AIMS For a better birth...

A much needed revolution

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Mavis Kirkham explores some of the fundamental changes required for continuity

Don't underestimate the change required to achieve care grounded in relationships. Continuity of midwifery carer results in good outcomes for mothers and babies and it is good for the midwives who provide that care.[1] The Cochrane review based on 15 trials and involving 17,674 women found that women at high and low risk of problems around childbirth who received continuity of midwifery care were 24% less likely to experience preterm birth, 19% less likely to lose their baby before 24 weeks gestation and 16% less likely to lose their baby at any gestation, when compared with women receiving medically-led or shared care. Women receiving this care also had fewer caesareans, more spontaneous vaginal births, fewer antenatal admissions, shorter postnatal hospital stays and their babies had reduced neonatal admissions.[2]

The positive spiral

Continuity of carer creates a virtuous spiral of relationship. Women get to know their midwife and, as trust develops, they feel increasingly able to discuss their worries with her. They feel safe in the familiar relationship at the centre of their care. Feeling safe produces profound changes in blood chemistry: the adrenaline surge produced by the threat of white coated strangers administering tests to women who feel they are on a conveyor-belt is replaced by the oxytocin enhancing experience of feeling nurtured and befriended.

Midwives invest time in learning about their clients and their problems because they will be providing future care and can be of ongoing help to them. These midwives',loyalties focus therefore on their clients and the small team of colleagues with whom they work.[3] This gives midwives job satisfaction and protects them from the uncertainties and fear associated with playing a small role in a large organisation where bullying and constant movement are normal. It also creates a community of practice which fosters learning.[4] Thus midwifery care can flourish and midwives can feel safe in their chosen area of work, rather than constantly meeting new clients and being threatened with being moved to other areas of work. Where midwives feel safe and protected from organisational threats they are thereby protected from frequent adrenalin surges and are rewarded with higher levels of oxytocin. Between carer and client oxytocin levels are highly contagious, thus the virtuous spiral continues. Even in emergency situations, the female responses of 'tend and befriend'[5] can be prioritised.

Obstacles and Contradictions

Prematurity and stillbirth are identified as major problems in this country. Research also shows birth by caesarean section to be linked with major noncommunicable diseases in later life.[5] Given the positive outcomes outlined above, it is logical to assume that continuity of midwifery care would be welcomed and rapidly implemented as an important answer to major health problems, especially as this has been Department of Health Policy since 1993.[6] Yet this is not the case.

Relationship based midwifery care does not fit with modern NHS values and philosophies. It has often been said that if continuity of midwifery care was a drug it would be unethical not to give it to all childbearing women. As it is not a drug, no-one makes a profit from it, and no multinational drug company has an interest in spending vast sums on advertising its good outcomes. Partly because of the efforts of the companies which produce drugs and technological innovations, such products are purchased and used to try to improve health outcomes. Staff costs, on the other hand, are seen as overheads which should be steadily reduced. Yet birth is about relationships and it is relationships which sustain people through major life events. Thus we see a major contradiction between the economic values of our society and its health services, and what we know works around birth.

Within the dominant mindset, efforts to counter prematurity and stillbirth seem still to focus on intensive monitoring of mother and baby and the search for a technical intervention, rather than seeking to foster the environment which best supports mother and baby together. Centralisation, standardisation and market economics have been the dominant concepts in maternity care over recent years. Organisationally, NHS maternity care has been centralised into large units based on an industrial model where care is highly fragmented. Standardisation of services is seen as the way forward. The contradiction with the rhetoric of maternal choice is largely ignored. Indeed we have the ridiculous situation where, should women choose to decline some aspects of care, themmidwife is likely to find she cannot proceed to the next computer screen which records the consultation.[6] NHS management thoughts seem to be focused on ever closer control of the workforce through prescriptive policies, guidelines, protocols etc, though wider management,theory emphasises workers using their skills to the full and exercising the autonomy which links with job satisfaction.[7] Ironically many midwives leave midwifery because they cannot practice as to the best of their ability and make full use of their professional judgement.[8] At management level, there seems to be a fear of trusting midwives to do midwifery and to organise themselves in a professional manner. Yet, in other settings, this can work well with fewer managers and more clinical workers.[9,10]

Beyond the economic and management values that, block efforts to implement continuity of care, I think there are deeper issues concerning power. Care based on technology and drugs makes women into patients and staff into the active players around birth. For all the rhetoric around client choice women and midwives experience there is great pressure to go with the flow of the current model of care.[11] Where supportive relationships can develop, women feel safer and stronger and a good birth is the making of a strong mother. This is not the way to create compliant patients or consumers. Where

midwives' loyalty is to their clients they will advocate for those women rather than being a compliant workforce. An alliance of stroppy women and stroppy midwives is not part of the script for the NHS in times of austerity, cutbacks and managerial dominance.

Money, fear and coping in the short-term

Research suggests that continuity of carer would not cost more because of shorter hospital stays and fewer tests and interventions[12] and because the flexibility of such care can match the input of midwives time to women's needs.[13] The long term savings resulting from the prevention of prematurity and later diseases have never been examined. NHS management is under great pressure to save money in the short term and we therefore see caseloads in existing continuity schemes increased to the point where the midwives involved can no longer provide good care and where their own health is threatened. Under such pressure neither managementnor clinical midwives can plan for long term health improvement.

Women and midwives report fear and bullying within NHS maternity services as currently organised. With, continuity of carer and small teams of self-organising midwives, this could change in a very positive direction. With the will to change, this could improve the wellbeing of all concerned and save money. Where does the will to change come from?

Major Change is Needed

So the introduction of continuity of midwifery care is not just a matter of organisational adjustment. It is a major change in the way care is organised and in the culture and values which underpin that care. The interests of the producers of drugs and technical equipment are dominant, so we spent vast sums electronically monitoring babies' heartbeats in labour and booking women for birth in obstetric units in the face of the research evidence that this is not in the best interests of most of them. We do not implement research which demonstrated the effectiveness of care grounded in relationships. It is evident that the values that underpin commercial organisations are not the right values for public services[14,15] Midwifery and birth are rooted in relationships which flourish in a context of generosity yet the organisational context is one of meanness, doing more for less cost and these values are at the heart of government policy for the NHS.

With successive cuts in services, midwives battle on trying to provide good care but many are so overstretched with just coping that they cannot contemplate long term change. The culture of the service supports the status quo and this is reinforced by fear. As an innovator in a very different area of health care observed '*Culture has tremendous inertia… Culture strangles innovation in the crib.*'[16] Managers are required to '*internalise the market*'[17] and it is a rare midwifery manager who has the vision to look to the long term or who retains true midwifery values. These wonderful women are often bullied by general management.

Management values centralise, standardise and cut staffing. Yet we have the evidence that, for birth, small is beautiful, relationships are of crucial importance and, where relationships can develop, outcomes

improve for all concerned. Change won't come from the vested interests within maternity services, or from tired and oppressed midwives. It will take tremendous pressure from outside the system, then an alliance can be built with midwives to bring about this much needed revolution.

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