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Attacks on Midwives, Attacks on Women's Choices

Nadine Edwards, Jo Murphy-Lawless, Mavis Kirkham and Sarah Davies ask whether it is a Human Rights issue

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Midwives in the UK today are facing immense pressures. This article will argue that if women's rights and choices in childbirth are to be respected and strengthened, it is essential that midwives themselves are cared for and valued.

We acknowledge that if there are serious concerns about a midwife's practice, these should be examined, in order to protect the public. These cases should be judged against the Midwives Rules and the Nursing and Midwifery Council (NMC) Standards. This article, however, is concerned about the growing dominance of managerial and obstetric control and the enforcement of standard packages of care which vastly diminish midwifery practice and women's options for birth. Furthermore, it is argued that this climate has led to the isolation and scapegoating of many midwives. These midwives are often the very midwives whom women have described as exceptional for their holistic and woman-focused care,[1] and who have often been at the forefront of extending midwifery knowledge and skills[2,3,4,5,6,7]

Background context

Government policy promises choice, but is prepared to offer very little to women outside large consultant-led units that are understaffed and about which there are increasing safety concerns related to high levels of intervention and insufficient staffing (BBC Panorama 2011[8] and Jo Murphy-Lawless's article on page 22). These concerns include:

- the decreasing midwife to birth ratio, due to a rising birth rate, increased complexity of cases,[9] the dropout rate amongst the more-highly educated, newly-qualified midwives,[10] and long-term vacancy rates. Heads of Midwifery confirm their concerns about recruitment and retention as a serious problem [11]
- the numbers of 'near misses' in the maternity services overall[12,13] and the numbers of women giving birth unattended in hospital [14,15]
- the increasing numbers of babies being born to vulnerable women[9]
- stress and heavy workloads which are implicated in the continuing shortage of midwives[10,11]

Additionally, proposals to close freestanding birth Centres on economic grounds (for example Corbar in Derbyshire and Jubilee in Hull) assume that women who currently use these centres can be 'absorbed' into consultant units with no increase in staff.[15] These decisions are increasing pressures on women and

practising midwives who must work in and give birth in centralised maternity units, working in a system of payment by results.16

In this climate, rather than care being tailored to the individual woman any deviation from 'standardised' care now has to be justified.17

A continuation of the 'global witch-hunt'?

In 1995 Marsden Wagner, the then Director of Maternal and Child Health at the World Health Organisation (WHO), wrote an article in The Lancet entitled 'A global witch-hunt'18 In the article, he describes incidents where midwives, often home birth midwives, across many of the high-income countries have been investigated, harassed, prevented from practising midwifery, and even imprisoned. He comments that this often follows the death of a baby: 'One death, even if not preventable and not the result of any mistake, suddenly negates years of impeccable statistics'. He points out that this is not what usually happens to a practitioner in a hospital setting providing medicalised care during birth. His main thesis is that those being scrutinised, victimised and penalised are providing woman-focused care that is research-based and humane, but which differs from the accepted package of the medical model.

Move the clock forward to 2009. In South London in the UK, midwives from the Albany Midwifery Practice attended a woman in labour at home. The birth was normal and straightforward but the baby collapsed at 25 minutes of age. The midwives immediately resuscitated the baby and transferred her to hospital, but tragically she died a few days later. Without carefully investigating the case, the Trust suspended the home birth service the following day, and the Practice's contract with the Trust was terminated a few weeks later, thus closing down an exemplary service that the Albany Midwives had successfully provided for 12 years.7 The records of the women who had been attended by the longest-standing Albany Midwife were trawled through; she was subjected to a lengthy supervisory investigation, and reported to the UK regulating body for midwives, the Nursing and Midwifery Council, by her Head of Midwifery.

