AIMS For a better birth...

# Women and midwives working together

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AIMS members, midwives and doulas attended the AIMS talk in Sheffield at the Showroom Cinema on Friday 24 April, and our speaker Mavis Kirkham, Professor of Midwifery at the University of the West of Scotland, opened with a quote from Margaret Mead:

'Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.'

Good maternity care, good birth and successful breastfeeding have a positive long-term impact on families, lasting at least a generation; continuity of care reduces small-for-dates babies and premature birth, and a reduction in both of these leads to less cardio-vascular disease in later life for the infant; breastfeeding also has a lifetime effect for both mother and baby; and we know that postnatal depression negatively affects educational achievements. Nurturing mothers and babies therefore has a massive value for future generations.

In talking about the primary aim of maternity care, which is providing care that makes a mother feel safe and valued, Mavis pointed out that mother and baby are a unit and if nurtured as a unit they flourish. In all her years of practice as a midwife, Mavis has yet to meet a mother who is not deeply committed to the welfare of her baby. It should be our aim, unless in the most extreme circumstances, to treat mother and baby as a pair and not 'cast them asunder' when it is no longer an intrauterine affair.

Given that the use of technology in birth can cause a negative hormonal cascade, we need to provide a space where mothers feel valued and safe and can achieve physiological birth, which cannot be bettered. This centres on relationships, and there is much research on the benefits of continuity of care; we have created a model of care for maternity that does not promote relationships, and has led to criticisms of staff for lacking compassion.

The dichotomies of expert and patient, hierarchy and control, surveillance and risk assessment, and the notion of 'right course of action' all characterise the medical model of healthcare provision, rooted in our societal values. They all combine to emulate an industrial model, characterised by a focus on efficient throughput, fragmented care, centralisation, economies of scale, standardisation and consumer choice within a culture that generates fear. These models reveal contradictions in relation to birth. The medical and industrial models produce fear and guilt, generate performance anxiety, generalise instead of focusing on the individual; they depend on a right course of action in place of flexibility and tolerance of uncertainty. Where, in contrast, optimal conditions for birth require confidence, love and generosity.

Medical and industrial models focus on the short term, whereas optimal conditions for birth have a multitude of long-term positive impacts.

In discussion with Mavis, we wondered about the impact of these contradictions and how it seems that rather than being in awe of birth, often the atmosphere in the birth arena seems to be in fear of death. She suggests that mothers and midwives can create a midwife-led place of safety for birth and for practice; with continuity of care, as in New Zealand, contributing to the reinvigoration of midwives: a refuge where 'small is beautiful', a community owned and managed hub where relationships are prioritised. There would be an emphasis on continuity, respect and equality, and non-violent communication, dialogue, 'peace and power'. We need to learn to be still and calm and to exude safety and nurturing, while acknowledging that if we set up such a place of safety we will need to maintain it. Medical definitions of safety don't fit these criteria; authoritarian medical models make women powerless; birth centres come and go, winning awards for excellence and then closing.

Mavis's vision is for a strategic nationwide plan and action for a network of Centres for Birth, along the lines of a hospice where the quality of care is paramount and there is an independence from medical treatment. This would first necessitate the difficult task of wresting control over birth away from the medical model.

Secondly, since hospices require large amounts of charitable money, and new parents are unlikely to make bequests or fundraise, it would require non-NHS money and a good business plan to put to commissioners. But the big obstacle would be insurance: insurance companies have an immense impact worldwide on maternity care, partly because of the huge sums of money at stake. 'Nofault compensation' may be one way to proceed, as in New Zealand where in the event of a baby being born with severe disability lifetime care for that baby is assured. Women and midwives can create awareness about insurance control, and a more just situation.

At the end of the evening, as I was leaving, I met the community midwife who had enabled me to birth my second baby at home, 18 years to the exact hour : I was able to express my sincere gratitude and appreciation for her wonderful nurturing and care. As I return to teaching a small active birth class, I am struck by how much fear has been instilled into the women who arrive at my door and I am saddened to see that there is no longer any continuity of care available for these women such as there was for me.