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Why Birth Centres Fail

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Mavis Kirkham, Ruth Deery and Deborah Hughes offer a case study

In 2010 we published 'Tensions and barriers in improving maternity care: the story of a birth centre'.[1] This anonymised birth centre was opened following an excellent feasibility study. Its clients were highly satisfied with their care, the building was well suited to its purpose and its original, dedicated staff were recruited specifically to work there. Nevertheless the birth centre was wound down and after only five years, it was closed in 2007.

This birth centre came out of the closure of the local maternity unit. During the public consultation before the closure, the health authority decided to explore the option of a birth centre so that giving birth locally remained an option for some women. The acute trust, responsible for maternity services, was opposed to this plan. However, the health authority proceeded with the feasibility study, which strongly recommended a birth centre, staffed by midwives who were committed to a birth centre concept.[2] Under some duress, the acute trust accepted the plan, despite opposition from many trust managers, obstetricians, general practitioners and midwives.

After studying the views of all those involved we concluded that the birth centre lacked support from local midwives, who were mourning the loss of their local maternity hospital and trying to adapt to working in a more distant centralised unit. They saw the birth centre as a small and ineffective gesture towards keeping maternity services in their town, though, in other circumstances many of them may have supported its woman-centred and midwife-led philosophy. The birth centre posts were advertised externally and appropriate midwives were appointed.

Despite their commitment and initial successes, these midwives gradually left the service because, lacking support from trust management, they were unable to develop the birth centre as they aspired to do. The opening hours of the birth centre were then restricted, community midwives who were already overstretched were required to staff it; bookings decreased and the service spiralled down.

Midwifery managers were given the extra responsibility for the birth centre as well as their existing work. They also had to cope with the ever-changing management tiers above them in the trust, and its constrained financial circumstances. The Birth Centre underwent a rapid succession of changes in its short life, which took it ever further from the model proposed in the feasibility study and accepted by the commissioning health authority. Each intervention exacerbated staffing problems and led to a reduced service for women. No strategic move was taken to defend that service or retain its midwives.

Inter-professional collaboration and trust are regarded as essential for developing a social model of maternity care, promoting physiological birth and improving services.[3, 4, 5] Yet, no one in this study saw it as their role to facilitate the development of such trust and collaboration between professionals. Indeed the evident lack of collaboration around the birth centre served to undermine trust. The Birth Centre midwives themselves had little power to develop the social model of birth at any wider level than their relationships with individual mothers. When their antenatal role was removed and the opening hours of the Birth Centre were restricted, even this central relationship was threatened. This threat to relationships was not acknowledged by management when these cuts in the service were instituted. Indeed some managers argued that these relationships should be curtailed because they were seen as 'elitist' and deviant from the prevailing medical model, rather than as a very different social, midwifery model which could coexist with mutual benefit.

Birth centres have long been established as midwives' territory,[6, 7] where they feel secure, to which they are committed,[8] and which provide a safe base within which they can exercise their clinical skills. The midwives in this study were not able to establish their territory and felt isolated from, rather than integrated with the mother unit, not just geographically but professionally and philosophically. It is difficult for midwives to facilitate safety and empowerment for women if they feel threatened and undermined in their work setting.

This Birth Centre was no one's baby, but it was part of a NHS trust where all those concerned, except for its original midwives, felt that they had more than enough to cope with without it. No one in a position of power championed the birth centre. It seems vital for any birth centre's success that it has champions amongst the powerful in the local community and in the NHS structures in which it is situated. In such circumstances it is scarcely surprising that it failed to thrive. As a result of this research, other studies and our experience of working in birth centres, we made a number of recommendations to help those considering establishing a birth centre, or seeking to retain one.

These included:

1. Birth centres need allies including:
    - Support from committed local service users
    - Midwives who want to work with the autonomy and full use of their skills that a birth centre makes possible.
    - Midwifery leadership and management committed to the birth centre; leadership within

the birth centre with access to senior management and involvement in the forums where the birth centre will be discussed. At least one senior midwifery manager committed to the birth centre, who will support it in management forums and liaise between it and other services.
    - Obstetricians in the unit where transfers are received who understand the role of the birth centre.
    - Supportive GPs
2. Education is important for all involved. Selfawareness and skills of facilitation and relationship are essential for all involved and learning together can be very helpful. Further development on leadership within midwifery is crucial.
3. A clear vision and targets for the birth centre need to be agreed and understood by all of the staff who work in or link with the birth centre.
4. Public relations are important and regular meetings of all those who support the birth centre can ensure smooth running and be able to anticipate many potential problems.

Fear of Excellence

The current market values now underpinning public services create considerable problems[9, 10] The desire to cut costs means that staff use of time is increasingly strictly controlled. In this situation, management, far from striving for excellence, tends to fear it[11] and we hear the terrible arguments for closing birth centres, and other innovative services on grounds of 'equity', meaning the lowest common denominator of service provision. This approach, for those who hold it and for those who battle against it, has the sad result of lowering everyone's expectations of maternity services.[12]

In the reality of the modern, cash strapped NHS, excellence is a distraction and managers are required to use all their energies in coping with budgetary pressures. In this context the medical and the centralised industrial model of maternity care is taken as the norm and the social model of care, as exemplified in birth centres, is seen as deviant. Professional dissonance follows for midwives. There is just no energy to think of a different way of doing things, even where, ironically, it may save money. In a society which fears birth, a fear of difference is evident, as well as a fear of excellence.

Recent Developments

Recently we have seen the closure of many birth centres. Over the years Mavis Kirkham has been to many meetings to defend the birth centres at Darley Dale and Buxton. In the past a rallying of local support and producing evidence of their excellent clinical outcomes has been enough to save these centres from threat of closure. The meetings last year were very different. The funders accepted that these units were centres of excellence yet they were seen as a luxury which could no longer be afforded. It was firmly stated that money could be saved by closing the units which was needed for other services such as coronary care. One cannot argue with the statement that it is cheaper not to provide a service! There was no sense in which money was ring-fenced for maternity services and no-one cared that money

spent on good maternity care now could save on the coronary care budget in future years. Behind all this was the assurance by the local consultant maternity units that

they could absorb the cases that currently went to the birth centres at no extra cost. There seemed to be no concern that those units would thereby be slightly busier and presumably the care given would be slightly worse. Once again, there was no aspiration to excellence or a desire to retain excellence by those who hold the pursestrings. The consultant units had no real interest in the birth centres and the lowest common denominator of service was seen as acceptable. Both these birth centres are now closed, despite massive public opposition locally and their long and excellent histories. This demonstrates that birth centres, like many women-focussed phenomena, are backed by the establishment only when it is easy to do so. In more challenging times, the lack of deep ideological, institutional and political commitment is exposed. This relates to all services for which women are the main beneficiaries, not just birth centres and demonstrates how far feminism (or what remains of it) still has to go to secure women-focussed services for the long term, in good times and bad.13

Despite the official rhetoric of maternal choice, other birth centres have recently closed. There is no strategic assessment of maternity services, simply the lopping of items, such as birth centres, which can be identified on a balance sheet. Never has the gap between the rhetoric and the reality of maternity services been greater.

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