At the inquest into the case described above, the Coroner found that there was no evidence of neglect on the part of the midwives. Despite this, the midwife had to complete the previously ordered supervised practice programme of 450 hours (the maximum that can be imposed), and, at the time of writing, the NMC is continuing to investigate her referral. The Trust also maintains on its website that the Albany Practice was closed due to concerns about safety and has so far refused to remove this information, even though the internal audit on which it is based has been independently reviewed and found to be flawed.19 A report on the Practice by CMACE has also been heavily criticised20,21, 22,23

Between a rock and a hard place

Successive governments' policies state that midwives must support women's decisions about their maternity care and in particular must support normal birth where possible. This approach has been written into UK policy documents on the maternity services since 199324, 25,26 Thus, in order to

support women who decide to avoid medicalised care, many midwives have redeveloped and extended a philosophy of midwifery care based on an extensive body of clinical and practical knowledge to support normal birth. A midwife must be able to exercise her professional autonomy and skills base in order to support each woman in her care and meet the standard laid down under Rule 6 of the current Midwives Rules and Standards, which states that the midwife:

'Must make sure the needs of the woman or baby are the primary focus of her practice'

'Should work in partnership with the woman and her family'

'Should enable the woman to make decisions about her care based on her individual needs' 27

The standard seems crystal clear : the woman and her baby must be the midwife's first priority and she must support the woman. In reality the tensions are potentially lethal for women, babies and midwives. As far back as the 1980s, midwives were facing these difficulties. Jan Jennings in 198028 and Jilly Rosser in 198829 were two midwives who focused on the women in their care, both of whom suffered bleeding at home. These midwives transferred the women to hospital in their own cars because they judged that ambulances were not going to reach them quickly and that the women would not receive the urgent help they needed quickly enough. What did they do wrong? They failed to call an ambulance and wait for it to arrive, rather than transferring the women in their own cars.

In 1988 there were no fewer than four midwives under investigation by the UKCC's (the then regulatory body for nurses, midwives and health visitors) Professional Conduct Committee. In each case the outcomes were excellent for the mother and baby following the clinical care and decisions made by the midwives to support women in unexpected circumstances. Yet all were suspended from practice and Jilly Rosser had to take out a High Court proceeding to have her suspension overturned29

Move the clock forward again to 2009. A senior hospital midwife in Paisley, near Glasgow, received a call very late one night while on duty. The call was from a distressed midwife on one of the Scottish islands. The midwife on the island was on her own and attempting to arrange a transfer for a woman who was over seven months pregnant, who had a previous caesarean section, was bleeding and having contractions. The island midwife had already contacted the hospital in Glasgow that covers the island and had been told that it was far too busy that night and was unable to help. The Air Ambulance was insisting that a midwife accompany the helicopter. A number of calls were made back and forth and finally the midwife in Paisley discussed the situation with her two senior midwifery colleagues on duty, carried out a risk assessment, contacted obstetric and paediatric colleagues and decided that they could assist with the transfer and receive the woman and her unborn baby. The midwife went with the Air Ambulance to the island and a successful transfer ensued. The mother later publicly thanked the midwife for her help.30 The midwife however was heavily criticised by her midwifery Manager. What did the midwife do wrong? She followed her Midwives Rules - to put the women and baby at the centre of her care - but apparently failed to follow local protocols, which were unclear, but required her to 'escalate' the problem and also contact her 'Site Controller' who was not a midwife. Presumably, the midwife (like

Jilly Rosser and Jan Jennings) was concerned about the time delay for a woman in need of urgent help, and felt confident that as an autonomous practitioner, she was making a competent decision, having reviewed all the possibilities in an emergency. Common professional expectations require midwives to respond to women's needs, but organisations are primarily concerned with the organisation's needs, and only concerned with women once they are their 'patients'. As Mavis Kirkham describes in herarticle on page 13, this is not about woman-focused care, this is about systems-focused care. Recently, a midwife was even required by managers to do an assertiveness course in order to be able to persuade women to fit in to local maternity protocols. Yet as one midwife pointed out about a woman who did not take her advice, 'She didn't book me to bully her ... She booked [me] ... to get out of being bullied'[31]

What is all this about?

To return to Marsden Wagner's article, he observed that 'there is no apparent slowing of the global witch-hunt'. He predicted correctly: since the high-profile case of Jilly Rosser[29] and the case of Jan Jennings[28] in the 1980s, there has been a steady and increasing stream of midwives reported to the NMC. The NMC states that between 2005 and 2009, 397 midwives were ordered to undertake supervised practice while 120 midwives were referred to the NMC Fitness to Practice Committee. The number of referrals increased between 2007-2008 and 2008-2009 from 29 to 44 midwives. Marsden Wagner describes this phenomenon of persecution as an attempt to exert 'control of maternity systems', by 'display[ing] lack of safety'. This is very clear in the charges brought against midwives who have been reported to the NMC and their Local Supervisor of Midwives over the last few years. Safety is defined as obstetric safety, which in and of itself is not necessarily safe[32,33, 34]and in which midwifery knowledge and skills are largely unrecognised and dismissed. As pointed out by the Department of Health, 'Safety is not an absolute concept. It is part of a greater picture encompassing all aspects of health and well being' [24] but this is frequently ignored. Thus midwives face charges of not carrying out procedures which in fact will not add to the safety of the woman and her baby while the attentive care they do give is not seen as contributing to safety. For example, midwives have been accused of failing to monitor babies' heart rates at 15-minute intervals and after each contraction while the baby is being born, failing to carry out regular vaginal examinations, and/or failing to monitor women's temperatures.

