AIMS For a better birth...

The emperor has no clothes

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Beverley Beech looks at what went wrong with improving maternity care

In 1993 the House of Commons Select Committee published its report of its investigation into maternity care. Finally, we saw that an influential body had understood what women had been saying for years. We expected change; recommendations to be implemented; the quality of maternity care to improve enormously; and we expected women to be cared for by skilled midwives offering care in the women's own homes or in small birth centres, and for obstetric units to care for those women with complications who really needed their care.

So, what went wrong?

The policy of building bigger and bigger units, without any research demonstrating that these units improve care, continued unabated. Midwives moved into universities, where they became skilled at studying and undertaking research, but in the process lost the vision of being 'with woman'; they also lost the skills of attending women expecting babies presenting by the breech, or twins. Some midwives saw the opportunity to establish real birth centres, which were women focused, free-standing and designed to develop midwives' skills; and some supported a growing home birth service for those who did not want to leave their homes for the birth. Slowly, the midwives gained confidence, their transfer rates dropped significantly, women were delighted with the care they received, and their outcomes were far better than those of the centralised obstetric units.

The Albany Midwifery Practice carefully researched its outcomes and was revealed as the Gold Standard for quality midwifery and as a result became a target for closure. Over the years, innumerable numbers of these small midwifery practices and free-standing midwifery units have been closed down, often on the spurious grounds that they were not used enough or that the obstetric unit was short of staff and the midwives were needed there; and, in the case of the Albany, a spurious allegation that they were not 'safe'.

In Wales, a strategy for normal birth was developed with a target of 10% home births. Years later, it has yet to be achieved, but at least they are trying; no other region in the UK gets even close to that figure.

Despite a growing mountain of research demonstrating that one-to-one, case-load, midwifery offers the bestquality care, few areas provide this. Instead, Trusts continue with their policy of centralised obstetric care. More small midwifery units are being closed and protests from local people have little effect. The fact that these large, centralised, maternity units (which even the President of the RCOG acknowledged

as 'baby factories') are understaffed, and inappropriate places for fit and healthy women, is ignored.

But what is the effect on fit and healthy pregnant women? They end up having 'ordinary bad births'. They enter hospital fully expecting to have a 'normal' birth, unaware that fewer than 10% will be successful. Instead of having a confident, supportive midwife with them, they will be left alone for a great deal of the time and when their labour slows or stops they will be pressed to agree to an induction or an acceleration. Instead of being supported to follow their body's signals they will invariably be confined to a bed and soon faced with a forceps delivery or a caesarean section. Battered and bruised, they leave hospital convinced that their body was not up to it, rather than understanding that the conditions in these units present huge barriers to successful birthing. TV programmes like 'One Born Every Minute' and 'The Origin of Us' undermine women's confidence in birth and persist in portraying birth as dangerous, painful, and stressful.

Centralised obstetric care prevents midwives from supporting well-motivated women to have normal births. This is not because there are a few 'bad' midwives out there but because of the systemic, structural and ideological problems these huge obstetric units create. This Journal focuses on the effects centralised obstetric care has on women and midwives. Nadine Edwards summarises the findings of the Confidential Enquiry into Maternal Deaths which highlights that far too many of these deaths were preventable, with symptoms that doctors and midwives should have detected and acted upon; but under our present fragmented, centralised care this becomes almost impossible.

Centralised obstetric care results in a lack of trust in women, the birthing process and midwifery, where policies, procedures and environments, have been set up to measure, check and generally interfere. There is a belief that birth is likely to end badly rather than go well. Few women complain. As Louisa explains on page 8, the trauma of an 'ordinary bad birth' is just too hard to address for many years - a not uncommon experience. Susannah Sweetman and Catherine Rennie describe their first 'ordinary bad birth' and Susannah goes on to describe a beautiful second birth at home, but one that she had to fight for. Fit and healthy women should not have to go through an 'ordinary bad birth' before they can explore the possibilities and arrange a good, straightforward, empowering birth for the next baby. Since the publication of the Winterton Report, we have known what is needed to give women and babies the best chance of a good birth, and the pile of supportive research grows by the day; but we have failed to find an effective means of implementing real change in the face of a medicalised structure that is determined not to change.