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To be or not to be?

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Beverley Beech takes a look at what women want from supervision

In December 2014 the Ombudsman's report on Midwifery Supervision and Regulation questioned the value of statutory supervision of midwives. His report commented on the failure of supervision at Morecambe Bay to identify and act on poor midwifery practice and expressed concern about the conflicts of interest between the regulatory and supervisory roles of Supervisors of Midwives. This is something AIMS has been concerned about for a very long time. supervisors of midwives are midwives who have undertaken extra training to support midwives, promote excellence in midwifery and protect women and babies from poor practice: they can be an invaluable source of support for those women whose decisions differ from the conventional provision of care.

In the present climate of understaffing and overmedicalised birth, supervisors of midwives exercise a great deal of power ; but are also constrained by their employment regulations and Trust policies. Too many excellent, competent, midwives who have been truly supportive of women centred care have been referred to the Nursing and midwifery Council, often for the most spurious of reasons.

In 1998 Clare Fisher made a formal complaint about a series of investigations, comments and general bullying. Her colleagues questioned the wisdom of this, as they feared she would be victimised, and that is precisely what happened. In contrast, the NMC took no action for bullying and mal-administration against Gillian Harris, the lead SoM at Carmarthenshire NHS Trust, who vigorously pursued unjustified complaints about Clare Fisher to the NMC, and who was subsequently promoted and retired on a pension.

In 2014, following subsequent appeals to the Ombudsman, Clare was exonerated. *'The unfair treatment and maladministration outlined in the DTR remains unremedied. It has caused Ms A significant hardship and injustice over a prolonged period. The failures have affected her career and reputation, caused her to practice in England and have caused her personal anguish...*' He recommended that Clare be awarded £75,000 damages.

In 2013, six years after being illegally suspended by an LSA midwifery Officer, Val Beale, Julia Duthie was finally exonerated by the Nursing and midwifery Council who were required by the Court of Appeal in 2012 to reconsider three allegations of misconduct. The judge overturned the other allegations.

These are but two examples of a number of women-centred, skilled midwives with unblemished records who have appeared before the NMC only, eventually, to be exonerated after years of prevarication and

stress. One of the problems is the supervisory process which, once set in motion, appears to develop a will of its own.

The supervisors are not accountable and the procedures do not allow for any appeal and, all too often, the midwives are told that they are not allowed to speak to anyone about their alleged failings. The Trusts have no right to impose this restriction but, unfortunately, the midwives invariably comply until it is too late and they are on the treadmill.

There are hundreds of supportive, knowledgeable, and skilled supervisors of midwives out there giving the kind of support and encouragement that enhances midwifery skills. In her article Supervision: where now?', (on page 14), Tania Macintosh looks to the future and how midwifery supervision could be developed to bring women and midwives together and offer the support and safe space to empower both midwives and women.

So many women, who make decisions that are challenging to the medical orthodoxy, may spend months battling to get the kind of care they want; it can be a lonely and anxious time, not knowing what to expect and whether the support they need will emerge. very regularly women contact our helpline because they want maternity care that is unusual: this is often a home birth or a VBAC but could be a 'gentle' caesarean section or some specialised advice for a medical condition. It is rare that an appeal to a supervisor of midwives does not solve the problem, by supplying personalised care which responds to the woman's wishes at the same time as providing reassurance for her own midwife.

Sometimes the situation is a very urgent one where the 24 hour availability of supervisors is key: one example last year in South Wales involved a woman who had booked a home birth for her first baby; had declined ultrasound scans; was thought to be six-weeks post term and was put under considerable pressure to accept an induction. When she declined this, two social workers arrived unannounced at her door, demanded to be let in and cross-examined her about the safety of her birth choices. The woman was alone at the time and very alarmed and upset. An immediate phone call to the LSAMO completely transformed the situation: the referral was withdrawn, good midwifery care provided and her baby was born safely and happily at home. It was just as well that she had refused an induction, as her baby was nowhere near six weeks overdue. It is hard to imagine how to handle such a situation without supervisors of midwives making themselves available to women.

While midwives work hard to support and empower women we also have a responsibility to support and empower them. It is only by developing supportive networks of women that we will be able to encourage and promote the kind of woman-centred care we want.