There is no scientific basis for requiring midwives to carry out any of these practices routinely, and in most cases the women had strongly stated verbally and in writing that they did not wish routine care of this kind. Despite this, where these charges have been brought, most of the midwives have been found guilty of misconduct and given lengthy conditions of practice, or have been struck off the NMC register. Many of the charges against midwives providing the non-medicalised care that women requested focused largely on their record-keeping, or on charges that would not have contributed to a different outcome for the baby. To go back to the issue of temperature, for example, in one case, a midwife was charged with not recording the mother's temperature. The midwife agreed that she had not done so, because in her clinical judgement, there was no need to take the mother's temperature and thus none to record. Nevertheless, she was found guilty of the charge of not recording the temperature, and this contributed to a verdict of misconduct. Yet the standard of record-keeping under examination is better

than many records often seen in hospitals. Fur thermore, poor record-keeping, unless persistent, should be dealt with locally, on site. It seems extremely difficult for midwives to get this right: one midwife was told at an NMC hearing that her record-keeping was too good and therefore she could not possibly have written the notes during the woman's labour and birth - despite the woman stating that the midwife wrote up the notes during the labour and in her presence.[35]

Midwives defying rules and regulations - at their peril

We are now experiencing a very complex political environment about health care systems in general. Specifically, in relation to childbirth, this centres on containing and reducing the burden on organisations of risk related to adverse outcomes.[36]' [37] This is leading to increased pressures to contain and centralise practice in accordance with institutional requirements rather than individual need. One midwife told us that she recently visited the unit where she had previously worked. She observed that the midwives there are now required to sign and date a contract in women's notes which says that they will perform a vaginal examination every four hours, and listen to the baby's heartbeat every 15 minutes in first stage of labour and every five minutes in second stage of labour. A rigid adherence to guidelines and protocols has been prioritised over a response to the wishes and needs of individual women whenever and wherever those women's choices are not the same as management-defined 'right' choices.[38] This is most apparent in concerted actions against home birth practitioners, but there is also a pattern of victimisation of midwives within local NHS trusts. Thus while Independent Midwives are particularly at risk, any midwife can face:

- immediate restrictions being placed upon their practice by employers, midwifery supervisors and/or the NMC
- being suspended and subject to internal professional investigation by employers and/or supervisors, without proper safeguards or representation or with anything clear against which to measure their practice
- attacks on the credibility of their knowledge and of their professional practice
- systematic isolation, and where they are employed by the NHS, gagging clauses being imposed
- an unseemly length of time for the investigation process to take place, in which period the selfemployed, suspended midwife is deprived of her livelihood and suffers fur ther from isolation; investigations have been known to take in excess of five years since the precipitating incident
- inadequate support and representation from trade unions and other professional bodies - in the recent Glasgow case, the Royal College of Midwives representative agreed with a midwife's employer that her actions were wrong
- damaging press publicity

This conflict between perceived institutional interests and the professional autonomy of the individual midwife has resulted in a climate of silencing and bullying, to the detriment of midwives, midwifery practice and ultimately of women who are deprived of best professional care. Whenever and wherever skilled practitioners are prevented from providing what women request, 'Women in that community [...]

lose the freedom to choose among a broader set of options for giving birth'18 - many of which have been shown to be beneficial.

