouraging the employment of women in the general practice of midwifery with the understanding that they call in obstetric physicians to that small percentage of cases which really require any serious interference."

*THE TIMES*
*OCTOBER 10th 1865*

## MEMBERSHIP FORM

I would like to join AIMS/renew my membership. I enclose a cheque/P.O. (payable to AIMS) for:

(Institutional Membership paid via an agency is subject to a £6 surcharge)

| | | | |
|---|---|---|---|
| £10.00 | Membership including Journal | £15.00 | Groups and institutions |
| £8.00 | Journal only | £12.00 | Overseas members |

Please delete as appropriate and send to:

**Nadine Edwards, 40 Leamington Terrace, Edinburgh EH10 4JL.**

Name .....

Address .....

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..... Telephone No. .....

If a new member how did you hear about AIMS?

*If you would like to help AIMS but feel you cannot afford the membership fee, please send what you can. We do not want to debar anyone from membership on account of low income; above all we value your involvement and support. Thank you.*