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A Duty of Obedience or a Duty of Care?

Professor of Midwifery Mavis Kirkham looks at who the midwife is serving

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Recent changes in society and in maternity services have had a great impact upon midwives, their management and their supervision. As well as being medicalised and technologised, maternity care takes place within large organisations which regulate the activities of their employees in increasingly great detail. The proliferation of protocols, procedures, policies, clinical guidelines and similar documents aims to lay down what midwives should do in any situation. Whilst not called rules, these documents rapidly fossilise into rules, especially when their uptake has financial implications as in the guidelines laid down by the Clinical Negligence Scheme for Trusts[1] Risk management - the management of the risks which patients bring to Trusts - is seen as requiring increasingly close control over all employee activities.

Research shows NHS midwives are obedient creatures.[2] The more detailed the level of obedience required, the easier it is to get something wrong and the more midwives become fearful of getting something wrong, which makes them more compliant. For example, research on the impact of stillbirth upon midwives showed those interviewed to be fearful, not of providing inadequate support for the grieving parents, but of overlooking some aspect of the complex documentation required in these circumstances. Some of these midwives had been reprimanded for this, which made them and their colleagues more anxious in this regard.[3]

Added to the general fear of birth in modern society and the fear of inaction which underpins the medical model of care, midwives fear of committing organisational sins of omission creates an atmosphere around birth which can destroy the confidence of all concerned. Such fear and anxiety is corrosive and creates the worst possible physiological climate for birth. Midwives fear for their jobs and, with centralised ser vices, the next potential employer is likely to be distant. This means that I cannot name individuals in this article.

All these pressures towards obedience and the need to protect the employing organisation are keenly felt by midwives. Employers want midwives to efficiently process women and provide a ser vice that is formulaic rather than responsive to the needs of individual mothers.Yet midwives[4] and mothers [5] want individualised care in the context of good relationships. Midwives whose care deviates from the local routine in response to mothers can find themselves being disciplined by their employers. This is an incredibly stressful and lonely experience which has damaged many individuals.

In this context, the supervisor of midwives is in a very difficult position. Originally the inspectors of

midwives, supervision was created to ensure that midwives observed the standards required of their profession.6 In 1936 the name was changed to supervisor and the remit was widened to require the supervisor to be a 'counsellor and friend of midwives, rather than a relentless critic' (Ministry of Health Letter 1937, quoted in Jenkins 1995; 52);7 yet she was still required to police the profession. These two requirements create a tension at the heart of supervision, though some supervisors manage that tension creatively and supportively. Now that there is such pressure from employers to ensure that midwives are obedient to local practices, supervisors are under pressure to be inspectors, monitoring and disciplining midwives to fit in with local NHS requirements.

I know a midwife who, after supervisory investigation of a case where the mother wished to birth at home, was required to do an assertiveness course in order to better persuade women to transfer to hospital according to local protocols. When another midwife was in a similar situation, mothers whose home births she had attended wrote letters of support and praised her sensitive care.

Yet when these cases were examined and some found to not exactly fit the local guidelines for home birth bookings, what the mothers saw as success stories were taken as evidence against the poor midwife. Recently two independent midwives have been judged to be in need of 'developmental support' because the supervisor was unhappy with them not following NICE Guidelines on the frequency of auscultation in labour, though the guidelines are not evidence based and the mother did not want these guidelines to be followed. These cases are problematic because there is no clear pathway for appeal against supervisory decisions, unless they involve referral to the Nursing and Midwifery Council.

My own supervisor is excellent and I happily travel a distance for her valuable support and advice. She has recently been sidelined from her senior midwifery position when another reorganisation of local services required her to reapply, yet again, for her post. It is fortunate for me and other midwives that she is still a supervisor. I know another midwife who has recently resigned as a supervisor because she does not want to be 'just a management lackey', though her supervisees hold her in high regard.

Where does this leave maternal choice and the midwife's duty of care? It is my impression that it is just those midwives who listen to individual women and respect their choices who are most likely to suffer disciplinary action from supervision or from their employers. Independent midwives are disproportionately represented amongst those referred to the NMC and they are the group of midwives sought out by mothers who are unwilling to accept the standardised package of care offered to them within the NHS and who seek carers who are highly flexible and supportive.8 In the investigations which followed one case where a baby died, the independent midwife reported being told that she 'listens to women too much' by both a supervisor of midwives and the Nursing and Midwifery Council.8 It is also my impression that midwives who give continuity of care within the NHS, and who thereby come to know and respect the choices of their clients, are also particularly vulnerable to close scrutiny from employers and supervisors. The closure of the Albany Practice in London and the One to One Scheme in Sheffield are examples.

When midwifery managers and supervisors are requiring a duty of obedience rather than care, who is

there to support midwives who listen to women? A friend of mine, facing a disciplinary hearing for supporting a mother's choice, was recently advised by her RCM union representative to take out of her statement her consideration of the dynamic nature of practice and the need for client consent to care to be ongoing and for care to be negotiated in the light of individual women's choices.

Whilst Department of Health policy suppor ts maternal choice,[9,10,11] there have always been locally defined 'right choices' and pressure on midwives to 'go with the flow' of local practices.12 These pressures can provide a rationale for supervision if it is strong and truly independent. Recently, many cases have been brought to my attention where supervisors seem to be enforcing obedience to local practices rather than the Midwives Rules and Standards.

As care becomes standardised and midwives become increasingly obedient, they can even be judged as guilty of serious misconduct because their practice does not fit with the norm. This has happened even when the guidelines underpinning normal practice are not evidence based and a judgement of 'failure to' implement such guidelines implies a power that the midwife does not have over the behaviour of mothers who have made their own thoughtful decisions.13

Rules and routines sustain us, they mean we don't need to think and there isn't time to think about everything. But if everything is governed by rules, we get out of the habit of thinking and that is dangerous. Midwives continue to leave the profession because they cannot practise to the best of their ability and midwives and mothers seek relationships which are increasingly rare in standardised, centralised ser vices. Is midwives' alliance 'with institution' now, rather than 'with woman'?

References

1. NHS Litigation Authority (2008) Clinical Negligence Scheme for Trusts. Clinical Risk management Standards for Maternity Care. London, Willis.
2. Hollins Martin CJ and Bull P (2008) Obedience and conformity in clinical practice. British Journal of Midwifery 16;8.
3. Kenworthy D and Kirkham M (2011) Midwives Coping with Loss and Grief: stillbirth, professional and personal losses. Oxford, Radcliffe.
4. Ball L, Curtis P and Kirkham M (2002) Why Do Midwives Leave? London, Royal Collage of Midwives.
5. Kirkham M (ed.) (2010a) The Midwife-Mother Relationship. Second edition. Basingstoke, Macmillan
6. Heagarty BV (1996) 'Reassessing the Guilty: The Midwives Act and the Control of English Midwives in the Early 20th Century. In Kirkham M ed. Supervision of Midwives, Manchester, Books for Midwives.
7. Jenkins R (1995) The Law and the Midwife Oxford, Blackwell
8. Kirkham M (2010b) Review of cases cared for by independent midwives where a stillbirth or neonatal death occurred. University of Dundee, Department of Nursing and Midwifery.
9. Department of Health (1993) Changing Childbirth: Report of the Expert Maternity Group.

London, HMSO.

10. Department of Health (2004) National Services Framework for Children, Young people and Maternity services. London, DH.
11. Department of Health (2007) Maternity Matters: choice, access and continuity of care in a safe service. London, DH.
12. Kirkham M and Stapleton H (eds.) (2001) Informed Choice in Maternity Care: An evaluation of evidence based leaflets. York, NHS