Fear and bullying

Returning again to Marsden Wagner's article, even in 1995 the level of fear was palpable, and he gave examples of practitioners who might have spoken out to support accused midwives being intimidated and threatened. While this fear is more overtly prevalent in the US, one UK midwife told us that most of her colleagues were too frightened to give evidence during her hearing, fearing that they would be bullied next. Others have been told: 'It will go badly for you if you turn to outside help' and 'You are not to speak to us except through ...' When women organised support for a midwife, she was repeatedly accused of 'organising a targeted campaign against us'. The cost can be extremely high. The cost to women, as Marsden Wagner pointed out is the loss of options for childbearing, leaving some women feeling that they have no option but to birth without a skilled attendant. The cost to midwives is their livelihood, reputation and health of themselves and their families. One midwife told us that her NMC hearing was the worst experience of her life; other midwives have become emotionally and physically unwell; one midwife asked AIMS not to take up her case as she could feel her health deteriorating just thinking about what had happened; another midwife lost her income, home and health and 'The first thing she knew about the [NMC] trial was by reading it in the press and seeing it on the news'.

We know of at least one NMC case where fur ther charges were added after a hearing had commenced and, like Jilly Rosser, several other midwives have had to appeal to the High Court against striking-off orders. Other midwives, already under severe stress as a result of investigations into their practice, have felt increased anxiety, fear and isolation when required by employers 'not to talk to anyone' about their case. In one instance this precipitated deteriorating mental health.

Undue intrusion into midwives' lives During investigations midwives can also face the problem of their personal medical records being subjected to surveillance at the request of the NMC. These requests are made with the threat that if midwives do not comply in releasing their medical records, they may be referred to the NMC Conduct and Competency Committee with fur ther sanctions because of what is viewed as their non-compliance. This is an area of growing concern. Article 8 of the European Convention on Human Rights states that there must be respect for a person's private life, including 'correspondence'. In line with the convention, Article 8 of the UK Human Rights Act, 1998, states that there must be respect for one's private details which must be kept confidential, including medical records. These actions of the NMC therefore may become the basis for a legal challenge in the future about the undue surveillance of private citizens.

While, as Marsden Wagner suggests, attacks on midwives can lead to solidarity between midwives, and others who share their values, it is very isolating for the individual midwife who bears the brunt of the attack. Babies do die. Tragic losses do occur. The midwifemother relationship should be the basis from which both begin to make sense of this loss. Instead midwives are swept into this quasi judicial process through which they often lose the relationship with the woman that has meant so much to them and to

the woman.39 To be deprived of the relationship with the mother in this way is clearly a Human Rights issue for midwives who bear the fur ther damage to themselves and their working status. All of this puts women and babies at risk: as mentioned previously, more women who want midwifery support are feeling they have no option but to give birth at home alone and more harm and distress are caused all round. Even if out-of-hospital midwifery care was shown to have slightly poorer outcomes than medicalised care in hospital, women should be able to make their own decisions: but medicalised care in hospital is not safer than skilled midwifery care at home or in a birth Centre. Skilled midwifery-led care improves a range of outcomes (women are more likely to breastfeed, feel in control, and be satisfied) and reduces the use of a range of obstetric interventions such as induction/acceleration of labour, regional anaesthesia, instrumental delivery and episiotomy.40' 41'42

What can we do?

The solutions, Marsden Wagner suggests, 'begin with raising the public's awareness of the witch-hunt and its basis in political not medical issues'. His focus on these events as political in nature echoes the long history of witch- hunts which most often took place in the midst of political turmoil where authorities tried women as witches because they saw them as a subversive challenge. This might well be said of our maternity services now (see Jo Murphy-Lawless on page 22). It makes no sense that the same group of government and governmentsanctioned regulatory bodies, such as the NMC, who talk with increasing emphasis on the need for safety in maternity services, make them less safe by attacking midwives. At the time of writing, the National Patient Safety Agency, on behalf of the government, has left a crucial monitoring instrument of maternal well-being, the National Confidential Enquiry into serious morbidity and mortality, with a less certain future, and data currently being collected on an interim basis only. This is a clear example of the fragmentation of our maternity services which has contributed so significantly to the trauma of women and the dilemmas of woman-centred midwives and which continues apace. It is clear that in the broader arenas of government policy, the commitment to womancentred care is a meaningless statement. At the other end of the spectrum, the midwives who are fully committed to the needs of pregnant women, who exercise fully their duty of care, and who work hard to update their skills, challenge these meaningless promises. Therefore, we must challenge processes, at local and national levels, which are jeopardising the ways midwives undertake their obligations. As Beverley Beech has said, the midwife should be able to have confidence in stating: 'You were not there, I was, and I made my clinical decision at the time.' It is up to us to reinforce her sense of confidence.

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